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Political Mobilization and Conflict among Western Urban and Reservation Indian Health Service Programs

RODNEY L. BROD and RONALD LADUE

Composed of over three hundred tribes, the American Indian[1] population now numbers more than 1.5 million and consistently has had a birthrate twice that of the United States population.[2] In their attempts to obtain adequate and equitable health care and alcohol and substance abuse services, whether on reservations or in urban areas, American Indians tend to rely upon the American institution called the Indian Health Service (IHS), which is a branch of the Public Health Service located within the United States Department of Health and Human Services. Based on the 1980 census, "59 percent were included in IHS's estimated service population"[3] and were located in the thirty-two reservation states.[4] In 1970, over half (54 percent) lived in rural areas and only one-fourth resided in urban areas,[5] but by 1980 "almost two-thirds of [those] identifying themselves as [American] Indians lived off reservations, tribal trust lands, or other Indian lands," over half (54 percent) lived in metropolitan areas, and nearly "10 percent were on or near reservations that were in or contiguous to metropolitan areas and were served by IHS urban or tribal facilities."[6]

In addition, the estimated IHS service population for fiscal year (FY) 1990 of 1,103,608 American Indians represents a 33 percent increase from 1980 and a 140 percent increase since 1970.[7] Not

Rodney L. Brod is Professor of Sociology, University of Montana, Missoula, Montana. Ronald LaDue is Adolescent Aftercare Counselor, Blackfeet Alcohol Program, Browning, Montana.

only service population increases, but also issues of poor planning, mismanagement, escalating and "catastrophic" health costs, federal budget constraints, and other problems have resulted in smaller delivery, and consequent increased pressures for possible IHS program elimination and change.[8] As the United States congressional assessment concluded in 1986,

> Unlike the previous three decades, where attention was primarily directed at adding new initiatives, hard choices will most likely have to be made among Indian health care programs, either in terms of discontinuing some activities outright or in determining which activities should be cut back more severely than others.[9]

Such health service changes and eliminations likely would be accompanied by difficult issues of IHS program eligibility; they also may be expected to bring about increased levels of inter- and intra-ethnic group conflict and mobilization, particularly among urban and reservation American Indian groups directly and/or indirectly competing with one another for scarce resources. However, these are no longer mere speculations about possible outcomes; rather these events have been and now are occurring in western IHS service area regions of the country where the vast majority of American Indian people (over one million) reside.[10]

The 1980 census indicated that 81 percent of the Eskimo and 57 percent of the Aleut populations were still concentrated in Alaska. "As with the total American Indian population, most of the American Indian reservation population lived in the West (74 percent)"; in fact, five states, Arizona, New Mexico, South Dakota, Montana, and Washington, "contained 72 percent of all American Indians on reservations."[11] It is precisely in these western reservation states that pressures are becoming even more acute, particularly as the Indian Health Service regional apparatus, through its official organizational agents, becomes "socially involved" to the extent that it is the primary factor in generating interorganizational conflict and resulting political mobilization among urban and reservation IHS-funded Indian health and alcohol programs.

AMERICAN INDIAN HEALTH AND POLITICAL MOBILIZATION

In general terms, ethnic mobilization, as opposed to the federal government's historical policy of assimilation (ethnic demobilization), may result when the government's institutional agency "apparatus is not merely something that must 'cope with' the mobilization of ethnic groups, but is at times itself a critical factor in generating such ethnic mobilization."[12] Accordingly, the birth and subsequent expansion of the United States, through the growth of its institutions, while relatively slow, has not been inconsequential in its effects on ethnic affairs. This is especially the case of American Indians, who constitute ethnic groups that historically "were most immediately and profoundly affected" by American state-building activities, particularly those involved in the westward expansion of the state's jurisdiction beyond the Mississippi.

At first, the fledgling American government dealt with "Indian problems" by directly involving its military (a relatively mature institution) and its "Office of Indian Affairs," established in 1824. But as the American state itself expanded and matured, this "office" was moved in 1849 to the newly created civilian institution, the Department of Interior, where it was simply called the Bureau of Indian Affairs (BIA).[13] Shortly thereafter, American Indian political mobilization also was shaped by unilateral United States Indian legislation and policies applied during four major periods of state-building activities: "Assimilation and Incorporation" (1880–1933), "Indirect Rule" (1933–1946), "Termination" (1946–1960), and "Economic Development and Self-Determination" (1960–1980).[14] The shifting character of these state-building activities and Indian policies and, particularly their effects on the development and expansion of pan-Indian political interests (e.g., the "Indian vote," "Indian Power," Indian hiring preferences) and pan-tribal organizations (e.g., NCAI, AIM, CERT) are especially useful in expanding these arguments to federal institutional realms beyond the military and BIA.

Because such reasoning correctly and accurately describes the dramatic effects on interethnic relations by America's earlier state-building efforts through its institutional extensions, the military, the BIA, and their related Indian legislation and policies, similar arguments are extended here to the case of inter- and intraeth-

nic group mobilization effects resulting from the arenas of growth and decline exhibited by that American institution solely responsible for the health care of most American Indians, the Indian Health Service (IHS). That is, the IHS, as an extension of the American state, also has exhibited periods of uneven growth and, more recently, signs of institutional decline as well. Moreover, the impacts of such activities, particularly those of recent decline, on intra- and intertribal group conflicts and mobilization, have been irregular and not particularly well understood.

Along with these more general insights, utilizing the heuristic reasoning of an "open natural systems" approach, in which complex organizations are viewed as "loosely coupled" and reciprocal systems rather than "closed rational" systems, can further explicate the independent nature of politics as a generator of American Indian mobilization and conflict.[15] At this more empirical level of ongoing organizational operations and administrative decision-making, we may better view and comprehend both the unevenness of growth and the decline in the state's political apparatus, and we can appreciate more fully the independent effects of the state and its institutions on minority political mobilization. With these particular arguments, we also can describe and understand more specifically the effects of the institutional growth and recent decline of the Indian Health Service on the political mobilization and conflict brewing among several western urban and neighboring reservation American Indian groups with IHS-funded programs.

INDIAN HEALTH SERVICE PROGRAMS

Since the Transfer Act of 5 August 1954, the Department of Health and Human Services (DHHS), through the Indian Health Service (IHS) of the Public Health Service (PHS), has been responsible for providing federal health services to American Indians and Alaska Natives. In FY 1990, the service population is estimated to be 1,103,608 American Indians and Alaska Natives, a 140 percent increase from the 1970 service population of about 460,000, and a 33 percent increase from the 1980 service population of about 829,000. In both census years, the IHS service population consisted of nearly six out of every ten American Indians in the United States population.[16]

According to the IHS,[17] its mission "is to ensure equity, availability and accessibility of a comprehensive high quality health care delivery system providing maximum involvement of American Indians and Alaska Natives in defining their health needs, setting health priorities for their local areas, and managing and controlling their health program." This current stance has been influenced by several important legislative acts. Since 1975, the Indian Self-Determination Act has built upon IHS basic policy

> . . . by giving Tribes the option of manning and managing IHS programs in their communities, and provides for funding for improvement of Tribal capability to contract under the ACT. The Indian Health Care Improvement Act, P.L. 94-437, passed in 1976, as amended by P.L. 96-537 in 1980, was intended to elevate the health status of American Indians and Alaska Natives to a level equal to that of the general population through a 7-year program of authorized higher resource levels in the IHS budget. Appropriated resources were used to expand health services, build and renovate medical facilities, and step up the construction of safe drinking water and sanitary disposal facilities. It also established programs designed to increase the number of Indian health professionals for Indian needs and to improve health care access for Indian people living in urban areas.[18]

To accomplish these goals from 1980 to 1987, the IHS contract and grant obligations for tribal health grew from $122 million to $211 million, a 73 percent increase.[19] The 1987 figure of $211 million represents a 185 percent increase from 1979 an a 1,111 percent increase over the IHS tribal health budget of 1975.[20] However, as Figure 1 shows, prior to 1980, urban programs represented a ratio equivalent to just over 10 percent of the amount of IHS tribal funding, but since the stated policy began in 1980, the relative ratios or percentages allocated to urban programs have consistently been reduced to about 4 percent of the total amount of IHS tribal obligations in 1987.

Unfortunately, IHS-funded urban Indian health projects implemented pursuant to the 1976 Indian Health Care Improvement Act were "not subject to self-determination contracting because they were not among the functions conveyed to DHHS

by the Transfer Act.''[21] Tribes, on the other hand, were allowed by IHS regulations to administer by grant or by contract the same type of health programs as the IHS itself, but this component of the IHS self-determination program has never been larger than 10 percent of the annual tribal health contracts and grants. Thus, while IHS funding over this period was greatly increasing, with small, but growing amounts contracted directed by tribal health facilities and services on reservations, the percentages of IHS funds reaching urban Indian health programs was decreasing just as critical demographic changes were occurring that inevitably would mitigate and confound these plans.

Not only have the IHS service population numbers been increasing with population growth, but American Indians are residing in urban areas more than ever before. In 1970, over half (55 percent) of American Indians lived in rural areas, with about 20

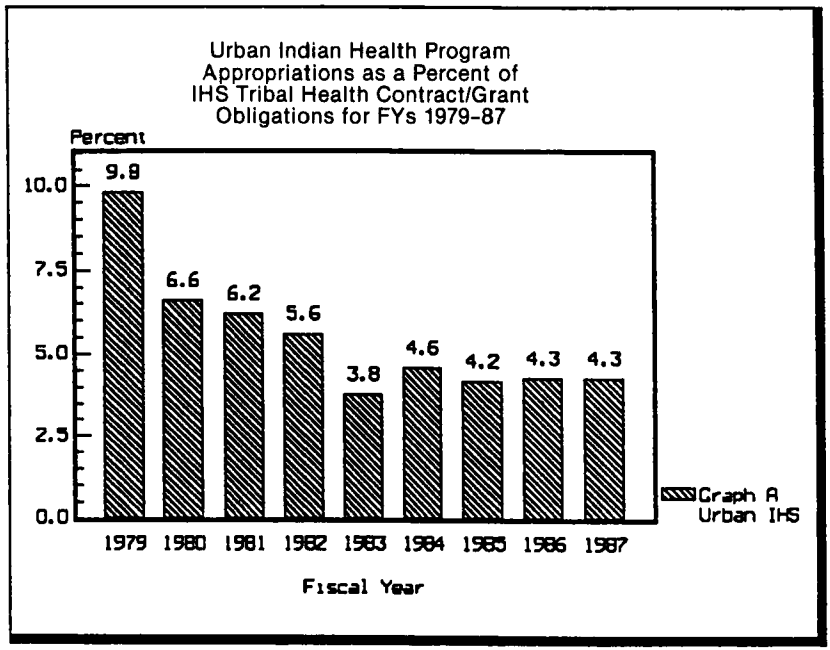

FIGURE 1: IHS, *Chart Series Book* (Washington, D.C.: U.S. Department of Health and Human Services, April 1988), Table 5.2, 55 and Table 5.4, 57.

percent in central cities and one-fourth living in urban areas; however, by 1980, 22 percent lived in central cities and nearly another one-third lived in urban areas outside central cities.[22] Furthermore, given the dismal economic, employment, and educational opportunities on many reservations in the western states,[23] there is little evidence that the trend toward greater urban residence of American Indians will not continue. Considering these general programmatic and demographic conditions, let us discuss urban Indian programs and how they have managed to operate using an extremely modest and increasingly smaller proportional amount of IHS funds.

IHS FUNDING OF URBAN HEALTH PROGRAMS

Overall, "about 10 percent of the Indians identified in the 1980 census were living on or near reservations that were in or contiguous to metropolitan areas," where they were served by IHS or tribal facilities.[24] However, until recently, "IHS-supported programs for urban Indians have always been viewed and treated as separate from IHS's reservation-oriented direct service system."[25]

> In 1972, IHS began to fund urban programs through its community development branch under the general authority of the Snyder Act. Appropriations were subsequently derived from the Indian Health Care Improvement Act of 1976, which authorized urban Indian organizations to contract with IHS to operate health centers and to increase accessibility of Indians to public assistance programs.[26]

Urban programs also have been distinct from reservation-based IHS direct services programs in that the former have emphasized extremely modest budgets under the 1976 Indian Health Care Improvement Act, and that IHS policies exclude urban programs from their self-determination program. In addition, urban Indians have increased access to existing services funded by public and private sources, outside of services directly provided and paid for by the IHS.

> Thus, IHS funds have provided an average of 51 percent of total urban Indian health program funds. Most

> of the programs offer a variety of social services and are "human service organizations." Thirty-two percent of the reported urban program encounters in fiscal year 1984 were medical; 10 percent were dental; 27 percent were health-related (health education, nutrition, mental health, optometry, and substance abuse programs); and 31 percent represented other community service contacts.[27]

Over the years, IHS support, or lack of support, for urban Indian programs has produced conflicts in and among the urban and reservation Indian communities. Until the congressional hearing in March 1985, when they officially retracted their organization's opposition to programs for urban Indians, the National Tribal Chairmen's Association (NTCA)[28] felt, and many tribal chairmen still feel, that

> [w]hen Indians leave their reservations and the jurisdiction of their tribes, they lose whatever degree of tribal affiliation is associated with residence on an Indian reservation . . . [and] that non-tribal organizations such as the non-profit corporations that operate urban Indian programs, should coordinate the services they provide for Indians with tribal governments and elected Indian officials. But coordination of services between urban Indian health projects and area tribes is a formidable task. In some urban centers, there are as many as 40 tribal governments nearby, and representation by tribes on governing boards might include over 80 different tribes.[29]

In contrast to tribally controlled programs which have required tribal enrollment and varying blood quantum standards for eligibility, another somewhat confounding eligibility feature among urban Indian health programs is that these programs often are required by county, state, and other federal sources of funding (the non-IHS funds) to serve populations that contain non-Indians; thus, "IHS regulations do not prohibit its urban programs from serving non-Indians. . . . The only requirement is that . . . the number of Indians served by each program be proportional to the amount of money provided by IHS."[30]

A further confounding factor has been that among major mi-

nority groups, American Indians, both urban and rural, have long been known to have the highest rates of intermarriage with non-Indians; for example, using 1970 census data, Montero found that Indian women (39 percent) and men (36 percent) had the highest rates of intermarriage of any United States minority group.[31] This phenomenon has not led to higher rates of assimilation, however, even in dominantly non-Indian urban areas; quite the contrary, as Steele has found, there is a strong tendency for the non-Indian in such marriages to be socialized and absorbed into Indian culture.[32]

According to Congress,[33] urban Indians and their organizations have always taken the position "that the Federal Government must provide health care and social services to Indians regardless of their chosen residence." While never documenting it, "the Federal Administration has consistently tried to end funding of these programs, claiming that alternative resources are adequate for urban Indians." Nevertheless, "IHS funds serve as core funding that enables the urban programs to seek out and qualify for other sources of care." Thus, without IHS funds, modest as they are, urban Indian centers would not qualify for most other types of funding. In 1986 the United States Congress, Office of Technology Assessment (OTA), concluded the following regarding the appropriateness of IHS funding of urban Indian programs:

> Considering the modest funds that have been appropriated for these programs, past government policies (e.g., allotment and termination) that broke up tribes and encouraged Indians to leave the reservation, and the use of IHS funds to help urban Indians qualify and gain access to other resources, these activities appear to be a logical and appropriate response that is not at cross purposes with IHS's reservation-oriented direct service care system.[34]

Two years prior to this statement (in 1984), there were thirty-seven IHS-funded urban Indian health programs in twenty states;[35] however, as the OTA also pointed out,

> [t]he fact that urban Indian health projects have been funded since 1976 by appropriations under the Indian Health Care Improvement Act, and have been operating under continuing resolution appropriations in fiscal

> years 1985 and 1986 in the absence of reauthorization, indicates that their future is uncertain. The Administration's IHS budget proposals in recent years and for fiscal year 1987 have eliminated funding for urban Indian health projects. The negative effects of the Federal budget deficit on overall IHS funding suggest that priority is likely to be given to maintaining reservation-based direct and contract care delivery programs, rather than to maintaining or expanding urban Indian programs.[36]

While urban funding has continued to some extent, this statement appears to have been somewhat prophetic. Given only a 1 percent increase in IHS appropriations, which, as we have shown, actually represents a 6 percent reduction relative to total tribal funding from 1981 to 1987, and a steadily increasing eligible service population, the case workload in IHS-funded urban programs has steadily dropped from its peak in 1981 of 665,980 to only 451,966 services provided in 1987. This represents a 32 percent drop in the number of total IHS services provided, especially community services (−44 percent), "other" services (−41 percent), and medical services (−21 percent).[37] With the funds for urban programs remaining fairly constant, the decreased workload may be explained in part by the increased costs and reduction of health care and services, but another part of the explanation may be that fewer urban health programs are being funded. As of 1 October 1987, the IHS funded only thirty-three Indian-operated urban projects across the country (11 percent fewer programs than in 1984), consisting of twenty-eight health clinics, and five community services facilities. These health clinics provided a total 434,714 services, while the community services programs provided another 17,252 services to urban American Indians and Alaska Natives.[38]

In this context of health service reduction and tenuous political climate, we now move to a more micro-level analysis of a particular IHS regional area and the recent events that have occurred among some of its urban and reservation IHS-funded health programs.

INDIAN HEALTH PROGRAMS IN THE BILLINGS SERVICE AREA

For FY 1990, 49,648 American Indians from the states of Montana and Wyoming (or 4.5 percent of the total IHS service population) were estimated to be in the Billings area service unit;[39] this figure represents a 39 percent population increase since 1980 and an 83 percent increase since 1970.[40] Although the service population from 1980 through 1985 represented a 20 percent increase, the total IHS budgets for the Billings area during those same years showed a 34 percent increase, reflecting the general push for improved facilities and greater tribal self-determination.

IHS 638 Contracts with Billings Area Tribes

Following the increased IHS 638 or "self-determination" contractual obligations in general, the Billings area increased from its first two awards totalling $469,660 in 1980 to twenty-three awards totalling $4,916,113 in 1985, representing 11.5 times the number of programs and 10.5 times the contractual funds awarded.[41]

Figure 2 shows the growth of IHS 638 contract dollar amounts for fiscal years 1979 through 1985.[42] These 638 contract dollars amounted to only 1.2 percent of the total Billings area IHS budget in the first year (1980), but have increased to 9.5 percent of the 1985 budget. Thus, tribes in the Billings area have not yet taken over the vast majority of responsibilities, partly due to "the IHS position that the administration and support responsibilities of IHS headquarters and area offices usually are not contractible, because such functions are difficult to associate with specific tribes."[43]

Billings Area IHS-Funded Urban Health Programs

In the 1980 census, more than one-third of American Indians in Montana (36 percent) and Wyoming (41 percent) lived off reservation, tribal, or trust land,[44] while more than one-fourth (26 percent and 30 percent, respectively) resided in the urban areas of those states.[45] Nevertheless, the Billings Area Indian Health Service (BAIHS), reflecting the overall IHS policy, has appropriated federal funds with an extremely small percentage budgeted for

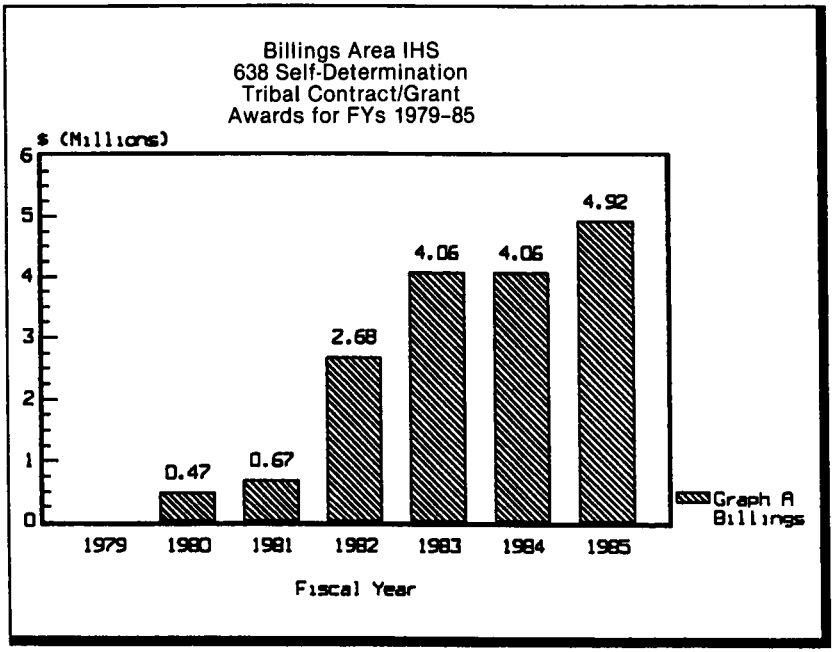

FIGURE 2: Source: U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290, Table 6-3, 219.

urban health programs. For example, in FY 1984, the BAIHS allocated less than 1 percent of its total appropriation, or the equivalent of about 10 percent of its 638 Self-Determination Act tribal contract dollars, to urban Indian programs in seven Montana cities (but none in Wyoming).[46]

Montana Urban Indian Health Programs. For years, urban Indian populations in relatively rural states like Montana with large tribally operated IHS facilities and services felt that their health needs were not being met. After passage in 1976 of P.L. 94-437, the Indian Health Care Improvement Act, Montana urban Indians finally obtained IHS funding indirectly through a contract with an "umbrella" organization called the Montana United Indian Association (MUIA), which then recontracted with member urban Indian groups in Havre, Butte, Billings, Great Falls, Miles City, Anaconda, Helena, and Missoula.

During the period from 1976 to 1983, the umbrella organization of MUIA represented Montana urban Indians' first opportunity to obtain and direct IHS health program funds on their own behalf. Such arrangements were the primary means by which urban American Indians in relatively rural reservation states could fulfill, at least to a small extent, the delivery of health care within the spirit of the Indian Self-Determination Act of 1975. For the first time, through their own efforts, urban Indians in states like Montana could assess and attend to their populations' own health needs and were free to plan and operate their own programs in a "self-determined" manner. As a result, a few of the programs were able to develop vital local health care networking that greatly benefited urban Indian people. But according to the BAIHS director, in Montana, the urban health

> funds were, in essence, divided equally without regard to health need, population, or proximity to greater reservation-based health resources. In 1983, the MUIA umbrella organization was discontinued as a funding conduit and funds were contracted directly with individual urban organizations. . . . During the life of Indian Health Service funding of urban projects, there ha[d] been no unified direction from IHS concerning the types of services that should be provided by the urban projects. In addition, the Indian Health Service ha[d] been lax in insuring the quantity and quality of services provided by the urban programs.[47]

By 1984, IHS directly funded seven urban Indian health programs in Montana, only three of which had been able to attract additional non-IHS funding (local, county, state, and or other federal funding); furthermore, only the program in Missoula had (four) additional sources of funding, such that less than half their program funds were provided by IHS.[48] Currently, there are only five urban Indian programs receiving funds from IHS. Thus, while other urban Indian health projects failed or were predominantly IHS-dependent, the Missoula Indian Alcohol and Drug Service (MIADS) and the Native American Services Agency (NASA), for example, have continuously served the Missoula, Montana urban Indian population for over fifteen years. Both MIADS and NASA have managed to survive the turmoil of policy changes and funding cuts in the 1980s. Much of the credit can

be attributed to both organizations' determination to provide essential alcohol and health services to Missoula urban American Indian people.

From the urban Indian point of view, however, many of their programs were left to fend for themselves in an increasingly competitive and uneasy relationship with their politically larger and stronger reservation neighbors. With fewer federal funds for Indian health, neighboring reservations with large IHS operations began to view competitively the nearby urban Indian health programs and funds, especially after 1983, when these urban programs were placed back under the "benign" but direct control of the Billings area IHS. Thus, an important mechanism of state-building/retrenchment found in the IHS during this particular period consisted of attempts to reestablish greater direct control over constituent minority groups through the "breakup" of Indian-generated, urban Indian umbrella health programs.

IHS-Proposed Elimination of Montana Urban Health Programs. The period following this 1983 decision was marked by further cutbacks and retrenchments in IHS that would directly impact not only the urban operations, but the reservation Indian health programs as well. The deteriorating fiscal situation and P.L. 117, which the IHS pushed through the Senate in 1987,[49] led to increased intergroup competitiveness on the part of the relatively stronger reservations. This competitiveness resulted in the Billings area IHS making its decision in the summer of 1987 to attempt to fundamentally change its urban (and tribal) health delivery. According to the Billings IHS director,[50] the direction of the urban Indian health service delivery was to be changed so as "to maximize the quantity and quality of health services available to Indians in Montana and Wyoming . . ." given that such efforts were "limited by inadequate funds and budgetary guidelines that limit how we can expend appropriated funds." The primary reason offered for this situation by the Billings area director was that it resulted from "the agency viewing the health of urban Indians separate from Reservation Indians." The supposed outcomes of this view were urban health "projects with services ranging from community outreach to physician staffed part-time clinics with great disparity in funding, quality of services, and management." To remedy this situation in Montana, the Billings Area Indian Health Service specifically planned

> to redirect its resources in the urban health budget line item to allow for a defined mix of services in urban communities that are not adjacent to Reservations. Simultaneously, we intend to insure equal provision of services in urban communities that are within service unit delivery areas. The effect of this move will be to increase services to Indians in urban communities throughout Montana. The community of Missoula will become part of the Flathead health delivery area with residents of Missoula, regardless of Tribe, having services equal to members of the Flathead Tribe living on the Reservation.[51]

Thus, without warning or consulting with its urban health programs or service populations, the IHS made plans during the summer of 1987 to "phase out" all urban Indian health service programs in areas adjacent to or near reservations, even though many of these programs had been operating since the early 1970s. According to the IHS plan, reservations such as the Flathead and Crow in Montana, which historically have had responsibilities for providing IHS services primarily to their own eligible members, would become responsible for health service delivery to all eligible Indians (and Alaska Natives) living in all urban areas on and near their reservations. The specific problems identified by the IHS concerning the accomplishment of this task for the urban area of Missoula, Montana revolved around

1. identifying eligible urban (and tribal) Indians,
2. insuring appropriate access to services provided on the Flathead Reservation; (i.e., dental, mental health), and
3. insuring that services presently provided in Missoula to Flathead tribal members would be available to Missoula Indians without consideration of tribal affiliation (i.e., outpatient care, prescriptions, hospital care, etc.).[52]

Concerning the problem of eligibility, at a public hearing in Missoula on 17 February 1988, the IHS director indicated that, based on his own figures which included the 1980 United States census estimates, there were at most only 575 IHS eligible Indians living in the Missoula urban area. In regard to the second and third problems, the IHS director indicated that it was

> not the intent of the Indian Health Service to decrease medical care services to Indians living in Missoula. It is our intent to increase these services and to make arrangements for people to get to Flathead for those services only available there. This will be done by using budget line items available for Reservation health delivery areas for services in Missoula. The impact will be to allow us to move urban budget funds to urban groups not contiguous to Reservations (Butte, Helena, Great Falls) with increased funding for clinical and medical social services.[53]

URBAN INDIAN HEALTH AND ALCOHOL PROGRAM MOBILIZATION

It must be recalled here that urban Indian health and alcohol programs in rural states such as Montana developed because of an historical pattern of neglect from IHS itself and from reservation IHS programs in failing to serve the health and alcohol and substance abuse needs of American Indians living in urban areas. Thus, from the point of view of urban IHS-funded health programs in cities near reservations, news of a "phase-out" of their "mature" and "hard-won" programs and networking came as a total shock. Reinvesting their IHS funds in health and alcohol programs of urban Indian centers not adjacent to or near reservations would certainly help the Indians in those cities. However, due to long histories of conflicts and problems with urban Indians trying to obtain needed IHS services both on and off the nearby reservations, the proposed changes were seen as potentially disastrous from the point of view of the "endangered" IHS programs in urban centers of Missoula and Billings that are located adjacent to reservations.

Endangered Urban Indian Alcohol and Drug Service Programs

Another important impact that the planned IHS phase-out included, but that was not specifically alluded to, concerned the urban alcohol programs in those "endangered" urban Indian centers. Specifically the plans included the phase-out of the urban Indian alcohol programs being supported by the Billings

Area Indian Health Service (BAIHS). Three programs were susceptible to this plan: Missoula Indian Alcohol and Drug Service (MIADS), Butte Indian Alcohol Program (BIAP), and the Thunderchild Intertribal Alcohol Treatment Center (TIAC), Sheridan, Wyoming. From the early to mid-1970s until 1983 and the final "phased transfer" to IHS jurisdiction of 158 Indian alcohol programs,[54] all three of the urban alcohol programs had been serving the American Indian people of their respective urban communities under the jurisdiction of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Not only had these programs legitimized their services through state certification and developed very strong service and political ties to other state, county, and local health and chemical dependency networks, but they also were considered by NIAAA and IHS to be "mature programs."[55]

From the point of view of these and other mature and "solid citizen" urban health and alcohol programs, justification for the phase-out of the urban alcohol programs was based not on program effectiveness, but entirely upon political maneuvering between the Billings Area Indian Health Service and/or several tribes in the BAIHS delivery area. Until the proposed change in the summer of 1987, the BAIHS had recognized the need for urban Indian health care programs that served their respective urban populations in need of alcohol and chemical dependence services. However, based upon tribal politics, new provisions for establishing and coordinating alcohol and drug abuse treatment programs for American Indians in the Anti-Drug Abuse Act of 1986 (P.L. 99-570),[56] along with P.L. 117 which the IHS pushed through the Senate in 1987, the Billings area IHS decided that the Montana urban Indian population did not need their own local programs and resources that directly addressed the alcohol and chemical dependency documented among the urban Native American population. Thus, the Billings area IHS chose to disregard the needs and desires of its urban-based American Indian populations, despite the well-documented facts that Indian people continue to become more urban, and that both Congress and the Indian Health Service (IHS) recognize that

> alcoholism and alcohol and substance abuse is the most severe health and social problem facing Indian Tribes and people today and nothing is more costly to Indian people than the consequences of alcohol and substance

> abuse measured in physical, mental, social, and economic terms. . . . Alcohol and substance abuse is the leading generic risk factor among Indians, and Indians die from alcoholism at over 4 times the age-adjusted rates for the United States population and alcohol and substance misuse results in a rate of years of potential life lost nearly 5 times that of the United States.[57]

More than one-fourth (26.5 percent) of all American Indian mortality in reservation states[58] is the result of "alcohol-related" causes such as accidents (16.0 percent); alcohol (e.g., chronic liver disease and cirrhosis—4.6 percent) or alcoholism (alcoholism, alcoholic psychosis, and cirrhosis), homicide (3.0 percent); and suicide (2.9 percent). These factors directly constitute four of the ten leading causes of Indian mortality in reservation states, according to the Indian Health Service and Congress.[59] In 1985, for example, the Indian age-adjusted mortality rates in reservation states for these "alcohol-related" causes were significantly higher than those for the general United States population: alcoholism (321 percent greater); accidents (124 percent greater); homicide (72 percent greater);[60] and age-adjusted suicide rate (23 percent greater).[61] "Indians between the ages of 15 and 24 years of age are more than 2 times as likely to commit suicide as the general population and approximately 80 percent of those suicides are alcohol-related, . . . [and] are twice as likely . . . to die in automobile accidents, 75 percent of which are alcohol-related."[62]

The IHS has indicated that, essentially, "alcohol abuse may significantly contribute in one way or another to each of [the top] 10 killers of Indian peoples."[63] Consequently, up to 70 percent of all treatment services directly provided by the IHS are expended to treat alcohol-related diseases, injuries, trauma, and sickness; also, between FY 1974 and FY 1977, alcohol abuse "ranked as the number one problem in terms of the number of patients seen by mental health staff within IHS."[64] However, as Congress has recently pointed out, "the Indian Health Service, which is charged with treatment and rehabilitation efforts, has directed only 1 percent of its budget for alcohol and substance abuse problems. . . . This lack of emphasis and priority continues despite the fact that . . . Indian Health Service officials publicly acknowledge that alcohol and substance abuse among Indians is the most serious health and social problem facing the Indian people."[65]

Regionally, the Billings area IHS chief medical officer reported recently that in Montana and Wyoming, the suicide rate from 1961 to 1985 increased 260 percent (i.e., from 8 to 28.8 per 100,000, compared to 12.3 for the United States); the 1985 homicide rate was 29.5 per 100,000, three times the national average.[66] During FY 1988, the Billings area IHS operated on an estimated total budget of just over $60 million; the FY 1989 figure is just over $62,431,000, but in contrast to these total appropriated amounts, relatively meager IHS funding is directed toward urban alcohol and health services.[67]

There currently are eleven alcoholism treatment programs operating in the Billings area IHS service delivery region, nine of which are in Montana, that must share less than 6 percent (or about $3.5 million) of the total BAIHS FY 1989 appropriation to treat a special population that is ravaged by alcoholism and drug dependency. Besides the inpatient facility at Thunderchild in urban Sheridan, Wyoming, which received approximately $450,000 in IHS funds allocated in FY 1989, both of Montana's urban Indian alcohol programs were initially targeted by BAIHS for potential elimination, but especially vulnerable was the Missoula MIADS program, which was "adjacent" to the Flathead Reservation; MIADS ($80,000) and BIAP in Butte ($68,000) together accounted for only about 4.2 percent of the BAIHS urban alcohol dollars and less than 0.3 percent of the total FY 1989 appropriation to BAIHS.[68]

Endangered Urban Indian Health Service Programs

In addition to, but not including, the urban alcohol programs just discussed, for the growing number of urban American Indians residing in the Billings area, there are only five urban IHS-funded health projects, which are all located in the Montana cities of Billings, Butte, Great Falls, Helena, and Missoula. Although more than one-fourth of Montana Indians reside in urban areas, their health projects in FY 1989 received only about $578,700 (or still less than 1 percent of the Billings area IHS appropriated budget) to provide urban health care services.[69]

In July of 1987, BAIHS issued Requests for Proposals (RFPs) from the Missoula, Billings, and Butte urban areas. By issuing the RFPs, the BAIHS was sending up a "smoke screen" to put the urban programs off balance by giving them the (potentially false)

impression and expectation of continued funding by the area office for the next fiscal year. After these urban programs submitted program proposals, the BAIHS recanted and issued its surprise reorganization plan. BAIHS sent phase-out letters in September 1987 to these urban Indian health projects, as well as to the Butte and Missoula alcohol programs. This provided very little time for urban Indian programs to challenge or for IHS to adequately communicate with endangered urban Indian communities regarding the IHS decision to close their programs.

Mobilization of Endangered Urban Indian Programs

These tactics, however, quickly resulted in mobilizing forces among the endangered urban Indian populations that challenged the unilateral decision made by the BAIHS director to phase out the targeted urban Indian health and alcohol projects. The Missoula community, for example, organized a letter-writing campaign that brought support from American Indian members as well as from key professional agencies. Letters and inquiries were sent to Montana's congressional delegation members to address the needs of the Montana urban Indian population from a national level. The federal fiscal year was rapidly coming to a close and no contracts had been negotiated or signed by urban programs. Because of the tremendous outpouring of support gathered in the Missoula, Butte, and Billings communities, the area IHS director succumbed to the initial round of urban Indian political mobilization pressure and extended all the urban contracts for six months.

From October 1987 to February 1988, then, the Missoula IHS-funded programs at Missoula Indian Alcohol and Drug Service (MIADS) and Native American Services Agency (NASA) met with Montana's congressional delegates; these contacts led to meetings with IHS officials from Washington, D.C. and the Billings area office. Also during this time period, a lawsuit was filed by the Billings Indian community as a means of temporarily blocking the area director's decision to close the urban programs. These mobilization efforts resulted in a 17 February 1988 public hearing in Missoula, Montana; officials from the BAIHS and the Confederated Salish and Kootenai Tribes (CS&KT) were invited. The Billings area IHS director addressed approximately forty to

fifty community members, representing all aspects of the Missoula health and alcohol services and the urban Indian community. Official representatives from the CS&KT chose not to attend the hearing; the tribes gave no reason for their absence.

During the February hearing the BAIHS director reiterated his plan to phase out the urban Indian health programs and stated that by his best estimate (based in part on 1980 United States census figures), there were at most only about 575 eligible American Indians residing in the Missoula, Montana metropolitan area. He also stated that a "sizable proportion" of the existing eligible urban Indian population consisted of members of the neighboring Salish and Kootenai tribes. When local Indians and health professionals questioned the veracity of his statements and the use of such statistical sources, the IHS director indicated that he really did not know exactly what the figures were, but since he had no up-to-date research, his office would continue to rely on his own estimates as a basis for planning. Urban community members then suggested that the IHS should conduct or fund a baseline study to obtain more accurate, current data on the Missoula urban area Indian population and health needs. The IHS director indicated that while he would not fund such a study, he would like to receive such data from other sources. This IHS decision left already underfunded local urban Indian health and alcohol programs to fend for themselves in regard to documenting their own IHS eligible population and health care needs.

One important event that quickly followed the February hearing was that the BAIHS called in the urban programs to negotiate contracts to cover the urban Indian health and alcohol programs for the remainder of the 1988 fiscal year. Within a couple of months, the mobilization activities of urban Indians and their endangered programs culminated in their presenting "hard data" from their local, unfunded health study (reported below) to Montana's congressional delegates, which eventually resulted in helping to delay any of the eligibility changes outlined in P.L. 117 until 1 October 1989. Also, the Missoula urban health and alcohol program funding eventually was extended through FY 1989 and beyond. Before discussing the results of that study, however, we will briefly describe some of the Flathead Reservation mobilization activities that followed the February hearing.

RESERVATION HEALTH PROGRAM MOBILIZATION

Although the Confederated Salish and Kootenai Tribes (CS&KT) sent no official representative to the February public hearing, there were tribal health personnel in attendance. After indicating at the hearing that the BAIHS would not fund a study of the urban Indian health service population and its needs, the BAIHS instead provided funds to the reservation-based IHS program for a feasibility study to assist the CS&KT tribes in carrying out the IHS plan for the tribes to take over the full responsibility of providing IHS services for all eligible urban Indians residing in urban areas on or near the Flathead Reservation.

The tribes' reservation-based IHS programs quickly realized that using the BAIHS estimates based on the census undercount of IHS eligibles, they could not reliably estimate the probable size of their health service population and therefore the extent of the tribes' added health delivery responsibility. The BAIHS had also indicated that the CS&KT tribes would have to insure "appropriate access to services provided on the Flathead Reservation (i.e., dental, mental health)" and "that services presently provided in Missoula to Flathead tribal members would be available to Missoula Indians without consideration of tribal affiliation (i.e., outpatient care, prescriptions, hospital care, etc.)."[70] Also, this additional responsibility probably would not be accompanied by any new money for the reservation programs, since the BAIHS director also had gone on record as indicating that the funds saved from the phase-out of Indian health programs in urban areas adjacent to the reservations would be redirected to urban IHS programs not "on or near" reservations, rather than to the affected reservation IHS programs.

Besides the programmatic implications of serving all eligibile Indians and Alaska Natives living in urban areas near the reservation in addition to their own tribal members, there also were the serious legal problems of extending the tribes' power and control beyond the external boundaries of their reservation. Furthermore, the IHS-backed P.L. 117 in the Senate proposed to change both eligibility rules as well as all IHS reservation service unit responsibilities.

In 1987, the IHS pushed through the Senate Public Law 117, designed to change the IHS eligibility guidelines of P.L. 94–437, the 1976 Indian Health Care Improvement Act. This legislation

was scheduled to go into effect by March 1988, but the eligibility rule changes met with opposition from all IHS service units, include the Flatheads'. According to the CS&KT tribal secretary in a recent interview,[71] "what IHS wants to do . . . is to change the eligibility to serve only those people who are members of a recognized tribe and to allow them services at any service area." Again, although IHS has estimated or projected the number of new cases that would be added to the reservation service units, "many tribes are concerned that their numbers are incorrect. Without better funding, coupled with an increase in our service population, people could be left without needed services." For these and probably other reasons, the results of their IHS-funded study and analysis produced a negative assessment and decision on the part of the CS&KT tribes. Thus, the tribes were not willing to take on the added responsibility for providing for the health service delivery to all the eligible Indians living in urban areas near their reservation.

URBAN INDIAN HEALTH STUDY

Meanwhile, in another important urban Indian mobilization response to the BAIHS plan to transfer responsibility for urban Indian health care delivery from the Missoula urban area Native American Services Agency (NASA) and Missoula Indian Alcohol and Drug Service (MIADS) to the Flathead Reservation PHS office, the directors of the MIADS and NASA, along with concerned urban Indians, were the motivating forces behind the development and implementation of an urban Indian health and IHS eligibility study.[72] Previous to this research, there had been three other major health studies performed in the Missoula urban area since 1977.[73] The significance of this is that one of the authors was principal investigator or served as a consultant for all four health studies completed during the period from 1977–1988. Another important point is that one of the authors served for five years as director of the Missoula Indian Alcohol and Drug Service (MIADS) until 1989; furthermore, the other author served on the MIADS board of directors during that period. Thus, when meeting with their congressional delegates, the Missoula urban Indian health and alcohol programs had well-documented, locally generated population and health study data over time to substantiate

their own claims. They mobilized efforts to obtain the specific data needed for checking the veracity of the Billings area IHS claims concerning the problems of urban Indian eligibility, access, and use of reservation- and Missoula-based tribal IHS programs and services.

Methodology

A research team consisting primarily of urban Native American residents and professionals developed a needs assessment instrument used to collect health care information and background data from 250 urban Indian households. This represented a 58 percent sampling of the list of Missoula's 431 urban area American Indian families located, verified, and compiled within a five-week period on a master list.[74] Composed of University of Montana undergraduate students, the interview team was able to obtain a sample that was quite representative (i.e., within 4 percentage points) of the population distribution represented by the master list; that is, about half (47 percent, compared to 51 percent of the master list) were households that contained no university students.

The sample of 250 Missoula urban area Indian households contained a total of 689 persons, over 92 percent of whom were identified as American Indian. Also, 132 households represented about 62 percent of all 212 university Indian students, while the 118 non-student households represented 54 percent of the non-student Missoula Indian families compiled on the master list. It should be clear to the reader that while the master list contained all the households with one or more university students, it obviously did not contain the entire population of non-student Indian households in the Missoula urban area. Only those Indian families in Missoula whose addresses could be checked and verified within the five-week period (the time frame that the project could allot to that activity) were included in the master list. The sample also did not include Indian families from other urban and non-urban areas of Missoula County (for which the Flathead Reservation IHS program also would become responsible under the IHS proposed change). Rather, the sample represented only those Missoula urban Indian families with some programmatic connection or social relationship to the Missoula urban Indian programs (NASA and MIADS) or to the University of Montana.

Given the large numbers of students on the master list, as well

as the differences expected for households of Flathead Indian families, the analysis of data obtained from the sample systematically compared these subgroups statistically and reported any significant differences. The sample size of 250 households represented a standard error of only 3.2 percent, meaning that inferences drawn from the sample would be accurate to within 6.4 percent of the sample results 95 percent of the time, and that 90 percent of the time, the household parameters would be within 5.2 percent of the sample results. Similarly, for estimating percentages for individual demographic data, the total sample size of 689 persons within the households resulted in a standard error of less than 2 percent (1.9 percent); i.e., certainty of population parameters would then be within 3.7 percent of these sample results 95 percent of the time; one would be 90 percent certain that the estimates would be within 3.1 percent of the survey results.

Thus, the excellent participation rates (virtually all Indian families contacted completed interviews), the relatively high proportions of both students (62 percent) and townspeople (54 percent) from the master list who were interviewed, and especially the very high item response rates (92 to 100 percent of the sample completed the survey items) greatly enhanced the interpretations and conclusions drawn from the survey results.

Estimating Urban Indian Population

The 1980 United States census of population reported in 1982 a total of 853 American Indians living in the urbanized area of Missoula, Montana. Of these, 786 were living in households with an average of 2.9 per household, or an estimated 271 households.[75] The following year, however, a two-month survey of Missoula urban Indians by one of the authors[76] identified at least 491 American Indian households in the Missoula urbanized area (181 percent of the 1980 census figure), thus indicating that the United States census figure of 271 had underestimated the number of Missoula urban Indian households by at least 81 percent. Similarly, the 1980 United States census estimated that there were 1,349 Native Americans in Missoula County, with 3.17 persons per household, which resulted in 425 Indian households.[77] In a short five-week period, the study reported here was able to identify 431 Indian households in Missoula alone. With a 58 percent sample of these households, an average of about three (2.8) per-

sons per family was obtained, indicating that the population in Indian households of the city of Missoula in the spring of 1988 was about 1,200 as an absolute minimum, with nearly 2,000 residing in the total urban area.[78] But the actual Indian population obviously was larger, since the 431 identified households did not constitute all of the Indian families in the Missoula urban area, let alone all of Missoula County.

Unfortunately, such discrepancies in the 1980 census figures for the Billings area (Montana and Wyoming) states are typical in Indian country. For example, the United States census Indian population figure for the Billings area underrepresented by 27 percent the IHS Indian population estimate, and for some tribes, the census figure undercounted by more than 50 percent, when compared to the IHS figure; e.g., the census figure underestimated the Rocky Boy Reservation's IHS population by 62 percent. Furthermore, the United States census overall estimate of the Indian population in the Billings area underestimated by 75 percent the December 1981 tribal estimates; the Indian population of some tribes (e.g., Blackfeet, Fort Belknap, and Rocky Boy) in the Billings area were underestimated by more than 87 percent by the 1980 census figures.[79]

Urban Tribal Affiliation and IHS Eligibility

At the 1988 Missoula public hearing, the BAIHS claimed that tribal members from the adjacent Flathead Reservation constituted a "sizable proportion" of the IHS eligible urban Indian population in Missoula, and consequently the Flathead Reservation health program should be responsible for all eligibles, regardless of tribal affiliation. The study demonstrated, however, that among the total interview sample of 689 persons, the most frequent tribal affiliations were Blackfeet (22 percent) and Chippewa-Cree (19 percent); moreover, those identifying themselves as Flathead tribal members constituted only 16 percent of the urban population. Even if an Indian household was identified as Flathead by virtue of containing at least one person from the Confederated Salish and Kootenai Tribes, only one in five sample households would be so designated. For heads of household, the major tribal affiliations again were Blackfeet (25 percent) and Chippewa-Cree (15 percent), followed by Flathead (14 percent), non-Indian (9 percent), and Indians from other tribes (37 per-

cent); similarly, the respective 1981 figures were 23 percent, 17 percent, 16 percent, 14 percent, and 30 percent.[80]

In addition to identifying urban tribal affiliations, another main purpose of the Missoula Indian health survey was to ascertain the extent to which urban Indians were enrolled members of their respective tribes, as this would make them eligible for services from the Flathead Reservation PHS under P.L. 117. The Billings Area Indian Health Service had asserted that only 575 IHS eligible American Indians resided in the Missoula metropolitan area and that "a sizable number" of those eligible were enrolled Flatheads. Over seven in ten (72 percent) of the 640 persons in the interview sample reported being tribally enrolled members. If all of the seven percent who did not indicate their tribal affiliation were included as "not enrolled," then two-thirds of the total 689 Missoula Indian householders were on their tribal rolls. Applying these figures to the 431 Indian households identified in the spring of 1988 indicates that, at the very least, there were 800 to 860 IHS eligible American Indians in the city of Missoula and about 1,340 to 1,420 in the Missoula urban area. However, there were very likely many more, particularly if the other non-reservation urban and rural areas of Missoula County had been included.

Flathead urban Indians also were no more likely than non-Flatheads to be enrolled, so that only about one in six of the Missoula IHS-eligible Indian population was enrolled on the Flathead Reservation. In fact, the only significant household group differences found were among student vs. non-student heads of household; 84 percent of the former (possibly due to tribal education funding being contingent on tribal enrollment status) and 71 percent of the latter were tribally enrolled. Clearly the empirical data did not support the BAIHS claims regarding either the number or the assumed tribal affiliation of the IHS eligible population of Indians residing in the Missoula urban area contiguous to the Flathead Reservation.

Status of Urban Indian Households

To better provide for urban Indian health care, it was felt that planners and administrators also had to take into account the current demographic and socioeconomic status of the Indian households that comprised the potentially impacted urban area where

health and alcohol programs were in danger of being eliminated by the IHS. This study obtained data to support a number of important implications.

Demographically, two in three Missoula urban Indian households were headed by only one adult. Furthermore, over half (54 percent) of the families were headed by a female, and this figure had remained virtually the same over the past dozen years. Typically, non-Flathead student families had lived in the Missoula area for an average of only one to two years, but the modal category for them was less than one year. In contrast, 60 or more percent of the other Indian families had been Missoula residents for three or more years, and over half of the Flathead households (especially the non-students) reported five or more years of residence.

Health planners also would need to consider the fact that about six in ten Missoula urban Indian households were living below the poverty level, with a median annual family income of only $7,155. This occurred despite the fact that since 1981, Indian families appeared to be having significantly fewer children and the households were much more likely to contain a single adult. The level of poverty was primarily accounted for by the fact that over half (51 percent) of the heads of household were unemployed, about the same as the 1981 level. In 1981, heads of non-student Indian households had an unemployment rate of 30 percent; however, the 1988 figure had increased to 42 percent. Substantially more non-Flathead university student heads of household (62 percent) reported being unemployed than did their Flathead peers (48 percent), non-Flathead Indian residents (45 percent), and Flathead townspeople (32 percent). With Flathead households containing more children, per capita incomes were calculated. Nevertheless, Flathead townspeople had significantly higher annual per capita family incomes ($4,194) than did the other three comparison groups, particularly the non-Flathead Indian householder figure, which was only $2,161. Clearly, the socioeconomic levels of these urban Indians would have serious consequences for proposed elimination of urban IHS funding.

Urban Indian Access and Use of Health Service Programs

Missoula urban Indian families indicated that their top health care needs centered primarily on services such as dental (79 percent), optical (60 percent), prescription drugs (50 percent), physical and

routine checkups (48 percent), emergency medical care (38 percent), prenatal/well child clinic services (20 percent), substance abuse counseling (9 percent), and medical specialists (4 percent). However, the high levels of poverty and unemployment among Missoula urban Indian households were reflected in their reported difficulty in obtaining health care outside the Missoula area and their growing dependence upon local Indian-operated programs for immediate health care.

Among urban Indian heads of households, although about 84 percent of the students and 71 percent of the non-students were enrolled members of their tribes, less than one in four indicated that they or family members were in a position where they had to travel to their home reservation for health care. When this did occur, nine in ten of these families reported that travel constituted a hardship. The clear implication is that health care travel away from the Missoula urban area would be economically prohibitive, and therefore unlikely.

Table 1 shows that only about four in ten families indicated having access to services at the Flathead Reservation PHS in St. Ignatius, Montana, but only one-fourth (26 percent) of the Missoula metropolitan Indian families have ever used those services, about the same as in 1981. In contrast to non-Flathead Indian

TABLE I
Health Service Accessed and Used by Missoula Indian Families

Health Program	Access*		Use**	
	Freq.	Percent	Freq.	Percent
Nat. Am. Serv. Agency	110	44.5	68	27.6
UM Health Service	86	34.8	67	27.3
PHS—St. Ignatius	99	40.1	65	26.4
Msla City/Co. Health	105	42.5	47	19.1
Medicaid	57	23.1	46	18.7
Contract Health Care	59	23.9	45	18.3
Msla Alcoh. & Drug	101	40.9	35	14.2
Other Service	28	11.3	28	11.4

Note: Percentages do not add up to 100.
* 247 of 250 households.
** 246 of 250 households.

families' access (36 percent) and use (17 percent), Flathead family use (64 percent) of the St. Ignatius PHS was significantly greater. Interestingly, in contrast to the (74 percent) access reported by Flathead student households, only about four in ten non-student Flathead families indicated having access to those same Public Health Service facilities on their own reservation. The obvious differential levels of the Flathead PHS access and use by families from different tribes, as well as those with differing statuses within the Flathead tribe, appear to have important implications for the ability of the PHS at St. Ignatius to equitably serve families from its own tribe, let alone those from other tribes.

In Missoula, the Native American Services Agency (NASA) was the health program service accessed (45 percent) and utilized (28 percent) most often by Indian families, regardless of tribal affiliation or student status. Furthermore, the utilization had increased dramatically since 1981 when it was only 18 percent. Similarly, about the same percentages reported having access to the Missoula city/county Health Department services (42 percent) and the Missoula Alcohol and Drug Service (41 percent), but only about one-fifth (19 percent) of them had utilized the former program, and just over 14 percent of the families actually had used the MIADS service. Significantly, these access and use figures for MIADS also represented increased access and utilization over the respective 1981 figures of 12 percent and 3 percent.

The unexpectedly low and differential levels of access and use of the Flathead Reservation PHS reported above were in sharp contrast to the equal tribe, student, and non-student access and use of the urban, Indian-operated programs and city/county Health Department services. The significant increased utilization patterns of these urban programs, especially the IHS-funded Missoula urban Indian-operated health and alcohol and drug service programs, indicated that they had become essential to and increasingly critical as integral component parts of the Missoula urban Indian health care delivery system, a point that observant local health-related agencies and officials had consistently reported.

Another health system component consisted of contract health care, which showed access (24 percent) and use (18 percent) levels comparable to those of Medicaid. Compared to Indian townspeople (11 percent), University of Montana students—non-Flathead (33 percent) and especially Flathead (44 percent)—were much more likely to have access to contract health care, and, clearly,

university students also tended to access and utilize the University Health Service. Finally, very few Missoula Indian households (only 6 percent) indicated access to other health care services such as private insurance, and even fewer had private physicians. Given the devastating rates of poverty and unemployment that tend to produce this dismal figure, the Missoula urban area Indian health (NASA), as well as alcohol and drug (MIADS) programs and services, need to be maintained and preferably strengthened to assist the growing Missoula, Montana urban Indian population in obtaining a reasonable level and quality of health care.

CONCLUSIONS: DISCUSSION AND IMPLICATIONS

The study results clearly have dispelled the 1980 United States census estimated Indian population in Missoula County. While the census estimated that there were about 425 Indian households in Missoula County, our five-week survey efforts encountered 431 Indian households, primarily in the city of Missoula, not including the other urban and rural areas of the county. While this difference may be attributed to substantial undercounts on the part of the Census Bureau (which have occurred in many reservation and urban areas), it might also reflect some growth in the Missoula urban Indian population over the past decade.

In either case, utilizing the census figures as the basis for program planning caused gross underestimations of the Native American population, particularly that found in the Missoula urban area. This was precisely the problem that occurred in February of 1988 when the Billings area office of the IHS utilized 1980 census and their own estimates to assert that there were at most about 575 eligible American Indians residing in the Missoula, Montana urban area. When local Indians and professionals questioned the use of such statistical sources, the BAIHS indicated that they really did not know exactly what the figure was, but since they had no updated research, they would continue to rely on their estimate as a basis for planning. When local professionals then suggested that the BAIHS should conduct or fund a study to obtain more accurate, current data on the Missoula urban area Indian population and health needs, the IHS indicated that they would not fund such a study. That BAIHS decision, coupled with

the proposed elimination of IHS support of Indian health programs in urban areas adjacent to reservations, prompted the political mobilization efforts of urban and nearby reservation Indian health programs, both in the Missoula/Flathead and Billings/Crow areas.

Estimating Urban Indian Health Service Populations

The research reported here thus represented a localized form of political mobility and a self-initiated study of the health delivery eligibility and needs of the Missoula urban Indian population. In particular, the study found that at an absolute minimum, the 575 figure that the IHS was using to make major decisions regarding health care delivery for Missoula urban Indians underestimated the eligible population by 40 to 50 percent in the city and by over 100 percent in the urban area. Specifically, the results indicated that in the late spring of 1988, there were at least 800 to 860 IHS eligible American Indians living in the city of Missoula, about 1,300 to 1,400 IHS eligible Indians in the Missoula urban area, and very likely many more. This meant that the BAIHS had underestimated the eligible Missoula urban Indian population by about 126 to 143 percent. Yet these figures are conservative, since our short, five-week data gathering period did not identify all the Indian households in the city of Missoula, let alone all those in the surrounding urban area, as well as other urban areas in the county, for which the Flathead Tribal IHS Program would also be responsible under the BAIHS proposed changes.

Utilizing the erroneous census-based figure of the Billings area IHS, a decision to make the health care of Missoula urban Indians the sole responsibility of the Flathead area IHS would have then placed the Confederated Salish and Kootenai Tribes (CS&KT) in the position of having to take on a much greater burden than they bargained for. Due to the political mobilization of both urban and reservation Indian health programs and to the service area social, cultural, and economic impact studies mandated by P.L. 94–437, IHS eligibility changes in the recent amendment P.L. 117 were delayed until 1 October 1989; specifically, the law requires that with tribal consultation, the IHS must submit social, cultural, and economic impact assessments as well as a fiscal impact study for each service area.

While the IHS has already submitted its fiscal impact study to

the office of the assistant secretary for health, our study has shown that the tribes' worst fears, about underestimating the number and predictability of the new eligible cases that would be added to a particular reservation's service area, are probably well founded. In addition, tribes have had neither the time nor the resources to complete the social, cultural, and economic impact studies on service units that were needed if the rule changes were to go into effect. Tribal governments "were called to meet and develop those projections," explained CS&KT tribal secretary, Joe Dupuis. "And we were supposed to have the answers by October 1, but there is no way for us to complete a study in that time frame. In June, a House appropriation bill deferred the effective date on the rule change until further financial impacts are known."[81] Tribes have asked the Senate to do the same and requested appropriated funds to do all these studies. There obviously will be other issues (e.g., legal) as well should such changes occur, but for sound decision making, the urban and tribal programs need to have more accurate and up-to-date information than the census and IHS estimates have provided thus far.

Implications

The results of this local Indian population health needs study have important implications for those IHS personnel and tribal and urban Indian persons responsible for planning, funding, and administering health care programs for urban American Indian population centers located in reservation states like Montana, particularly if those urban populations are "on or near" Indian reservations.

Urban Indian Population and Health Planning

This study has shown that the 1980 United States census figures have greatly underestimated the Native American population in urban (and rural) areas.

> Planners and administrators of health delivery programs who develop plans based in whole or in part on census figures must be very careful not to underestimate the extent of the urban and reservation Indian populations.

If the BAIHS census-based eligibility plans had been implemented, their results would have created a much greater burden than anticipated on Montana tribes such as the Confederated Salish and Kootenai Tribes and Crow. Similarly, other tribes adjacent to large urban Indian populations may have these same problems if the IHS has its way with eligibility changes contained in P.L. 117. Despite a recent proposed plan for obtaining "alternate counts" in the summer of 1990 and using ethnographic studies to assess the behavioral causes of undercounting, the 1990 decennial census figures are not likely to greatly improve in regard to undercounting of Indian populations.[82]

> Indian health care planners and administrators need to devise or obtain more reliable population estimates in order to provide soundly-based and adequately-funded health delivery systems for urban (and rural) American Indian populations.

In this regard, the IHS decision not to fund urban Indian assessments left already underfunded local urban Indian health and alcohol programs to fend for themselves in documenting their own population and health care needs. Furthermore, the IHS has not provided additional funds to tribes to implement mandated social, cultural, and economic impact studies on service areas potentially affected by P.L. 117.

> Health care delivery, particularly large-scale planning and proposed changes in urban and reservation Indian health care as well as alcohol and drug service programs, must be based on well-designed and fully-funded population, fiscal, social, cultural, economic and health needs assessment research.

In retrospect, the results of this unfunded, locally generated, urban Indian study suggest that the IHS positions and proposals in these instances were at best mistakes, or worse, further examples of "unplanned planning."

Urban Indian Household Demographic Changes

The results of this study indicate that to provide better urban Indian health care, IHS and health planners and administrators must take into account the current and changing demographics and the devastating socioeconomic status of urban Indian families.

> In particular, health planners and administrators must take into account the fact that Indian populations are becoming more urban and more dependent upon local urban Indian health and alcohol programs. Congress and the IHS therefore must reconsider recent IHS policies of reducing urban Indian health program funding, of "phasing out" urban programs adjacent to Indian reservations, and of changing eligibility so as to make Indian reservation IHS health programs responsible for any and all members of federally recognized tribes.

In addition, health planners and administrators must take into account the fact that a majority of urban Indian households tend to be below the poverty level and headed by a single adult who is likely to be female and unemployed, and that the unemployment rate of urban Indian heads of households probably has increased since 1980.

> Therefore, any proposed changes in eligibility and/or location of IHS-funded Indian health and alcohol services must provide the additional resources necessary to insure that poverty-stricken urban Indian populations will have full and equal access and use of such IHS-funded health and alcohol programs and services.

Urban Indian Health Care Service Needs

Urban Indian families continue to report high levels of health care and service needs in the areas of dental, optical, prescription drugs, physical and routine checkups, emergency medical care, prenatal/well child clinic services, alcohol and substance abuse counseling, and medical specialties. Unfortunately, except for dental services, the number of IHS medical, community, and "other" services has been steadily declining.

> While the types and levels of health needs of urban Indians may vary from one area to another, health care programs and services that address these specific urban health needs must be adequately designed, funded and/or maintained.

Even though most urban Indians in our study were enrolled members of their tribes, few traveled to their home reservation for health care; almost all reported that doing so was a hardship.

> Program planners and administrators must consider the unemployment, poverty, and resulting unlikelihood of urban Indian families obtaining health care by traveling away from that urban area.

Only about one in four urban Indian families reported having access to and actually utilizing the adjacent Flathead Reservation PHS facilities. In contrast to non-Flathead Indian families' relatively meager levels of access and use, urban Flathead family use of these facilities was significantly greater. Also, in contrast to the high levels of access reported by Flathead university students, urban Flathead families had relatively low levels of access to the PHS on their own reservation.

> As they evaluate the ability of the reservation PHS programs to equitably serve Indian families from their own tribe as well as those from other tribes, Indian health planners and administrators must consider the serious implications of inter- and intratribal differences in the levels of reported program use and access.

Our study has shown that, over time, local urban health service programs have become the most accessed and utilized by all types of urban Indians, regardless of tribal or student status. Similarly, urban Indians have come to depend on local city/county Health Department services and urban Indian alcohol and drug service programs. Furthermore, the utilization levels of these local Indian urban programs have significantly increased since 1980.

> Indian health program planners and administrators must consider that IHS-funded urban programs like the mature Indian-operated health and alcohol and drug programs have become increasingly essential and crucial components of the urban Indian health care delivery system, and that rather than a policy of status quo or, worse, program elimination, these programs require increased levels of IHS funding to reflect their increased use levels.

The study found that only about 6 percent of the Missoula Indian households indicated having access to private insurance or private physicians. Furthermore, Missoula Indian families had devastating rates of poverty and unemployment, showed an in-

ability to travel outside the area to obtain health care, reported differential and relatively limited access to and use of the IHS on the nearby Flathead Reservation, and indicated continued and growing dependence upon and utilization of local urban Indian health care services.

> Contrary to the recent IHS proposed eligibility changes, the results of this study have demonstrated the urgent need for continued and strengthened support of the urban IHS-funded Indian programs and services now operating, particularly those mature programs that already have a long, demonstrated record of positive results.

Urban Indian Health Care Research Needs

The research reported important differences in health care needs and delivery among Flathead, non-Flathead, student, and non-student subgroups. There are many other important subgroup comparisons that should be studied to assist Western urban (and rural) Indian populations in obtaining an adequate level of health care and alcohol and drug counseling and services. Areas of growing concern are the health status and health care needs of two important groups: Native American youth and elderly.

> Since little is known about the special needs of the growing number of elderly Native Americans, and this is especially true regarding the urban Indian elderly, further analyses of relevant study data must be funded to ascertain the extent and types of health status and special health care delivery needs and problems of Indian elderly.

Recent work by Finley[83] has carefully documented that in comparison to local and national Indian and non-Indian levels, alcohol and drug abuse among Missoula Indian junior and senior high school students occurs at significantly greater levels. These students also started their abuse patterns at significantly earlier ages (i.e., in elementary school), a key fact that local intervention programs in the junior and senior high schools fail to address.

> Analyses of the special health care service needs of the urban Indian youth are therefore warranted; such analyses, along with those of Finley and others, will aid

greatly in obtaining the funds necessary for critical alcohol and drug prevention programming directed at serving urban Indian youth, particularly those at the elementary school level.

Indian Health Service and Indian Mobilization Research

Drawing on the theoretical ideas of Enloe, Nagel, Weick, and others, an initial but partial theory has been outlined here regarding federal institutional growth and decline and their potential impacts on intra- and intertribal group mobilization. Mobilization among Indian health service programs was argued to result from the growth and recent decline of the Indian Health Service, that arm of the federal government specifically mandated to deliver health and alcohol services to over two-thirds of all American Indians and Alaska Natives residing in the United States. Specifically, we have shown how recent retrenchment on the part of the IHS and one of its western regional service areas has resulted in empirically demonstrated consequences for the levels and types of political mobilization and conflict reported among both urban and reservation Indian health programs, and ultimately on this federal agency's ability to influence, operate, and deliver adequate Indian health care and alcohol services.

Additional critical research is needed, however, regarding the initially expanding and now declining roles of the IHS and their relationship to Indian political mobilization and conflict, in order to clarify the underlying causal mechanisms and conditions operating in this vital area of Indian health care and its delivery to urban as well as to rural and reservation areas.

While the primary study reported here began as a result of political mobilization efforts of concerned urban Indian people, it is their and our hope that this expression of ideas, research, and implications will become an important, useful initial source for achieving improved levels of health care delivery and alcohol and drug service programming for all American Indians and Alaska Natives.

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NOTES

1. For purposes of discussion, the term *American Indian* will be used to refer to persons from American Indian and Alaska Native nations.

2. Philip A. May, "Motor Vehicle Crashes and Alcohol Among American Indians and Alaska Natives," in *The Surgeon General's Workshop on Drunk Driving: Background Papers*, Office of the Surgeon General, U.S. Public Health Service (Washington, D.C.: U.S. Department of Health and Human Services, June 1989).

3. U.S. Congress, Office of Technology Assessment, *Indian Health Care* OTA-H-290 (Washington, D.C.: U.S. Government Printing Office, 1986), 36.

4. "A State is considered a 'Reservation State' if IHS has responsibilities within the State." Besides Montana, there are 31 other states that are considered by the IHS to be "Reservation States"; see Indian Health Service, *Chart Series Book*, 4.

5. Office of Technology Assessment, *Indian Health Care*, 64.

6. *Ibid.*, 36.

7. Indian Health Service, *Chart Series Book* (Washington, D.C.: U.S. Department of Health and Human Services, April 1988), Table 2.1, 13; Office of Technology Assessment, *Indian Health Care*, Table 4-3, 88.

8. Office of Technology Assessment, *Indian Health Care*, 1-40.

9. *Ibid.*, 39.

10. Indian Health Service, *Chart Series Book*, Table 2.1, 13; May, "Motor Vehicle Crashes and Alcohol."

11. U.S. Department of Commerce, Bureau of the Census, *American Indian Areas and Alaska Native Villages: 1980*, PC80-S1-13 (Washington, D.C.: U.S. Government Printing Office, August 1984), 2-4.

12. Contrasted with the concept of "nation," which refers to the horizontal legitimization of power, the "state" is essentially "the vertical structure of public authority," which allows politics to be treated as an independent rather than dependent variable in ethnic relations. See Cynthia Enloe, "The State and Minority Political Mobilization," *Majority and Minority: The Dynamics of Race and Ethnicity in American Life*, ed. Norman R. Yetman (Boston: Allyn and Bacon [1982], 1985), 79-88.

13. *Ibid.*, 81.

14. Joane Nagel, "The Political Mobilization of Native Americans," *Majority and Minority: The Dynamics of Race and Ethnicity in American Life*, 457-63; reprinted from *Social Science Journal* 19:3 (July 1982).

15. Of particular interest here are administrative decision-making models that feature the social process of "enactment," in which relevant organizational

environments are actively "created" by administrators, and are then "externalized" and perceived by them as problems with which they and their organization must "cope." See Karl E. Weick, *The Social Psychology of Organizing* (Reading, MA: Addison-Wesley [1969], 1979); also see W. Richard Scott, *Organization: Rational, Natural, and Open Systems* (Englewood Cliffs, NJ: Prentice-Hall, Inc. [1981], 1987), 89-90, 105.

16. Office of Technology Assessment, *Indian Health Care*, Table 4-3, 88; Indian Health Service, *Chart Series Book*, Table 2.1, 13; Bureau of the Census, *American Indian Areas and Alaska Native Villages: 1980*, Tables A and B, 2.
17. Indian Health Service, *Chart Series Book*, 1.
18. *Ibid.*
19. *Ibid.*, Chart 5.2 and Table 5.2, 55.
20. Office of Technology Assessment, *Indian Health Care*, Table 6-1 and Figure 6-1, 217.
21. *Ibid.*
22. *Ibid.*, 64.
23. *Ibid.*, 193; for a discussion of the inferior educational and literacy levels found among adult American Indians, see Rodney L. Brod and John M. Mc Quiston, "American Indian adult education and literacy: The First National Study," *Journal of American Indian Education* 1(1983): 1-16.
24. Office of Technology Assessment, *Indian Health Care*, 198.
25. *Ibid.*, 199.
26. *Ibid.*, 36.
27. *Ibid.*
28. National Tribal Chairman's Association, testimony before hearing of the U.S. Congress, House of Representatives, House Committee on Interior and Insular Affairs, H.R. 1426, Indian Health Care Improvement Act of 1985 (Washington, D.C.: 19 March 1985).
29. Office of Technology Assessment, *Indian Health Care*, 199.
30. *Ibid.*, 36-38.
31. Darrell Montero, "The Japanese Americans: Changing Patterns of Assimilation Over Three Generations," *American Sociological Review* 46 (1981), 834.
32. C. Hoy Steele, "The Acculturation/Assimilation Model in Urban Indian Studies: A Critique," in *Majority and Minority: The Dynamics of Race and Ethnicity in American Life*, 335-36.
33. Office of Technology Assessment, *Indian Health Care*, 38.
34. *Ibid.*
35. *Ibid.*, 36.
36. *Ibid.*, 200.
37. Indian Health Service, *Chart Series Book*, Chart 5.4 and Table 5.4, 57.
38. *Ibid.*, Chart 1.4, 9.
39. *Ibid.*, Table 2.1, 13.
40. Office of Technology Assessment, *Indian Health Care*, Table 4-3, 88.
41. *Ibid.*, Table 6-3, 219.
42. *Ibid.*, Table 6-3, 219 and Appendix C, 345-346.
43. *Ibid.*, 217.
44. Bureau of the Census, *American Indian Areas and Alaska Native Villages: 1980*, Table 2, 15.

45. Office of Technology Assessment, *Indian Health Care*, Table 3-4, 66; also see U.S. Department of Commerce, Bureau of the Census, *General Population Characteristics: Montana*, PC80-1-B28 (Washington, D.C.: U.S. Government Printing Office, March 1982), Tables 30, 37, and 50.

46. Office of Technology Assessment, *Indian Health Care*, Table 5-19, 196; Table 6-3, 219; Appendix C, 345.

47. Duane L. Jeanotte, Director, Billings Area Indian Health Service, letter to James A. MacDonald, chairman of the Board of Directors, Native American Services Agency (NASA), Missoula, Montana (8 April 1988).

48. Office of Technology Assessment, *Indian Health Care*, Table 5-17, 194 and Table 5-19, 196-97.

49. This amendment to P.L. 94-437, The Indian Health Care Improvement Act, would change the eligibility guidelines to serve people who are members of federally recognized Indian tribes or Alaskan nations and would allow them services at any IHS service area.

50. Duane L. Jeanotte, letter to James MacDonald, February 1987.

51. *Ibid.*

52. *Ibid.*

53. *Ibid.*

54. Indian Health Service, *Alcoholism/Substance Abuse Prevention Initiative* (Washington, D.C.: U.S. Department of Health and Human Services, 1986), 21-23.

55. *Ibid.*, 23; the term "mature programs" was given to those 158 Indian alcohol programs that had received NIAAA support for at least six years prior to being transferred to the jurisdiction of IHS in 1983, based on P.L. 94-437 of 1976.

56. National Institute of Justice, *NIJ Reports: Drugs and Crime* (Washington, D.C.: U.S. Department of Justice, March/April 1987), 8-10; for details, see "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986," *Congressional Record* 132, 144-Part II (Washington, D.C.: U.S. Government Printing Office, 17 October 1986), H11259-H11264.

57. "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986," *Congressional Record*, H11259.

58. Indian Health Service, *Chart Series Book*, 4.

59. *Ibid.*, Table 4.6, 32; "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986," *Congressional Record*, H11259.

60. Indian Health Service, *Chart Series Book*, 2-3.

61. *Ibid.*, Table 4.9, 35.

62. "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986," *Congressional Record*, H11259-H11260.

63. Indian Health Service, *Alcoholism/Substance Abuse Prevention Initiative*, 7.

64. *Ibid.*, 12-13; these IHS figures are based on J. M. Andre, *The Epidemiology of Alcoholism Among American Indians and Alaska Natives* (Albuquerque: Indian Health Service, Office of Alcoholism Program, 1979).

65. "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986," *Congressional Record*, H11260.

66. Associated Press interview with Dr. Dean Effler, Billings area IHS chief medical officer in "Indian Health Service official comes under fire from tribes," *Missoulian* (28 July 1989), A-10.

67. The appropriated dollar amount figures of $60,171,726 for FY 1988 and $62,431,768 for FY 1989 were verified by the author in a telephone conversation with Cindy Sacks, financial management officer, Billings Area Indian Health Service, Billings, MT, 27 July 1989.

68. The approximate dollar amounts used here were obtained by the author in a telephone conversation with Rod Robinson, Alcoholism Program, Billings Area Indian Health Service, Billings, MT, 27 July 1989; also Indian alcohol and drug programs in Montana and Wyoming are listed in National Institute on Drugs and National Institute on Alcohol Abuse and Alcoholism, *National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs* (Washington, D.C.: U.S. Department of Health and Human Services, 1989), 195-96, 369-70.

69. The approximate dollar amounts reported here were obtained in a telephone conversation with Ken Nicholson, Billings Area Indian Health Service, Billings, MT, 27 July 1989.

70. Duane L. Jeanotte, letter to James MacDonald, February 1987.

71. "Tribes Oppose IHS Changes," *Char-Koosta News* 18:31 (21 July 1989), 2.

72. This unfunded study represented a cooperative assessment of the health needs of the Missoula, Montana metropolitan American Indian population during the spring of 1988. The research reported here was completed and prepared in cooperation with the Missoula Indian Alcohol and Drug Service (MIADS), the Native American Services Agency (NASA), the Missoula School District #1 Indian Education Project, the Public Health Service of St. Ignatius, Montana, the University of Montana departments of Native American Studies and Sociology, and the University of Montana Center for Population Research. For a full description of the urban Indian health study reported here, see Rodney L. Brod, Ronald LaDue, and Ben Stiffarm, *Health Needs of the Missoula, Montana Urban Native American Population* (Turah, MT: Missoula Indian Alcohol and Drug Service and Native American Services Agency, autumn 1988); copies can be obtained from Dr. Fred W. Reed, director of the Center for Population Research, Department of Sociology, University of Montana, Missoula, MT 59812.

73. Two of the three prior studies are available from the author and include Rodney L. Brod and Roy Garvin, *Urban Indian Health Care: An Assessment of Missoula, Montana* (Missoula, MT: Qua Qui Corporation, 1977) and Rodney L. Brod, *Missoula, Montana American Indian Health Care: Characteristics and Assessment* (Missoula, MT: Qua Qui Corporation, 1981); the third study, E. Metzgar, *Missoula, Montana Indian Health Care Follow-up* (Missoula, MT: Native American Services Agency, 1986), is no longer in print.

74. The research team used a "snowball" technique over a period of only five weeks to compile a non-redundant master list of 431 American Indian households, which represented more Indian families than were identified in the entire county in the 1980 census.

75. U.S. Department of Commerce, Bureau of the Census, *General Population Characteristics: Montana*, Table 30.

76. Brod, *Missoula, Montana American Indian Health Care.*

77. Bureau of the Census, *General Population Characteristics: Montana*, Table 30.

78. The estimates of 1,181 for city and 1,960 for urban Missoula were made

by Rodney L. Brod in a report to the NASA and MIADS programs, Missoula, Montana (28 January 1989), 1-3; estimates were based on three sources: Brod, *Missoula, Montana American Indian Health Care;* Brod, LaDue, and Stiffarm, *Health Needs of the Missoula, Montana Urban Native American Population,* 1988; and Bureau of the Census, *General Population Characteristics: Montana,* Tables 30, 37, and 50.

79. The percentages of underestimation of the 1980 census figures reported throughout this article were derived by dividing the IHS service area (or the tribal population or local enumeration) figures by the U.S. census estimates and subtracting 100 percent; estimates for all the figures used here were found in Office of Technology Assessment, *Indian Health Care,* Appendix A, 263.

80. Brod, *Missoula, Montana American Indian Health Care,* 4–5.

81. "Tribes Oppose IHS Changes," *Char-Koosta News,* 2.

82. Leslie Brownrigg and Elizabeth Martin, "Proposed Study Plan for Ethnographic Evaluation of the Behavioral Causes of Undercount" (Alexandria, VA: Census Advisory Committee of the American Statistical Association and the Census Advisory Committee on Population Statistics Joint Advisory Committee Meeting, 13–14 April 1989). The methodology of this proposed study, however, is flawed in several ways in regard to studying American Indian populations; for example, the study includes only 4 reservation and 2 urban areas slated for the special enumerations during the summer of 1990. Unfortunately, the summer months are when most Indian people go visiting, find temporary summer employment away from home (e.g., firefighting), and attend powwows and religious celebrations; also, many urban areas contain colleges and universities with Indian students, who are resident users of IHS-funded urban health and alcohol services for 9–10 months of the year, but are also likely to be away from the urban area during the summer months.

83. Britt Finley, "Social Network Differences in Alcohol Use and Related Behaviors Among Indian and Non-Indian Students, Grades 6–12," *American Indian Culture and Research Journal* (this issue); also see her study, *Patterns of Alcohol and Drug Related Behavior among Missoula County Youth: Indian and Non-Indian* (Missoula City/County Health Department, Missoula County High Schools, Missoula School District #1, and Missoula Indian Alcohol and Drug Services, summer 1988), 1-39; Indian Health Service, *School/Community-Based Alcoholism/Substance Abuse Prevention Survey* (Washington, D.C.: U.S. Department of Health and Human Services, 1987), 4–16.