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**DEBATING IDENTITY:
URBAN INDIANS IN THE HEALTHCARE SYSTEM**

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B.A. Anthropology, University of Montana, Missoula, Montana, 2006

Thesis presented in partial fulfillment of the requirements for the degree of
Master of Arts, in Anthropology, Cultural Heritage

The University of Montana
Missoula, MT
Spring 2008

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Debating Identity: Urban Indians in the Healthcare System

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In recent years, the public health sector has recommended that healthcare practitioners become culturally competent in order to reduce health disparities in minority groups. It was reported later in the Surgeon General's Report (1999) on mental health, that culture shapes the healthcare experience for minority groups and in turn may influence the treatment course. Cultural competence models have been proposed in conjunction with the development of ethnic-specific mental health clinics, where practitioners and patients are ethnically similar, and programs are designed with the groups' unique cultural needs in mind. This poses a particularly unique dilemma for urban Indians as their identity has come under social and legal scrutiny, which resulted in a debate over eligibility for federally administered health services. In a justification to cut funding for urban Indian health centers, the current administration has put their existence into question, saying that they offer duplicate mental health services that can be found elsewhere in the community.

In light of the current debates over continued funding, I examined cultural competence practices and health treatment at the Missoula Indian Center, an urban Indian center with a staff of eleven and a client base of just under 1,500 people. I interviewed all of the employees and counselors at the Indian center, as well as conducted ethnographic observation of client/provider interactions. Eight of the eleven staff members are American Indian and most consider themselves urban Indian, therefore I was able to gain an understanding of cultural competence practices through the lens of both ethnic urban Indian and non-Indian providers. The data suggests that urban Indian centers provide necessary services for transitioning American Indians, yet there is not a conclusive argument that the cultural component is the primary force making these centers necessary and successful. Some data suggested that the availability of services and cultural resources make these centers a primary choice for urban Indians seeking mental health care.

ACKNOWLEDGEMENTS

This project got its start as I began planning my thesis under the initial guidance and support of Dr. G.G. Weix. She then introduced me to a new educator in the field of medical anthropology, Dr. Sarah Horton, who served as committee chairperson. To her I give special thanks for encouraging me and supporting me through every turn this project took from development to completion. With her continued support and tireless efforts this project took on significant importance. I would like to thank Dr. Horton for providing me with the tools, and knowledge necessary to complete a project of this nature. I would like to thank Dr. Richard Sattler for guiding me through the process, answering all of my questions every step of the way. And I would also like to acknowledge Dr. David Beck for participating in my research by serving on my committee.

I also give my sincerest thanks to the employees at the Missoula Indian Center for sharing with me their insights and personal experiences, and for welcoming me into their organization.

For her attention to detail, I would like to thank Krista Nelson for her editing guidance and sharing of knowledge during the writing process. And also a special thank you to Saul Steuer who gave me encouragement and support during the course of my research, beginning from day one. Mention too, must be given to my parents Dan and Laurie Klahn who supported my quest for higher education.

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INTRODUCTION

Culture and Health Disparities

Culture and ethnicity are gaining recognition as key determinants of mental health and wellness. The public health field has placed more emphasis in recent years on examining the social influences of health and treatment, revealing that ethnic minorities suffer disproportionately from mental illness. In 1999, The Surgeon General released *Mental Health: A Report of the Surgeon General* which was criticized for lacking a comprehensive discussion about the relationship between ethnicity, culture and mental health. Health disparities in ethnic minority populations were mentioned yet did not play a central role in the Report.

Released later, the supplement¹ to the Report, *Mental Health: Culture, Race and Ethnicity*, spurred an outburst of discussion by public health officials, medical anthropologists and others working in mental healthcare. Doris Chang (2003) highlights these issues in response to the supplement that followed; she reports that the supplement sought to 1) understand mental health disparities for ethnic minorities, 2) present evidence on the need for mental health service programs to meet those needs, and 3) document promising directions toward the elimination of mental health disparities. Cultural competence, ethnic-matching between patient-provider and more specifically ethnic specific mental health centers were proposed as models for eliminating mental health disparities.

Cultural Competence

Cultural competence models propose that systems, agencies, and practitioners build the capacity, skills, and knowledge to respond to the unique needs of populations whose cultures are

¹ The supplement focused on American Indians and Alaska Natives (AI/AN), Latinos, Asian and Pacific Islanders and African Americans.

different than what might be called mainstream American culture. Thus providers who are culturally competent, and who may share the ethnic background of their patients, may help reduce disparities in mental health care.

Patients who were in ethnically concordant relationships with their physicians rated their physicians as significantly more participatory than those who were in ethnically discordant relationships (Cooper-Patrick et.al 1999). Therefore ethnic-matching in mental healthcare is growing increasingly popular. Ethnic-matching is shown to improve communication and further allow the patient to have greater opportunity for participation in treatment programs. Joan Weibel-Orlando (1984) examined Indian alcohol treatment programs in California, and found that the use of ethnically-based treatment options and providers were more congruent with the cultural norms and values of many Indian cultures: “The alcoholism counselor, who is more often than not both Indian and a recovering alcoholic himself, is analogous to the elder in tribal rites of passage,” (1984:63). This sense of comfort is viewed as an essential part of mental health and addiction treatment for not only American Indians but also urban Indians—as urban Indians are in both a transition from reservation to urban life, and in a stage of transition from at-risk to well.

Organizations that utilize cultural competence programs are shown to have the following results: 1) improved quality of care, 2) positive health outcomes 3) effective patient/provider communication, and 4) a decrease in health disparities. Goode et.al (2006) found that utilizing approaches designed with and for the intended audience and consistent with the audience’s values, beliefs, and preferred ways of getting information, demonstrated significantly increased behavior changes compared with either no intervention or interventions that were not culturally competent.

Critiques of Cultural Competence

Although there are many good arguments for establishing ethnically-specific health care programs, anthropologists have criticized the use of culture in these programs as a typified and generalizeable category. This can lead to use of ethnicity as a convenient shortcut to identify a patient group as "at-risk" groups; in turn, it can cause stereotyping of patients by staff.

In anthropology, there are debates about the essentialized way that culture is used in cultural competence training and program development. The current anthropological discourse on culture is inherently at odds with the clinical use of culture (Taylor 2003). Taking a critical look at the ethnicization of psychiatric services, Santiago-Irizarry (1996) discusses the challenges this can create with an evaluation of three Hispanic mental health clinics. She points out that by lumping cultural traits together, ethnically-specific clinics may result in the creation of a generalizeable ethnic category, by which mental health professionals might stereotype their clients. This may result in a neglect of individual difference, and create problems in service delivery.

Culture is deployed in this setting through a Boasian paradigm, which dominated anthropological discourse on culture in the early 20th century. Boas' concept of cultural determinism implied that culture is the primary force that shapes and molds human behavior (Sidky 2004). Unfortunately, this reasoning is based on inadequate logic, because it implies that culture becomes a force that is beyond nature or structural relationships. Ultimately, culture in this sense is a force, which imposes "determinative influence" (Sidky 2004).

There is not a consensus or universal acceptance of the definition of culture by academics, medical professionals or lay people (Song 2003). Culture is hard to define, and lends itself as a convenient category which acts as a way to generalize interactions (Santiago-Irizarry

1996). Professionals in the mental health sector often assume that members of ethnic groups are more similar than they actually are (Gropper 1996). Because the use of culture in the health service sector is based on a "primitive" understanding of culture, professionals assume that it exists naturally (Song 2003). Therefore, the clinical use of the term "culture" and the definitions set forth about what components are "typical" of a culture may perpetuate the stereotyping of certain groups in contrast to the rest of society. The use of culture in this context assumes that characteristics of culture are stable and unchanging (Song 2003).

In the past, using culture as a category allowed federal agencies to ignore intra-group differences and define nationality and history under an umbrella term like American Indian, which is used in the clinical setting as a category by which staff can typify their clients (Taylor 2003). In this case, identity and culture are organized as an essentializing set of traits that must be identified and transformed into dominant norms of members of that cultural group (Santiago-Irizarry 1996).

This poses a particularly interesting dilemma for urban Indian clinics, as urban Indians themselves are a highly diverse group and may include federally recognized Indians or non-federally recognized Indians, with a varied set of cultural, historical and religious ties (Forquera 2001). Because there is not a consensus on the definition of urban Indian, and there is not a consensus on the definition of culture, what do urban Indian clinic counselors use as a measuring stick for identifying who urban Indians are, and how to design culturally competent care for them? This is a question which has been largely overlooked in medical anthropology. There are very few urban Indian clinics in the U.S., and there is very little data or empirical research on urban Indians, and healthcare services. Therefore my primary intention is to contribute to fill the gap in data (Forquera 2001).

Urban Indian Identity

One of the primary issues affecting American Indians in the 21st century is the question of who has legitimate claim to say he/she is an American Indian and by what entity those claims are legitimated (Churchill 2004). When defining who makes up the American Indian population, there are multiple points of view on which to base that definition. These ideas vary within the Indian community as well as within the governing or lawmaking community, neither of which have an agreed upon definition.

There is a complex history of Indian definition, influenced by changing economic and political contexts beginning with the federal policies in the 19th century or earlier (Warne 2007). The United States government, through the establishment of its policies² declared the right to define American Indian authenticity. The original definitions of "Indianness" remained accepted throughout the history of United States governance and remain popular today; A/I remain the only group in America that are legally defined based on ancestry and blood relatedness (Philleo 1997). In addition, they are required to have proof and documentation of their ethnicity or their line of descent as an American Indian. Because of the use of federal policies in defining Indian identity, the "authenticity" of Indian identity is constantly subject to scrutiny. Debate over the claims of authentic "Indianness", are especially relevant to the urban Indian population.

Even if urban Indians internally define themselves as such, they are frequently viewed as "inauthentic" both by tribal members on the reservation and by mainstream standards. Many are viewed as having abandoned traditional ways, and as having transitioned into a more "westernized" lifestyle, where they may potentially lose touch with their heritage (Venne 2004).

² (1) United States Constitution, (2) The Snyder Act 1921, (3) The Transfer Act 1954, (4) Indian Sanitation Facilities and Services Act of 1959, (5) The Indian Self-Determination and Education Assistance Act (enacted 1975), (6) Indian Healthcare Improvement Act of 1976, (7) The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, and (8) The Indian Child Protection and Family Violence Prevention Act of 1990. This is not an exhaustive list.

Although the authenticity of urban Indians is questioned by the pan-Indian community, the government and medical professionals define urban Indians as “American Indians who have moved from the reservation into urban centers”³. This definition continues to acknowledge that urban Indians are still recognized as American Indian, they have simply moved away from the reservation. While cultural competency programs serve as a source for redistribution of resources to minority populations (Santiago-Irizarry 1996), questions of authentic Indianness and entitlement to services act as a barrier in the development of culturally competent mental health and addiction services for this group.

Ethnographic Research: Site Background

I conducted my examination of the use of culture in health care delivery at M.I.C. a clinic that has served Missoula area urban Indians since 1970. Although the center was able to provide health services in its earlier years, by 1986 the health programs were phased out. Currently M.I.C. offers mental health and addiction counseling, community outreach, social service referral and annual community cultural events. The center employs a staff of eleven, four of whom are mental health and addiction counselors. M.I.C. serves a population of over 3,000, with over fifty different tribes represented, the majority of whom are affiliated with the Blackfeet, Chippewa, Flathead, and members identified as "other" (M.I.C. Strategic Plan 2006). Over half of the service population, around 1,500 people, is estimated to be non-Indian clients, most of who are enrolled in M.I.C.'s alcohol program by order of the court⁴

³ This is the definition provided by the M.I.C staff members, and although not explicitly stated is the implied definition used in legislative decision-making and drafting

⁴ This is an estimate based upon interviews with M.I.C. employees. The center does not have a record of the actual number of Indian or non-Indian clientele. Although some estimates varied from this figure, this was the average noted by both the executive director, the intake coordinator and the billing/data coordinator and proves to be the most representative.

Urban Indian centers like M.I.C. exist all over the U.S., and many offer more comprehensive healthcare programs. There are thirty-four Urban Indian Health Centers (UIHC) in the U.S.. Montana has five urban Indian centers, and are located in the Billings Region (region four) of the Indian Health Service. Most UIHC's offer basic health services, mental health and addiction services and advocacy on behalf of their service populations. Many, like the Seattle Urban Indian Health Institute, and the Urban Indian Health Clinic in Reno, Nevada, offer ambulatory services, hospital care, dental, vision health and many more specialty services. One important goal of M.I.C. is to expand services to include more specialized medical care; however financial struggles have continued to restrict the implementation of the expansion. M.I.C. is a generally universal model for small-scale urban Indian health centers, which are centers often neglected in the literature and governmental consideration. However, because M.I.C. already has faced reductions in the health services it offers, its administrators and staff are perhaps even more acutely aware of the need to provide a compelling argument for the existence of urban Indian centers.

As Sue and Chu (2003) argue: "rather than developing broad theories to explain the mental health of ethnic minority groups, it may be wiser to begin an inductive process in which separate ethnic groups are studied and examined before construction of a more general theory." In order to contribute to the study of ethnic groups, I chose to conduct my research at a small-scale urban Indian center. Small-scale organizations often find it difficult to highlight their contribution to the community because they often lack the specialized medical services that are regarded among the most important by western biomedical standards. As the controversy surrounding the extension of AI/AN benefits to urban Indians continues, small-scale urban

Indian centers serve as a unique case for studying cultural competence practices; therefore I will critically examine the mental health, social and cultural services offered at M.I.C.

Objectives

There were three primary objectives that guided the qualitative research of this project. The first objective was to explore how urban Indian identity is situated within the context of healthcare and the daily operations of the M.I.C. Being Indian is a political identification and not a racial or cultural indicator; those who are not recognized by the government cease to have the legal rights afforded to those who are recognized (Venne 2004). AI/AN are the only group to have its identity defined and redefined by the government. Therefore the assertion of ethnic identity in this case performs a dual purpose, it allows groups to re-create their own identities against the conditions set forth by the dominant society, and it can influence a person's self worth and self-esteem (Song 2003). I examined the center's use of outreach, advocacy and cultural activities as a way to legitimate the authenticity of urban Indians within the community. In addition I examined how validating their status as urban Indian contributed to mental health treatment.

The second objective was to identify how debates over urban Indian authenticity influence the funding for urban Indian health care. As DelVecchio Good, et.al (2002), and Horton (2006) argue, the financing of healthcare coverage is relevant to understanding what happens within the clinical setting, how it influences clinical interactions, and further how these interactions result in decisions that may produce health disparities. They found that unequal treatment in healthcare is not only influenced by patient-physician relationships but also by larger organizational practices, cultures and healthcare financing. Thus, the funding streams

available to this non-profit urban Indian center take on a significant role in the provision of care to urban Indians and other of M.I.C.s clientele. Funding for urban Indian health care may be particularly jeopardized by a lack of support of the cause by both the federal government and by reservation Indians. In particular, my thesis will examine how historical definitions of Indian authenticity have influenced the funding trends for urban Indian health centers. Although The Seattle Urban Indian Health Institute and the I.H.S. have produced literature on the funding of urban Indian centers, to my knowledge, this is the first synthesis of this literature and the first sustained treatment of how questions about urban Indian identity have historically led to the under-funding of urban Indian health centers.

The final objective was to examine how definitions of urban Indian identity influence the development of culturally competent care. Choosing ethnic identity is a highly politicized issue, and may be shaped by the political climate of the time. The competition between groups for scarce resources, like healthcare, influences how groups represent themselves. The construction of urban Indians as having "lost" their identity is also political and has major implications on the way treatment programs are designed for these groups. How do urban Indian clinics develop culturally competent care for this population? With this in mind, is culture operationalized in the clinical setting as a fixed set of generalizable categories? Further how do M.I.C. staff members develop techniques for providing culturally competent care? Are there a fixed set of guidelines? If so, how are they developed?

Research Methods

In order to examine these questions I practiced two discrete data collection methods: 1) ethnographic interviews; and 2) ethnographic observation.

Interviews

I conducted thirteen⁵ semi-structured interviews with the staff at M.I.C. There are eleven staff members, and I interviewed the executive director, the administrators, the health clinic staff, and the drug and alcohol program staff. The interviews lasted between forty-five minutes and one hour long, and took place at the center during January and February of 2008.

Interview questions focused on how concepts of culture and identity are used at the center to treat mental health and addiction issues faced by urban Indians, and how the organization of such services around "culture" has become a contested issue for I.H.S., the federal government, and affiliated tribes. I asked staff members to describe what influenced their choice to work at an ethnically specific social service center and how their ethnic background played a role in the decision and also in their relationship with the client. I also asked staff members to provide narratives about treatment interactions where culture played a significant role in order to understand, from the staff's perspective, what cultural issues people face when receiving mental health or addiction counseling.

I chose to interview the staff rather than the clients for this project because I wanted to gain an understanding of how cultural competence is practiced and why it works from the perspective of the providers. It was important to understand it from this point of view because it reveals the mindset behind cultural competence practices. Because many of the staff members were also former clients of urban Indian centers, I was able to compare the views from their perspective as administrators and counselors with their viewpoint from the role of a client. Each interview was conducted privately, and although there were a set of questions I came prepared to ask, I let each person direct the conversation to the topics he or she considered important. The importance of doing this was that each person had a different experience or

⁵ I interviewed the administrative assistant and the clinic coordinator two times.

relationship with Native American clients, and I did not want to hinder the individuality of each response. The interview remained fairly unstructured, and it seemed a more comfortable setting for the participants.

Observation

I planned to observe staff-patient interactions in the reception area, however there were limited interactions during my observation periods. I did not set out to collect data on individual clients, but sought to examine how culture and identity play a role in the day-to-day interactions at the center. Although staff narratives depicted a clientele that often came to the center to “hang out” and socialize, my observations were drastically different from those described by the respondents. While I observed the reception area, clients would come in at a scheduled appointment time, and would go immediately to the service provider with very little interaction in the waiting area. There were two instances where the reception staff aided clients with various application procedures. However, I did not witness the social atmosphere described by staff members. At this time I do not have an explanation for this particular inconsistency, but it is something to be explored further.

Pre-Existing Literature on Urban Indian Clinics

Consistent with the findings of many researchers in the area of American Indian mental health and addiction service use, my literature review turned up little empirical or case-based studies that evaluated this topic (Forquera 2001; Garouette, et.al 2004; Goode, Dunne and Bonheim 2006; Walls, et.al 2006 and Weaver 1999). Studies of service use and satisfaction among minority groups in the U.S. are limited; however, studies of this nature are even more limited on American Indian groups (Garrouette, et.al 2004).

American Indians are the fastest growing population in the US according to the 2001 US Census, representing about 1% of the population. However, there are only a handful of published surveys about how Indian patients evaluate treatment services. In order to reduce health disparities, there is an urgent need to learn what urban American Indians think about the quality of care (Garwick 2000). There is little known about how urban American Indians feel about the quality of care, and therefore this may present challenges to ensuring culturally appropriate care (Garwick 2000). A large proportion of literature on cultural competence in service delivery focuses on the African American and Latino/ Hispanic groups.

While literature on Indian populations is scarce, literature on urban Indians is virtually non-existent. The primary source of information is produced through the Seattle Indian Health Board, or the Urban Indian Health Institute (UIHI) which is a program of the Seattle Indian Health Board. A report from the Henry J. Kaiser Foundation (2001) highlights the lack of data on urban Indians in terms of their health status or access to treatment. Neither the Indian Health Service (I.H.S) nor any other agency is responsible for collecting this data on a regular basis (Forquera 2001). The lack of research on urban Indians may derive from the politics of Indian identity and where urban Indians fit into this definition.

Significance

The Indian Healthcare Improvement Act (IHCIA) of 1976 is considered one of the primary legal authorities for the provision of healthcare to American Indians and Alaska Natives. The Act provides the basis for the funding of urban Indian centers, as it was intended to extend federally provided health care services to AI/AN living in urban areas through urban Indian centers such as M.I.C. The IHCIA was enacted into law based on findings that the health status of AI/AN ranked far below that of the general population (I.H.S. 2007). The Act established that

it was the Nation's policy to "elevate the health status of the Indian population to a level at parity with the general U.S. population." Since its first passage in 1976 the Act has been reauthorized four times.

The Act expired in September of 2000, but was extended in anticipation that Congress would hold hearings on the reauthorization proposals (I.H.S 2007). Tribal governments have been working with Indian health services and urban Indian health centers to bring this Act back to the table (I.H.S. 2007). At the time of this writing the reauthorization of the Act was up again for debate in Congress. The question of the cultural distinctiveness of urban Indians lies directly at the heart of the administration's argument for the unnecessary existence of urban Indian centers and thus the repeal of the Act. If the reauthorization of the Act is denied, AI/AN health centers as well as urban Indian clinics face loss of funding, and the threat of having to close their doors.

In an effort to repeal funding for urban Indian centers, the current administration argues that culturally/ethnically specific centers offer duplicate services that are currently available to urban Indians through community medical centers (Krisberg 2006). Therefore, the administration contends that by cutting funds to these duplicate centers, more funding would be available for services that serve a larger population. Yet urban Indian clinics argue that they are best equipped to provide culturally competent services to this population.

Although many urban Indians qualify for public programs like Medicaid, many refuse to go through invasive application processes, and many do not feel the need to use these services because of their entitlement to healthcare under past treaty agreements (Forquera 2001). In addition, ethnic minorities experience a disproportionate burden of mental illness, and are less likely to seek out treatment (Surgeon General's Report 1999). As Indians move off the

reservation in search of job opportunities and education many experience racism, loss of community support, and loss of identity, which leads to physical and emotional risks and more health problems (Forquera 2001).

Urban Indian centers operate in restrictive economic environments, where services are confined to a rigid set of guidelines, often established by the funding agency. Because many urban Indian clinics must justify their existence, evaluations of cultural competence take on significant importance in the development of health and social services (Fitzgerald 2005). Decisions to base care on certain "cultural" criteria or norms are justified based on the social values and beliefs of the group in question. Therefore, when health professionals fall into a position where they must justify their decisions, like when applying for funding, they must understand cultural competence and how they use it or risk putting their positions and/or organizations in jeopardy (Fitzgerald 2005). It is important then to uncover how ethnically specific services affect the delivery of health and social services in reaction to the current political and economic climate.

In the following chapters I will show how debates over funding are both a product of the questionable legal status and ambiguous cultural status of urban Indians but also of the limited availability of health care resources and funding appropriations. Debates over authenticity have played a major role in the history of funding urban Indian health centers, and I will provide an overview of how these questions have influenced urban funding, beginning with the initial development of urban Indian health centers in the U.S. I will show that M.I.C. seeks to reconcile these debates at a grass-roots level by promoting urban Indian culture through community events and cohesion in addition to culturally-based mental health and addiction programs. I will show how M.I.C. develops strategies for practicing cultural competence including the use of ethnic and

value matching between patient and provider, a cultural clinical atmosphere and traditional health models.

I will contrast these arguments for ethnic-specific mental health programs and more specifically urban Indian health programs, with a discussion of the essentialized construction of culture within the clinical setting. I will show how core pan-Indian values, which serve as the framework for urban Indian culture, can often be construed as essentializing and generalizing traits.

Finally, I will present the arguments for the continued funding of urban Indian clinics. I will present these arguments primarily from the point of view of the counselors and administrative employees at M.I.C. These discussions served as an integral component for uncovering the distinctive ability for the center to provide healthcare to urban Indians in the Missoula area.

FEDERAL INDIAN HEALTH SERVICES

The Status of Urban Indian Healthcare

In the U.S., individuals are not born with a right to healthcare; however due to the trust relationship with the federal government, providing healthcare to Indian populations is agreed upon as a right. The U.S. formalized its obligation to provide medical services to its indigenous populations with the authorization of a federal agency for this purpose in 1921. The ambiguous cultural status of urban Indians as not fully “Indian” nor as fully assimilated has led to contradictions in both funding for urban Indian centers and in the programs they offer. The massive federal Indian relocation programs of the 1950s—an attempt to assimilate American Indians into mainstream society—served to undermine the trust relationship and A/I rights to health care, as the federal government only extended this prerogative to reservation-based Indian populations.

While the federal government has attempted to define urban Indians as “less Indian,” reservation-based tribes have not fully supported funding for urban centers, as urban Indians are often viewed by tribes as having turned their back on their culture. I will show that the politics around urban Indian identity has compromised urban Indians’ access to healthcare, which has left urban Indian centers with no choice but to develop programs for non-Indian clients in order to attract mainstream funding sources. In this chapter, I will examine how these tensions have played out in the history of federal support for urban Indian centers.

A History of Urban Indian Healthcare Centers

In the early 19th century Indian Affairs was housed in the Department of War, and it was the responsibility of the military health services to provide basic medical care to American

Indians. In 1921, the Snyder Act was approved by congress. The Act serves as the foundation for the authorization of federal health services to American Indian/Alaska Native populations (I.H.S 2005). These pieces of legislation, in addition to earlier treaties, essentially act as contracts between independent governments: the governing tribal body, the federal government and the federal agency responsible for providing services like education (BIA), and healthcare. The responsibility for providing healthcare services was given to the newly created I.H.S in the early 1950s (Warne 2007).

There were many barriers to the use of I.H.S health services by urban Indian groups because the majority of these services were located on reservations which made it difficult for urban populations to access them. Financial pressures forced Tribal leaders to limit access to tribally-managed healthcare, and today, priority is usually given to local tribal members (UIHC Report 2007). Once a person leaves the reservation for a period of six months or longer, he or she is no longer eligible to receive free healthcare services; the benefits are generally restored once the person moves back to the reservation for six months or longer. For those who leave the reservation, finding out that health services are no longer provided free of charge can be a shock and may result in the neglect of preventative care. In addition, time constraints, plus the cost and lack of transportation between cities and reservations, contribute to the under-utilization of reservation-based services.

Most of the urban Indian populations were created after World War II, when the federal government embarked on a policy to terminate federal recognition and services to reservations. The federal government intended its termination and relocation policies in the 50s to assimilate Indians into the broader society, assuming this would lead to an increase in educational and occupational opportunities. Ultimately these policies were supposed to lead to Indian populations

being “free from government control and oversight” (I.H.S 2005) therefore abrogating the government’s responsibility for their welfare (OPI 2005). These policies moved several hundred thousand people from reservations into cities, but many returned to reservations with little or no skills for employment and with a disillusionment of government programs. Indian people who remained in cities experienced a lack of adequate housing, unemployment and poor health. In addition, many experienced racism and prejudice, often resulting in behavioral health problems. Most of the support promised by the government failed to materialize, and in many cases Indian people were left to survive on their own.

The American Indian Policy Review Commission found that the Bureau of Indian Affairs (BIA) had relocated over 160,000 American Indians to urban Centers during the relocation era (UIHI 2007); and in response, urban Indian community leaders began to develop culturally appropriate health care that addressed the unique social, cultural and health needs of the newly relocated population. In 1966, the federal government reacted by appropriating funds through the I.H.S to develop a pilot urban Indian clinic in South Dakota. This program showed promise and over the coming decades, more urban Indian centers were developed throughout the United States.

Advocates suggested that the availability of I.H.S.-funded clinics in urban areas may contribute to an increased utilization by the urban Indian population, especially for those who needed mental health services and addiction and substance abuse counseling. Urban Indian advocates generally uphold federal funding for urban Indian clinics such as M.I.C. as a way for the government to uphold its historic treaty obligations to Indians.

I firmly believe that Urban Indians have the right to health care. It is a grave injustice for anyone to think that urbans shouldn't receive health care or health care monies. It is almost like the government is trying to keep us all on the rez under their supervision as it was in the past – how shameful if that is in fact is

what they are trying to do. You would think the government would welcome this and actually try and help us even more to succeed in this brave endeavor. I know for a fact as I lived on or near my reservation so that I would not have to worry about my healthcare. It took a lot of self talk and strength for me to move to Missoula. I am still wondering if I did the right thing as I currently still do not have health insurance and have to rely on whatever I can to get the care I need at times. —Virginia 4/8/08

While the relocation program served as a way for the U.S. government to relieve itself of its responsibilities to the A/I population, including the provision of healthcare, Virginia points out that it also acted as a way for the government to maintain control over the Indian population. By eliminating their rights to benefits, the government is able to contain the population on reservations, thus increasing the amount of control the administration has over the A/I community. Although most of the clients at M.I.C. moved into urban Missoula by choice and not through a federal relocation program, the debates over responsibility to provide healthcare continue.

Funding Dilemmas

In the 1950 census it was reported that sixteen percent of the total AI/AN population, or 55,909 people, were living in urban areas. In the 2000 census there was a three fold increase, as sixty percent of AI/AN people were reported as living in urban areas—a figure which totals 1,497,402 (I.H.S 2007). In contrast to government intentions during the relocation era, many urban Indians have maintained their cultural identity. One limitation however was that they lacked strong community or tribal support, and their communities were isolated or fragmented and left little room for social and cultural networking (OPI 2005); thus it was assumed that they assimilated into mainstream society. Nevertheless Chadwick and Stauss (1975) argue that the acceptance of white material culture is often mistakenly equated with total acculturation. Indeed, urban Indian centers—the precursor to urban Indian health centers—are important vehicles for

keeping urban Indian culture alive.

The urban Indian associations that created these centers had limited budgets in their early years. However, they benefited from the influx of funding made available to them through the Great Society initiatives in the 1960s and later through programs for Native Americans developed by the Nixon Administration in the 1970s (Davis-Jackson 2001). The increase in funding opportunities allowed many urban centers to offer substance abuse counseling, as well as cultural events. Nevertheless, these centers remained funded primarily by Native American Associations, donors and other local groups.

In 1976 the Indian Healthcare Improvement Act (IHICIA) was intended to extend government-run health services to AI/AN living in urban areas, primarily through these urban Indian centers (Bergman 1999). Previously AI/AN who moved off the reservation were cut off from federal services, and the IHICIA was a way to return those services to urban dwelling AI populations. The IHICIA could have been stretched to include more of the urban population, but leaders of organized tribes, who were responsible for influencing federal policy, did not see themselves as representatives for those who had left the reservations (Bergman 1999). Some scholars point to the lack of support for urban Indians among the leaders of organized tribes (Bergman 1999) as the reason why the extension of services to urban Indians was not approved within the parameters of the Act. However an alternative explanation is that the lack of funding appropriated for urban benefits is the chronic underfunding of I.H.S services in general.

In the mid-1980s, urban Indian communities and centers suffered budget cuts intrinsic to the “Reaganomics” era (Davis-Jackson 2001). Despite the growing population of urban Indians, the I.H.S appropriates less than 2% of its funding for the maintenance of urban Indian clinics, and this figure has remained static. Facilities located in rural areas or on reservations receive

46% of the I.H.S budget, while 53% is given to tribally operated services (Forquera 2001). With less than 2% of the budget allocated to a population that accounts for about 67% of the total American Indian/Alaska Native population, there is speculation about the logic behind budget choices. Funds allocated to support urban Indian centers has often hinged upon debates about how “Indian” urban Indians are, with such centers receiving scrutiny from the federal government and tribal Indians alike.

The implication that urban Indians are culturally “not fully Indian” is a common theme in federal attempts to cut urban Indian center budgets. In the federal government’s justification for the proposed budget cuts, federal officials described urban Indian health programs as “duplicative of other public programs” and noted that federal funding for the expansion of community health centers would fill the gap if urban centers were closed down (Krisberg 2006). The Director of the I.H.S and a representative for the Administration repeatedly declined to argue the point further during congressional debates over the issue (Peuschal 2008).

In the most recent congressional hearing on the Indian Healthcare Improvement Act (IHCA) the President’s 2008 budget failed to allocate funds for urban Indian health services. The Senate Republican Policy Committee reported in a legislative notice that funds should be focused on Indian people living on or near reservations where there is a lack of access to health services (January 2008). The report included a response from the Department of Justice (DOJ) regarding the legality of “urban Indian” as a political identification;

The Department of Justice (DOJ) has raised constitutional concerns that the definition of “Urban Indian” may be an illegal racial classification rather than a permissible political classification. DOJ argues that because the term “Urban Indian” under the legislation includes individuals who are affiliated with state-recognized Indian tribes that are not federally-recognized, the legislation rewards preferences based on race. Federally-recognized Indian tribes are considered political entities by the federal government, so federal assistance is not considered to be based on race. However, it is not clear whether state-recognized

tribes would also be considered political entities by the courts. Supporters of the legislation argue that state-recognized tribes would meet the political test, but there are no federal court decisions on the question.

Thus the legality of their identity and eligibility for benefits as urban Indians will have to be determined by a federal court. Supporters for urban centers say that urban Indians are a segment of the population that America's leaders do not understand; therefore they tend to overlook their status as A/I and further their unique health needs. Members of the House Energy and Commerce Subcommittee on Health and of the Congressional Native American Caucus acknowledged that the US government still has an obligation to provide health services to Indians, and that it is important not to forget that many Indians live in cities (October 31, 2007). Even though the administration continues to propose budget cuts, Congress has steadily returned the money to the budget, and plans to continue through the proposed cuts for FY09.

There has been animosity in the past between tribal leaders and urban clinic administrators due to a lack of funding given to the I.H.S. Tribal leaders and communities often felt that urbans were people who chose to leave their culture and family behind. Today however, tribes are beginning to stand in support of urban health center funding,

The tribes tend to support urbans; although it wasn't always that way. There used to be a perception that urbans were taking away tribal money, but with more and more people moving off the reservation the tribal leaders realize that we (urban centers) are here to help their family members and friends when they move off, so they tend to support us more now.—Lisa 2/14/08

Regardless of the changing perception of urban Indians by tribal leaders, two of the administrators noted that when it comes to IHS' budget allocation conference each year, the tribes often fail to stand in support of funding for urban centers. Thus it is the responsibility of urban centers and urban Indian advocates to stand in support of them and their funding. For example, M.I.C. sends an advocate to the annual budget committee hearing and when the issue

of urban Indian clinics comes up for discussion, that advocate often has to stand in support of the budget renewal. Three M.I.C. employees that have served that role, noted that often they are fighting a lonely battle and that other agencies often fail to support them. There is a consensus among M.I.C. employees that urbans deserve claims to benefits as long as they are 1) enrolled and a member of a tribe and 2) they can prove it. American Indian identity and claims to authenticity rest in the amount of culture you possess; whether it is in practice or by familial line.

Although urban Indian centers have a focus on urban Indian healthcare, they must serve anyone who seeks assistance. As Ralph Forquera, the Seattle Indian Health Board Director noted in an interview with Matt Peuschal (2008), unlike Tribal or I.H.S clinics, urban centers are not exempt from federal or state non-discrimination rules. Thus to keep funding and a non-profit status, urban centers are required to serve anyone seeking health care. As a general requirement for both local and state grants, care is provided on a sliding fee scale, and based on income and family size (Peuschal 2008). At the Missoula Indian Center, much of the funding is reliant on the state alcohol and chemical dependency program, which requires that the center provide counseling to non-Natives.

History of Missoula Indian Center

The Missoula Indian Center has been established as a non-profit community-based organization since 1970. Originally, the center was known as Qua-Qui. Ronnie a current staff member was employed at Qua-Qui in the mid 1970s. She explained its importance to the urban Indian community as a reason for her decision to continue work there,

I worked at the center it was called Qua-Qui at the time; it was the first Native American center that was here in Missoula. It was... I want to say 76 or 77. One of the most important things for me was that I moved from the reservation to come here, and so it was really awesome to have that here, because, I don't know how bad it is today but it was really hard to come off the reservation. They had a lot

of programs out there, but this was before there was a war. Then there was a war that went on (referring to Desert Storm), and they threatened to take our funding. [Omitted Section] It was just something that at that time I felt more comfortable with because it really helped identify me within the community. –Ronnie 2/6/08

Originally, the founders of this organization saw a need for Native Americans who left the reservation to have access to a better way of life through education and/or employment. Qua-Qui offered health services in the late 1970's, but by 1986, Qua-Qui experienced organizational changes including relocation, the phasing of out on-site clinical services and changing the name from Qua-Qui to Native American Services Agency. Federal administrators often point to the high rate of organizational changes and staff turnover among urban Indian centers as evidence that they are unable to meet the demands of the growing community. Rodenhauser (1994) evaluated shortcomings of the health system that prevented American Indians from receiving adequate mental health care, noting that barriers included 1) under-funded and under-staffed organizations 2) inconsistent services and 3) staff burnout, among the most important. Miles, the clinic supervisor at the Indian center explained:

For a while the credibility of the center went downhill and I was interested in restoring it. For a while there was a high turnover rate for staff, and the reputation was being damaged. 2/11/08

In 1993, M.I.C. merged with the Missoula Indian Alcohol & Drug Services Agency and attempted to provide comprehensive health and chemical dependency (CD) services to the urban Indian community. During the merge, Qua-Qui changed its name for the last time to the Missoula Indian Center. M.I.C.'s services remain primarily outreach and referral, relying heavily on local and state agencies as their primary funding source. All of M.I.C.s alcohol and CD programs are funded through the state of Montana; the alcohol and CD program is the largest program at the Indian center, and is the only provision of direct care the center offers. The

center's non-Indian clients are enrolled in the alcohol or CD program because their eligibility is mandated by the state.

Other programs are operated under I.H.S contracts and grants, which restrict services to Native American clients and are primarily outreach and referral. Because the I.H.S urban Indian clinic fund is minimal, there are eligibility restrictions for the use of these services. Eligibility for I.H.S.-run services does not extend to *all urban* American Indians; it is in fact limited to members of the 562 federally recognized tribes. The eligibility rules set forth by the I.H.S. limit the service population to only 1.5 million of the 2-4 million individuals who would identify themselves as American Indian (Forquera 2001), excluding members of the 109 non-federally recognized tribes "terminated" by the federal government in the 1950s and others without federal recognition status (UIHC Report 2007).

Claims to Authenticity

In order to receive treatment at the Missoula Indian Center, an individual must be able to prove his or her identity as American Indian, unless he or she seeks treatment through the alcohol program. Documents acceptable to prove American Indian identity and eligibility include enrollment in a state or federally recognized tribe, proof of lineal descent up to the second generation, and the proper ID which includes a birth certificate or Tribal ID card, or any combination of the above. To offset the cost of treatment for those who do not meet the eligibility requirements for Medicaid or Medicare, M.I.C. utilizes a sliding fee scale. The I.H.S. funds only the operation of programs at M.I.C. but does not cover the cost for individual treatment regardless of enrollment or other identification markers. The I.H.S contract stipulates that M.I.C. must serve at least 45% American Indians, a stipulation that is primarily responsible for the need of individuals to have proof of identity before treatment.

Many urban Indians are eligible for health coverage under Medicaid or Medicare, which is true whether or not they are enrolled in a federally recognized tribe or if they receive I.H.S.-funded services. For different reasons, many eligible urban Indians do not enroll in public programs. Many believe that the federal government is obligated by treaty and law to pay for their health care. On the other hand, some argue that a legal government to government relationship ceases to exist, thereby treaty agreements are nullified. Healthcare is part of the trust relationship the government has with Indian leaders, therefore it is considered by most supporters and Tribal leaders as a legal agreement.

Other reasons American Indians fail to enroll in public programs are refusals to go through the intrusive Medicare/Medicaid application process, feelings of dehumanization by social workers and healthcare staff, or because A/I clients are told to apply through I.H.S. first. Many American Indian elders are not eligible for social programs like Medicare because they either lived on reservations their whole lives or never worked at a job subject to Social Security withholdings which would enable them to qualify (Forquera 2001).

As debates over funding continue, urban Indian centers are continually asked to justify their existence. One argument urban centers use is that they are well-equipped to deliver culturally appropriate care to urban Indians, and that they should continue to receive federal funding via the I.H.S as urban Indians are entitled to healthcare under legislative and treaty agreements. How urban Indian centers deliver culturally appropriate care is an issue that is important to uncover, as urban Indian centers remain a volatile entity as the IHCI (1976) comes up for re-approval by congress in 2008. The remainder of the discussion will involve a more thorough examination of the staff members and how their cultural background contributes to the culturally-sensitive care that urban Indian centers promote and offer to their clientele. Moreover,

I will present a discussion of the cultural components of mental health and chemical dependency treatment programs offered at M.I.C. and their relationship to funding streams. In the next chapter, we will see that M.I.C.'s inability to rely more on IHS funding streams has led to an interesting contradiction within its development of culturally-sensitive care.

CULTURE AND HEALTH

Cultural Competence and Urban Indian Health

Health professionals and social scientists have looked to cultural competence training as a possible way to eliminate health disparities in the mental health status of diverse ethnic and cultural groups (NCCC 2003). Legislative bodies are increasingly emphasizing the requirement that mental health and addiction counseling be culturally competent. Congress passed the Healthcare Fairness Act of 1999 and the Bureau of Primary Health Care released this Policy Information Notice 98-23 in 1998 which states—

Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socioeconomic status, housing status, and regional differences. Organizational behavior, practices, attitudes and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff.

These recommendations also appear in a 2003 report from the National Center for Cultural Competence, which cites the following critical factors for the delivery of culturally competent care: 1) understanding the values, beliefs and traditions of the group served and 2) understanding the needs related to health of individuals, families and the community. Some social scientists and health practitioners have proposed ethnic-matching between patient and provider as a way to ensure that the provider is competent in the values of the clinic's clientele. Ethnic-matching is also shown to increase health outcomes and improve communication (Cooper-Patrick 1999, Lau and Zane 2000, and Ziguras et.al 2003). Yet the value of ethnic matching may lie more in the provider's presumed lack of racism than in the claimed "cultural

competence” of the provider. Anthropologists have questioned the generalizable and outdated use of culture by clinics in the development of mental health and chemical dependency programs, and argue that cultural competence is a disputable ideal that should be reexamined (Fitzgerald 2005).

In this chapter, I will examine how the Missoula Indian Center negotiates this tension between an essentialized notion of cultural competence and the desire for ethnic matching of patient and provider. I will show how funding streams dictate the Missoula Indian Center staff’s hiring practices and the cultural composition of the staff, and how staff background influences the cultural competence practices of the Missoula Indian Center. Additionally, I will illustrate how staff understanding of urban Indian culture underpins the development of culturally sensitive mental health and CD treatment programs. I will explore how Indian staff members and non-Indian staff members perceived the influence of their cultural background on treatment outcomes and how each person used a discourse of culture to rationalize their aptitude for treating urban Indians successfully.

Although the language used to describe ethnic-specific care explicitly centered on culture and values, the arguments underlying cultural competence and shared values revolve on the experience of racism or discrimination at mainstream centers. It can be inferred from the narratives provided by the staff members, especially from those who utilized clinic services, that although a main reason for urban Indian clinics is the cultural knowledge and competency they possess, a more important aspect is the maintenance of a non-discriminatory atmosphere.

Finally, because many of the arguments for the uniqueness of the center focus on culture, I will critically examine how the Missoula Indian Center develops concepts of culture when

choosing cultural programs like the center's alcohol treatment program, and the use of smudging sessions.

The Center's Mission

The Missoula Indian Center operates under the conditions set forth by their funding contracts. The most influential funding source is the contract with the Indian Health Service (I.H.S); it outlines the center's hiring practices and board member composition. The I.H.S contract states that the Indian center must practice "Native preference" when hiring staff members. The executive director noted that although the contract says they must exercise native preference, they are not necessarily mandated to only consider Native applicants. The contract does however require that the Board of Directors contain at least 51% Native Americans, a requirement the Board must adhere to when it considers the composition of the governing seven-member Board. The I.H.S contract contains no explicit statement about tribal affiliation or tribal diversity, but the Indian Center Board currently⁶ consists of (M.I.C. 2006),

- Enrolled member of the Northern Cheyenne
- Enrolled member of the Apache
- Enrolled member of the SoKaogaon Chippewa Community, Mole Lake Band
- Enrolled member of Gros Ventre
- Enrolled member of Assiniboine Sioux
- Non-Native member

The diversity of the governing Board represents the diversity of the urban Indian community.

⁶ As of 2007 there are currently only six members sitting on the Board of Directors, although seven is the typical number

Promoting a diverse Indian community and maintaining generality was an important aspect in maintaining this urban Indian center that serves urban Indians with more than fifty different tribal affiliations. Due to the fact that the population served is a diverse mix of American Indians, it was very important the center ensure not to promote one tribe over another. When asked how M.I.C. develops culturally appropriate programs, events, activities and décor for its diverse clientele, employees reiterated a combination of the following answers:

We really try to keep our cultural activities and treatments general, we use a blending of options from all tribes, and then each of those programs are approved by the board before we implement them.—Lisa 2/14/08

We see culture here as a general thing, you know? We are just all Native Americans so we don't display any tribal favoritism—we keep cultural displays general and inter-tribal.—Shayna 2/5/08

When prompted to discuss these ideas of Indianness more thoroughly, there was not a clear response; that is, how do they ensure that activities represent inter-tribal Indianness without inadvertently representing one tribe over another, or one tribes values over another, etc.?

As Lisa points out, the board approves each of the center's programs, and the board is comprised of members from several different tribes, as well as one non-Native member. By having a diverse board to approve activities, it might be safe to assume that the approval process helps eliminate cultural problems. The board approval process may be the most appropriate way to assess the pan-Indian cultural activities they offer, because when asked what qualities make up urban Indian culture, the only response was that “they represent a general Indian population who live in urban areas, and not on the reservation.”

Center's Philosophy of Cultural Competence

I asked Lisa, M.I.C.s executive director to outline the center’s philosophy on cultural competence, and this was her response,

Our philosophy on culture and cultural sensitivity is outlined in our mission statement—but it is at the discretion of the counselor—Lisa 2/14/08

This is a very common response, even though the mission statement sets forth that,

The purpose of the M.I.C. is to promote and foster the health, education and general welfare of urban Native Americans in and around Missoula. M.I.C. provides an information and support system to the Native American community by networking within house programs and local health and human service agencies to provide maximum resources. M.I.C. also helps bridge the gap between relocating from reservations to urban life by functioning as the primary communication center. (M.I.C. 2008)

The mission statement does not establish guidelines for the maintenance of cultural sensitivity, but it does establish the primary purpose of the center and its goals for the community. Referring to the mission statement to describe how the center establishes cultural competence guidelines is thought provoking; the mission acknowledges the unique situation of urban Indians but does not establish practices for maintaining cultural sensitivity. As the second part of Lisa’s response implies, cultural competence practices are up to the discretion of the counselor or staff member which means that there is not an agreed-upon method to practice cultural competence, and each staff member will practice it differently.

MIC Staff and the “Cultural Component”

There are eleven staff members, eight of whom are Native American and three of whom are non-Native. Of the eight Native American staff members, there were six who identified themselves as urban. Although most of them identified with a tribe it did not influence their identification as urban. Of the three non-Native staff members, two of them said during the

interview that they are “exploring their Native heritage.” Although they had Native American heritage, the respondents did not know enough about their lineage to discuss it more thoroughly.

Many of the staff members referred to the “cultural component” as a primary reason that urban Indians are better served at M.I.C. versus a non-ethnically specific center. There are a number of pieces that make up the cultural component, and most are explained in terms of cultural values. Among those differences cited were:

- Understanding and acknowledging different cultural groups and inter-tribal differences that make up the clientele,
- Respect for gender norms and generational values

I will discuss each of these components in detail in the sections below.

Cultural Groups and Inter-Tribal Differences

Not only does the idea of culture come up in the discussion of the administration and development of M.I.C. programs, but it is also a primary justification for why M.I.C. is best equipped to treat the urban Indian population. Because urban Indians come from diverse tribal backgrounds, the counselor is expected to understand inter-tribal differences and also be able to uphold a pan-Indian culture without promoting one tribe over another. In other words, the counselors’ understanding of tribal differences is one reason why they feel their programs are successful.

Our cultural ethic supersedes professionalism here; we understand the subtle tribal differences. Because of that we are able to promote and implement common values, rather than tribally specific beliefs. For example we know that if someone dies in the Native community, some of our clients may be in mourning for weeks, and they will miss appointments, and won’t call to cancel, we just won’t hear from them; but we know this and we won’t turn them away for missing appointments like other clinics would.—Miles 2/11/08

The “cultural ethic” is a theme that is intertwined throughout the staff member discussions of cultural competence at M.I.C. Besides having the knowledge and understanding of transitioning Indian families and grievance customs, understanding American Indian gender and generational values/ethics was cited as an important cultural element of the center. Although staff mentioned these elements as essential when working with urban Indian clients, the clientele are diverse and their values and norms are on a continuum. The receptionist described it this way,

There are three groups I work with, the traditional...you know the ones who are right off the res. [she giggles], the urban, like the ones who are born in the city and don't know their language or heritage and the whites, I'm sorry I mean the non-Natives because we have others who come here. I can tell them apart, and so I know how to interact with them, like I do it differently depending on the person, but I mainly just try to stay friendly—Shayna 2/5/08

Thus staff reported that they adjusted their behavior to fit with these diverse groups of patients.

Respect for Gender Norms and Generational Values

Shayna is a Montana American Indian, who also considers herself urban; she believes that her cultural background was able to help her develop her knowledge of the three distinct cultural groups she described above. She adapts her conversation style to reflect the group that a certain client might belong to. As I pointed to earlier, the staff members may have a typified set of categories that they divide their clients into, which is one element of cultural competence that anthropologists often critique.

In addition, staff members provided a few more pieces of cultural knowledge they find indispensable when working with urban Indian clients. More than half of the respondents acknowledged the importance of respecting gender norms—

Like I know that older men don't like to talk to women so I understand that I am supposed to talk to the woman, and then he will tell her his answer and she will

tell it to me. But I know the respect customs, and it is important in getting the older men to feel comfortable. –Shayna

For example, in Shayna's response, she knows that because she is a woman she is supposed to talk to the wife, resulting in more effective communication with older male clients. This knowledge was also mentioned in four other interviews.

Respect for inter-generational norms was another emphasized piece of cultural knowledge that staff members acknowledged among the most important. When I asked Carla, the clinic coordinator, to describe a time where culture played a role in receiving health treatment she related a story that was intriguing. Although it was not directly related to mental health or CD care, she said that these problems occur frequently when working with Native American elders, regardless of the type of the outreach program in question. She said,

One of the problems though, with our small staff is the outreach. In Native American cultures we are taught to respect our elders. It is really hard to reach the older Natives like the elders, because of traditions about respect. Like because I am young, older women won't take me telling them what to do. Especially the women, because of their role in childcare and in the family it is hard for them to understand they need to take care of themselves too. It is a matriarchal culture, for most of us, well, in my tribe anyway, but they don't want a younger woman to tell them what to do. Even though I am not that young [giggles].

I knew it was a cultural problem. I was going to them and giving them all this education and they weren't listening to me because they are my elders. I finally had to get past this obstacle; I went to my mother and asked for her help. I explained to her my problem, and she said she would talk to the older women. But when I explained that she would have to get an annual exam and a mammogram she still didn't want to do it. I ran into the same problem with her. I started on her like 6 mos. in advance. She kept saying she didn't have any problems. I kept giving her this educational stuff and she wasn't responding. She finally said you don't know everything quit telling me what to do. I rephrased it as a problem that she could help me with. Finally she did, and she was able to reach out the other elders in the community because she is older and respected as well. So we have to face these kinds of challenges and if I hadn't been part of this culture I don't know if I would have been able to overcome those challenges with

outreach to elders. So, I had to use a roundabout way because I knew it was a cultural problem. –2/8/08

Carla was able to resolve the stigma of clinical healthcare to A/I elders because she was raised with an understanding of the cultural value placed on respect for elders. She was able to develop a plan to strengthen outreach efforts to A/I elders, by using her cultural understanding of respect for elders as her starting point. Although in this case cultural knowledge contributed to increased rates of treatment by older A/I women, the use of culture in this instance was specific to a particular barrier; whereas many cultural competence programs are based on a general understanding of cultural values.

Staff Philosophies of Cultural Competence

Due to the large sample of Native American staff members who considered themselves urban Indian, I sought to find out if their background influenced their choice to work at an urban Indian center. I found that for most American Indian participants, their cultural background was the primary factor influencing their decision to work at M.I.C., regardless of whether they considered themselves urban or not. Although A/I staff underscored their “cultural knowledge” as the most important reason for their decision to work at M.I.C., it was also clear that their experiences of discrimination in mainstream settings played an equally, if not more, important role. As I show below, while American Indian staff chose to work at the center due to specific experiences illustrating the need for ethnic-specific care, non-native staff chose to work at M.I.C. due to their understanding and sympathy with “Native American cultural values.” These narratives illustrate the ongoing tension between providing culturally competent care and essentializing Native American culture.

For example, Arthur, an intensive outpatient counselor, considers himself a traditional Native American. He advocates using “tradition” in treatment and listed A/I flute music, the medicine wheel and elders as part of his treatment therapies; he argues that his treatment methods are more congruent with A/I beliefs and values. Arthur was the only respondent who referred to the lack of understanding by western medical counselors as a reason for seeking employment at a Native American center.

It was important for me to work in an Indian center, because we learn in the Western World, you know we learn white-this...white-that...and those things don't apply to us, and it doesn't have a place in my counseling either. I can relate better with other Natives because it's easier to understand our way...--Arthur 2/12/08

Essentially, Arthur is saying that treatment methods taught in western medical education, neglect the experiences faced by American Indians, and also fail to incorporate A/I beliefs about health and mental well-being into counseling programs. In this case culture and treatment are viewed by Arthur as a way to combat the discrimination experienced at other clinics which he attributed to the lack of incorporating and understanding cultural models for wellness.

Ronnie, the administrative assistant, had a very different response. Ronnie felt compelled to work at an Indian center due to her past experience with urban relocation. Although her statement includes elements of Arthur's complaint, Ronnie described herself as an urban Indian who transitioned from reservation life in her teenage years, when she moved off the reservation she became a client at Qua-Qui. In addition, Ronnie's parents were activists and advocates for American Indians. It was her personal experience of leaving the moral support and parental influence during her transition from the reservation that made a large impact on her decision to work at M.I.C. Ronnie speaks of the center as a place that influenced her identity within the urban community.

One of the things I remember when I moved off the reservation was that it was really awesome to have Qua-Qui here. I don't know how bad it is today but when I moved off the reservation it was really hard...I felt more comfortable with going there because it really helped identify me with the community. My parents were activists in the community and my dad is well-known at the University and in the community because he worked to get education on the reservations...and that influenced me. So it was important to me when I started work at Qua-Qui, to work with Native Americans.—Ronnie 2/6/08

When Ronnie refers to “how bad it is today...” she is talking about racism experienced by herself and many other urban Indians upon their transition to urban life. Her choice to use services offered at Qua-Qui are a direct response to newly experienced discrimination, due in part to their cultural atmosphere and anti-discrimination efforts. Her response embodies many of the arguments urban Indian centers and administrators could use to justify the continuance of their budget. In this case, both the administrators and clients of urban Indian centers have the same idea about what the centers offer to their clients that is unique from other community services.

Both Arthur and Ronnie used their own personal experience with “culture-shock” as a measuring stick when choosing where to work, but others chose to work at an Indian center in response to a perceived need for Native Americans to treat other Native Americans. This was due in part to the perceived racism or discrimination at non-Indian agencies Carla, an RN and the clinic coordinator, made the decision to seek employment at M.I.C. because of her experience as a nurse in a community hospital:

I worked at a hospital before and the Native Americans that would come in to the hospital would always ask for a Native nurse. It was really important to them; they would tell me that it's just easier to have a Native nurse, and how happy they were that I am a Native American. So because of that experience it was important for me to continue to work with the Natives.—Carla 2/8/08

Thus whereas Arthur and Ronnie both personally understood the need for culturally-sensitive care from a patient's perspective, Carla understood it from the perspective of a care provider.

Each of these arguments highlights the fact that a lack of cultural sensitivity and indeed outright prejudice may compromise the health care urban Indians receive in mainstream settings. Moreover, taken together, these three narratives comprise different elements of arguments for cultural competence and ethnic-specific clinics—1) Western biomedical models are not an suitable framework for healthcare for ethnic minorities, 2) urban Indian centers are best-equipped to serve a transitioning population and 3) ethnic-matching between patient and provider improves health outcomes for minority patients.

Ethnic-Matching

It was typical for the Indian staff members to emphasize the importance of ethnic-matching as a means of providing culturally competent care, while it was typical for non-Indian staff members to emphasize their personal relationships with Native Americans and Native American culture. American Indian staff cited ethnic matching as the means towards providing culturally competent care. Some of the Indian staff stated in our interview that many of the clients specifically request Indian counselors, while the non-Natives did not mention this preference. A common justification for ethnic matching is illustrated in this response from Carla, M.I.C.s clinic coordinator (2/8/08),

We know certain customs that make it easier to communicate with the clients, like understanding how eye contact is a sign of aggression for many tribes. I think the native preference for hiring staff is really to make the clients comfortable.

Understanding cultural customs is an answer that is mirrored in Ronnie's response (2/6/08),

At a young age we are taught to respect the elders, also we understand that many Native cultures are matriarchal and so we have a better understanding about how to work within those frameworks. It was important to clients, when I worked at the Hospital to have a Native nurse, because I understand the Native pride—it's a cultural thing and it is hard for AI to ask for help—so we understand how to do outreach, promotion and prevention in a different way.

Thus many of the American Indian employees rely on their ethnicity as an essential part of effective communication with their clients. Ziguras et.al (2003) and Cooper-Patrick et.al (1999) also noted that one of the primary benefits to ethnic-matching was more effective communication between patient and provider. However, what staff members neglected to address is how their cultural background affects their relationship with non-Indian clients⁷.

Most of the respondents said that because of the “Native environment and staff” people feel more comfortable at the Indian Center, and that trust is a major component in that sense of comfort. Due to the longstanding lack of trust in government or western biomedical health services by Native Americans, the trust issue is one that cannot be ignored. The historic mistrust is defined by A/I experiences during the termination and relocation period, in which many experienced racism and hardships adjusting to a new health system that many feel were forced upon them. When asked why the respondent chose to work at an ethnic-specific center for urban Indians most answered the same way as Virginia (2/11/08),

I feel more comfortable working with Native clients. My cultural background is essential, there are lots of ways you can approach people, and my cultural background helps me approach elders, know that I am supposed to talk to the woman because I am a woman, and we are able to show respect to each other, and this is a place where people aren't afraid of us and our culture.

It is evident from this response that ethnic-matching was more important for the A/I staff members and clients, especially for traditional clients and elders.

Although American Indian staff stated their cultural background as a primary reason for working at the center, the three non-Native staff members noted their personal experiences with Native American culture as an influencing factor. The non-Native counselors (2) and intake coordinator had formal training in cultural competence, citing the social work program at the

⁷ This ethnic group was noted as being a large part of the clientele at M.I.C., yet throughout interviews the staff members chose not to address how their background influences relationships with non-Native clients, even with some questioning by the interviewer.

University of Montana as one form, and shorter training sessions or seminars as the other. In conjunction to formal training, all three pointed to personal experiences with Native American culture as a primary measuring stick for cultural competence; past friendships with A/I or previously residing in “Indian Country” may account for their ideas on the “cultural component”.

All employees mentioned the importance of being in tune with and adhering to Native American values, yet rather than adhering to an essentialized understanding of A/I values most pointed to personal experiences as the principal source of understanding. The non-A/I staff members used their background to explain why they were a “fit” with the center; they emphasized personal relationships with Native Americans as the reason for understanding cultural differences and pan-Indian values.

Although I am not native, I grew up in a community where there were a lot of natives, so I grew up with those values. Because I can relate and live by similar values the clients hold, they seem to trust me.—Kassie (2/12/08)

We can identify with our clients, we understand their family values, and Native counselors understand where the family has been and the struggles that they face when they move off the reservation. Plus, Native staff have a better understanding of how alcohol and depression affect Native families. Our I.H.S contract stipulates that we exercise Native preference for employees, but we will hire based on skill set and fit with the center.—Lisa 2/14/08

I am not Native, obviously, but I lived for a while in “Indian country” and have examined and participated in traditional healing methods, so even though I am white I don’t think it makes a difference.—Miles (2/11/08)

Although they are not of A/I descent Kassie, Lisa, and Miles justify their employment at M.I.C. based upon their past experiences and relationships with A/I culture and adherence to cultural values. Indeed, even when asked about the non-A/I staff members, the Indian staff would cite their “fit” with M.I.C. and more broadly their “fit” with Native American values as an important quality for maintaining their employment at M.I.C. Although value-matching was agreed upon by both Native and non-Native staff members as the most important aspect for

successful treatment of the urban Indian community, the importance of this characteristic is underpinned by the desire to eliminate feelings of racism experienced at other agencies.

In the case of non-native counselors, the matching of values stems from shared experiences, and each of the non-Native staff members points to their relationship with A/I culture as a measuring stick rather than an essentialized set of traits or values that anthropologists have criticized as a weakness in cultural competence models. However, while they might have personal experiences with Native Americans, their understandings of Native American values are influenced by other mediums. Kassie also mentions A/I values listed as a set of typical traits on a poster which informed her understanding of Native American values and beliefs.

I grew up with a best friend who was Native American, and I relate really well to the Native American values and beliefs. I am also a recovering alcoholic and drug abuser, and I entered a treatment program based on Native American spirituality. There was a presentation once in the alcohol class where they had a poster with one side that was “Native American values” and the other that listed “White values” I found that I sided mostly with the Native American values. I tried working elsewhere, and it just wasn’t a good fit. I really agree with the approach we take here, and in general the way Native Americans approach treatment—Kassie 2/12/08.

Kassie takes a multi-dimensional approach to explain her understanding of Native American culture. On the one hand, she uses her personal experience with her best friend as a measuring stick, and on the other she uses an essentialized set of “Native American Values” listed on a poster in a class on alcohol dependency. The essentialized values depicted on the poster are a clear example of how cultural competence practices can result in a generalizeable list of traits that might be associated with Indian culture.

The Indian Center prides itself on a more thorough understanding of the diverse values and beliefs that urban Indians hold, and the use of a generalized list of values appears to contradict the very foundation upon which the Indian Center rests. Although one Indian center

employee cannot speak to the greater mission and values of the center, her understanding of Native American values influences the daily operation of the center, and should thus be congruent with the core values established by the center. In addition, Kassie's statement illustrates the tension within models of cultural competence between a grounded understanding of Native American culture based upon lived experience and an essentialization of "Native American values" or cultural traits.

Thus, the staff at M.I.C. tends to emphasize that both ethnic-matching and value-matching contribute to greater cultural understandings of urban Indian clients. Administrative staff members argue that although they must exercise "Native preference" when hiring, they often rely on a mix of professional credentials and shared values and experience. They argue that shared cultural and ethnic background, although a benefit is not essential as long as the counselor is a "fit" with Indian cultural values. Although many phrase this issue in terms of the "cultural knowledge" or "cultural sensitivity" staff bring with them, it is clear that the discussion of "culture" disguises a practical concern to help A/I clients avoid the discrimination often faced in mainstream institutions.

Culture as Cure?

One of the primary critiques of cultural competence in anthropology is the essentialized use of culture in the clinical setting. Vilma Santiago-Irizarry (1996) argues that cultural competency programs frequently propose culture as a "cure" to the dysfunction perceived as the side-effect of culture "loss." M.I.C. staff similarly viewed assimilation and loss of culture as a primary reason some urban Indians experience high rates of alcoholism and depression; thus reinforcing a person's cultural identity should result in greatly improved treatment outcomes. The logic of such programs is that alcoholism in native communities historically accompanied,

and is the legacy of, European colonization. Contemporary rates of alcoholism are similarly seen as accompanying the government's attempts at forced assimilation, such as the urban relocation programs that in turn increased the population of urban Indians. Therefore, such programs attempt to restore urban Indians to traditional Native American culture in an effort to combat the perceived mental health effects of "culture loss."

M.I.C. uses a program for alcohol treatment developed by an American Indian non-profit based in Colorado Springs, and the message behind it seems to suggest that "getting back to tradition" is an important means to kick the alcohol addiction. The program is called the "White Bison Model—The Red Road to Wellbriety," and it was developed in 1998 by Don Coyhis of the Mohican Nation as a healing resource for Native Americans. This program offers wellness/wellbriety resources for Native American communities nation-wide, and many non-natives also use these healing resources.

The mission of White Bison, Inc. is to "bring one-hundred Native American communities into healing by 2010" (WhiteBison 2007). The organization holds national conferences, specialized community training events, Wellbriety coalitions, and its most popular event, Firestarters Circles of recovery. Firestarters Circles are made up of Native and non-Native people in communities who "work" the Medicine Wheel, and they meet in talking circles to evaluate how to incorporate "ceremony and local tradition into their own healing journeys." There are currently over 350 Firestarters Circles throughout the United States and Canada⁸.

The Wellbriety movement is dedicated to the history of Handsome Lake and the resistance to alcohol during European settlement. It is based on the healing techniques used by Handsome Lake, a Seneca from New York. Handsome Lake is a leader and prophet who preached to the morale and welfare of the Iroquois during a time when reservations were in their

⁸ Referred by White Bison, Inc. as Turtle Island

infancy and alcoholism was prevalent. In 1799, after a period of illness, due to alcoholism, Handsome Lake began to have visions about the dangers of alcohol, and began to warn his following of these dangers. His following grew as his “code” became more widely accepted. The *Code of Handsome Lake* was published in 1850, and has been regarded as playing a large part in Native cultural preservation (Walle 2004).

The philosophy behind this program thus emphasizes the continuing role of the forced assimilation of native communities in their high rates of alcoholism. It implies a parallel between the historic rates of alcoholism following the European colonization of Native Americans on the East Coast and the more recent history of alcoholism in Native communities, which increased during the end of WWII. From 1945 on, rates of alcoholism among A/I communities rose to an unprecedented level, and during the revival of the Native Pride movement of the ‘60s and ‘70s, the drive to achieve sobriety accelerated (WhiteBison.org 2007).

The White Bison Model uses the 12 steps from the AA program and blends it with the traditional beliefs of many American Indian people. The Wellbriety movement teaches that culture can help prevent chemical dependency and other dysfunctional behaviors. It utilizes the Daughters of Tradition prevention program to help girls avoid negative behaviors before they start. Likewise, it utilizes the Sons of Tradition Program for boys and young men to bring preventative attitudes and behaviors to young Native Americans. According to the organization’s website, the White Bison Philosophy for healing is based upon the principles, natural laws and values taught to American Indians by their Elders. Espousing culture as a “cure” (Santiago-Irizarry 2003), the White Bison model thus draws upon an essentialized and generalized version of Native American culture to attempt to offer culturally-consonant chemical dependency treatment.

The organization states that the White Bison Philosophy is this:

There exists a system of natural order that runs the universe. We follow the system of natural order in the healing process. Our trainings, programs, and services are based upon four categories of teachings:

- *The Four Laws of Change*
- *The Medicine Wheel and the 12 Steps*
- *The Healing Forest Model*
- *The Four Directions Teachings*

(White Bison 2007)

The Four Laws of Change is based on the Healing Forest Model, which states that 1) change is from within, 2) before development can occur, it must be preceded by a vision, 3) a great learning must occur, and 4) you must create a healing forest. These various “categories of teachings” thus rely upon metaphors of nature and of spiritual growth that are often common in pan-Indian views of traditional culture.

The Medicine Wheel and the twelve step program are designed in a series of sessions that enable people to meet individual treatment needs. Participants must share their experiences in a talking circle, called Circles of Recovery, which helps patients develop social and emotional bonds, trust, and healthy feelings that will help in the recovery process. The program appropriates the traditional 12-step program of Alcoholics Anonymous and instead focuses each step on pan-Indian values:

Step 1: Honesty

Step 2: Hope

Step 3: Faith

Step 4: Courage

Step 5: Integrity

Step 6: Willingness

Step 7: Humility

Step 8: Forgiveness

Step 9: Justice

Step 10: Perseverance

Step 11: Spiritual Awakening

Step 12: Service

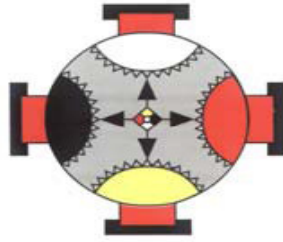


Figure 1

The twelve steps are taught in conjunction with the Four Directions Teachings, (see Figure 1). On the East facing point of the figure are steps 1,2 and 3 (Finding the Creator), on the South facing point are steps 4,5 and 6 (Finding yourself) , on the West facing point are steps 7,8 and 9 (Finding your relationships with others) and on the North facing point are steps 10, 11 and 12 (the wisdom of the Elders). The Wellbriety model proposed by White Bison, Inc. is thought to spread pan-Indian values that members of all tribes (and non-Natives alike) can relate to as a useable model for Native American wellness.

Clearly, then, the White Bison Model embodies the kind of generalized and typified approach to Native American culture that Vilma Santiago-Irizarry has criticized among cultural competence programs. Yet the center’s use of the White Bison Model for alcohol treatment also serves as an interesting framework through which to view the contradictions within urban Indian clinics between mainstream funding streams and culturally-specific programs. The alcohol dependency program (including the White Bison program) is funded by the State of Montana. Therefore it is open to non-Natives as well. In fact, both alcohol counselors said that non-Natives comprised the program’s largest group of patients. So although the center uses a model based upon “Native American values” to treat chemical dependency, the program has a primarily non-Native patient base. This is a contradiction that derives directly from the center’s diverse funding streams, due in part to its inability to rely exclusively on funding from IHS. The center

desires to serve the urban Indian population, yet because it is partially state-funded, it must maintain an open-door policy. Non-Natives are served by mandate of state contract requirements. The majority of these clients are mandated by court order (M.I.C. 2006).

This diversity of the center's patient base also leads to a tension within the center staff's approach to cultural competency. In order to address the treatment needs of the non-native population, the counselors cite using an interpersonal and holistic treatment style in their interactions with non-natives. When asked how culture is used in treatment, some staff describe the White Bison model in detail. Others, acknowledging the predominance of non-native clients in the chemical dependency program, say they stay focused on what the client says and that they use a "harmonious holistic approach," whereby they can stay "open to new healing methods and techniques." The more traditional members of the counseling staff also emphasize the use of tradition as a primary component of treatment, yet could not elaborate about what that meant specifically. Thus the center's reliance on state funding and its non-native patient base in turn leads to a tension within its philosophy of cultural competence between emphasizing tradition and emphasizing individually-tailored treatment.

All the responses eventually returned to the philosophy of patient-centered care, although all of them acknowledged that the cultural component was essential.

*Other programs are unfamiliar to struggling families who are moving off the reservation, so they prefer to come to M.I.C. because of the culture aspect. Chemical dependency and mental health are very personal experiences and M.I.C. and its staff have a better understanding of how it affects urban Indians.—
Lisa 2/14/08*

I think the culture aspect makes the center. You would be surprised at how many people call us years later to tell us how they are doing, and to thank us; so it's a huge difference as far as the culture aspect.—Carol 2/14/08

We use the cultural thing to bridge the gap between the individual and the problem. For instance we have familial and traditional options in treatment and

we try to highlight group unity so we can emphasize the selfishness of addiction. But we have to keep all our cultural activities general because we serve such a diverse Native and non-Native population.—Kassie 2/12/08

Yet quotes that stress the importance of using the “holistic approach”, and remaining “open to what the individual is saying” are vague and hard to pin down. Therefore it is impossible to have a discussion about cultural competence without examining the patient-centered care that many counseling psychologists and medical anthropologists have argued is a more effective model for mental health care.

The tensions between M.I.C.’s staff’s philosophies of care illustrate the difficulties with providing culturally-competent care to all members of different cultural groups. In response to the rise of support for cultural competence in healthcare, Danish et.al (2007) acknowledge the difficulties associated with the creation of healthcare practices in which every culture is fully understood by its practitioners. They argue that rather than training counselors in cultural competence for each different cultural group, it would be more effective for the patient to train counselors in interpersonal relationships, thereby creating "interpersonal effective care". The authors do not argue against cultural competence training, but explain that it would be more effective to be competent in the individuality of each patient. They propose that rather than grouping patients into cultural groups, it would be worthwhile to consider them not as passive agents in the treatment process, but as the primary actors. This proves a useful framework for examining the efficacy of cultural competence training, as the authors do not criticize the concept in its entirety, but offer a new perspective for looking at patient-provider relationships. Although proponents of cultural competence would argue that it is imperative to use a blended method where there would be an element of cultural sensitivity and competence on the part of

the provider, forming interpersonal relationships is a primary factor in promoting better health outcomes.

An examination of staff philosophies of how to provide culturally competent care at M.I.C. illustrates some of the contradictions within models of cultural competency. Staff members emphasized their comprehensive understanding of urban Indian culture based upon personal experiences with Native American culture which coexisted with an essentialized understanding of Indian values, as exemplified by the White Bison program. While these contradictions stem in part from a tension within the idea of cultural competence itself, they also derive from M.I.C.'s dependence upon public funding streams. The predominance of non-natives in chemical dependency programs designed to heal addiction created by European colonization vividly exemplifies the challenges facing urban Indian centers in using Native American culture as a "cure." Finally, assessing cultural competence and the use of culture in treatment in an urban Indian setting cannot be separated from an evaluation of how urban Indian identity is understood and reflected at the center. The following chapter is an exploration of how the Missoula Indian Center validates its unique ability to work with urban Indians, and how this results in greater access to health and social resources by the community.

JUSTIFICATION FOR URBAN INDIAN CENTERS

Fighting for Continued Existence

The previous chapters focused primarily on the history of urban Indian clinics and the mission and philosophy of M.I.C.'s program development and daily operations. These chapters illustrated the way that the federal and reservation conceptions of urban Indians as "not fully Indian" led to the precarious status of urban Indian centers, and how such centers also devised chemical dependency programs that emphasize the reversal of culture loss. I show the contradictions within both models of cultural competency and within typified ideas of "Native American values" and culture. In this chapter I will present the arguments in support of continued funding for urban Indian centers based on an observation of the center's environment and interviews with staff members. During the interviews I asked each staff member to describe the importance of the center and to justify its existence in light of proposed budget cuts. It was important to the staff members to have the opportunity to describe the unique culture of the center and to show how services, although delivered under the cloak of conventional mental health services, are particularly well-suited to serving urban Indians.

Transition to Urban Centers: The Urban Situation

In response to the proposed budget elimination for urban Indian centers, the Urban Indian Health Institute (2008) argues that conventional health agencies are ill-suited to provide culturally appropriate services to urban Indians and further, are not equipped to handle an increase in clientele (Peuschal 2008). If the eradication of financial resources for urban Indian clinics is approved by the federal government, M.I.C. employees agreed that Turning Point, the alternative option besides M.I.C., would not be prepared to handle the service population increase.

Turning Point is a program of Western Montana Addiction Services, and it provides substance abuse treatment programs that have up to a six month waiting list. In order to address this problem, the government proposes to increase funding for programs like Turning Point but it is clear that M.I.C. staff members do not believe it would be enough.

It has been a huge fight for us to keep our services, as you know. If urban centers were to be shut down it would result in a negative chain reaction. We are overcrowded as it is, if we had to send all of our clients somewhere else, where the waiting lists can be up to six months long, our people would probably not seek treatment.—Carol 2/14/081

There are limited healthcare resources in the community, if M.I.C. shut down, all of our clients would be displaced...and most would not be able to afford treatment. This could result in unnecessary incarcerations and would limit court referral sources for treatment plans. I think people would suffer, sometimes people need immediate care, and often the other services are unable to provide that—most are overbooked, and it takes months sometimes to get an appointment.—Lisa 2/14/08

Although it is understood that the current system would be unable to manage a service population increase, advocates for urban Indian clinics argue further that Turning Point does not offer culturally appropriate care. Turning Point programs are open to individuals from any cultural background, and are founded on Western biomedical models of treatment. These models of health and healing are often identified by A/I health practitioners as one reason why programs like Turning Point are ineffective frameworks to treat Native Americans. Yet more specifically, M.I.C. employees said other agencies lack an understanding of the urban Indian situation, which often leads urban Indians to seek treatment at M.I.C. In response I asked M.I.C. employees to explain why the center was better equipped to serve Missoula's urban Indian community as opposed to the other primary treatment option. Counselors explained that urban Indians face unique challenges when they move into urban areas and likened the transition to culture shock.

Culture shock can cause anxiety, surprise or disorientation and is experienced when people move into a different cultural environment (Zhou et.al 2008). Indian families moving into urban centers can experience culture shock in different ways; they may feel they do not belong or have difficulty transitioning to a new cultural environment and many have anxiety about the new policies that dictate their healthcare benefits. A/I families often find it difficult to leave their social support networks behind on the reservation and prefer M.I.C. because they feel as though they belong there, they are accepted, and they know the center is a place meant for them.

During interviews with M.I.C. employees, two staff members revealed personal narratives about the effects of culture shock upon moving to Missoula from the reservation. Part of their experiences included feeling noticeably out of place, and experiencing difficulties accessing social resources because of it. Carla noted that because she is a “dark” Native American she stood out, and instead of being able to blend in and participate in mainstream social activities she felt lonely and removed from the community. Similarly, Ronnie discussed culture shock through the lens of her school-age children; she explained the importance of having a social network that understands a person’s core cultural values. Her children experienced anxiety at school because they were unable to relate to the other children; those children lacked an understanding of A/I culture and in turn teased her kids because of their long hair or because they were “different.” She continued this narrative by saying that the M.I.C. is an essential place for people experiencing feelings of “otherness” and difference, because they can come in and just hang out with other Indians.

The anxiety associated with feelings of otherness and loss of community support was amplified when urban Indians experienced the loss of health benefits. Prior to leaving the reservation Ronnie and Carla felt comfort knowing that if they were to have any health problems

they would be insured, plus their practitioners would be knowledgeable in American Indian beliefs. Once in Missoula, loss of benefits proved to be a major component of stress and could be credited as a source contributing to higher rates of alcoholism and mental distress.

Receiving health services administered by A/I practitioners contribute to Ronnie and Carla's comfort level when on the reservation. Upon moving to Missoula the amount of preventative care they sought declined. In addition they neglected health needs out of fear of high prices and unsympathetic doctors. Both women said that it was one of the most difficult parts of moving to the city. Carla went so far as to say that even though the standard of healthcare on the reservation was similar to or below that of prisons, she would still prefer it over receiving no care at all. Their ability to see health care professionals who often shared their cultural background and provided a supportive atmosphere was essential to their satisfaction. Similarly, the unique ability for M.I.C. counselors to treat urban Indians is due to both their cultural congruence and shared experience with A/I culture and to the culture of the clinic. Because many American Indians continue to face racism when they move off the reservation M.I.C. strives to promote a discrimination-free atmosphere.

Culture of the Clinic

Much of the discussion surrounding the culture of the clinic and its importance to the people M.I.C. serves generally revolves around a transition from reservation to urban life. Although many of the clients are urban-born A/I, the framework for the clinic is centered on transitioning individuals with the idea that they experience racism off the reservation. To illuminate the need for the maintenance of a non-discriminatory atmosphere, many of the A/I employees referred to a time when they themselves transitioned from reservation life and experienced racism.

At the time Carla moved off the reservation, there were only ten other A/I students out of two-thousand at her Missoula high school. She experienced a great deal of racism in school; students put tooth paste in her hair, or sprayed perfume in her face as she walked down the hall. Carla ascribed this racism to the lack of understanding and knowledge about American Indians by “outsiders”.⁹ These ideas can be applied to the provision of health services to urban Indians. Because many A/I experienced racism at hospitals and other social services agencies, urban Indian clinics sought to provide an environment where A/I can feel comfortable, thereby increasing their chance of success in mental health treatment.

Health disparities among ethnic minorities remain prevalent in the U.S. DelVecchio Good, et.al. (2002) examined these disparities through a critical evaluation of the culture of medicine. They assessed how the healthcare industry is structured in such a way that it may contribute to overt and covert racism and unequal treatment in healthcare. When patients deviate from a typical patient role, such as urban Indians do, it can affect the treatment offered to them. In other words, because practitioners and their urban Indian clients have different understandings of benefits and treatment frameworks, the result may be an ineffective provision of care.

Due to prior experiences with other services in the area, many urban Indians simply refuse to seek treatment at other agencies. In a 2002 study Garwick et.al, suggested that obstacles to care for urban Indian families include lack of community-based services, ineffective communication skills by practitioners and problems with agency policies. In addition they reported that two of the top ten recommendations for improving care to urban Indian families were: 1) to ensure community participation in program development, and 2) to develop needs assessment and satisfaction evaluations, which was also part of the National Center for Cultural Competence’s 1999 campaign “One-hundred percent access, zero disparities.”

⁹ Carla referred to non-Natives as outsiders, or those who live off the reservation and do not understand A/I culture

American Indian and Alaska Native groups report the highest frequency of mental distress among all recorded ethnic groups at 12%; however, they rate the second highest of groups who did not receive mental healthcare or substance abuse counseling (Walls 2006). Barriers to receiving those services both include external barriers such as a common mistrust of government services; and internal barriers, or those that manifest within the system like funding, high staff turnover rates, and inconsistent availability of services (Walls 2006).

Disparities produced within the system are what Paul Farmer (2001) calls, structural violence. Take for example the government's proposal to increase funding for community health centers to pick up the slack for the elimination of urban Indian centers. It seems in theory that because the centers offer virtually similar programs, this would be a seamless changeover in the provision of care to urban Indians. The government continues to argue that taking this component away would have no influence on the success of mental health and CD treatment, even though culture is noted by a majority of health practitioners and other professionals to play an important role in mental health. Urban Indian clinic administrators continually argue that a change of this nature would be devastating to treatment outcomes for urban Indians.

Missoula Indian Center counselors and program administrators argue they have a special ability to provide culturally competent care to urban Indians. This serves as the primary argument underpinning their fight for continued funding. The employees regard M.I.C. as an agency with a better understanding of the urban situation due in part to the fact that many M.I.C. employees have experienced being an urban Indian. More specifically, they have a comprehensive understanding of the healthcare benefits and options available to urban Indians.

*People think we get a free ride, but we don't get s***, you know? It's a big misunderstanding about us urbans. When I lived on the res, I felt protected. I felt safe, but here [in Missoula] we don't have that safety. Our center gets limited IHS and grant money and we are unable to provide the services our community*

needs. We understand the circumstance of urbans better than other agencies. Us urbans are desperate to get healthcare, we don't just get it like they do on the res—Virginia 2/11/08

Virginia is ultimately arguing that alternative health agencies lack an understanding of the complexities of A/I health benefits. Often A/I clients are told at the time of payment to submit a claim to I.H.S, and many of them do, only to be turned down because of their status as “urban” A/I. Clients can become frustrated when their health provider is unable to assist them with proper payment plans, and it is possible that the lack of understanding by other service agencies results in perceived discrimination by urban Indian clients.

At the Missoula Indian center, the administrative and billing employees often take extra time to help a client submit paperwork and apply for proper funding. This can provide a source of comfort for many clients and help eliminate perceived discrimination. In addition the clinic produces informational packets for urban Indians explaining health benefits, or the loss of health benefits for urban Indians. Interestingly, M.I.C. contacted I.H.S to explain that many of their clients were unaware that moving into the city would result in a loss of benefits and asked if the agency would be willing to supply that information; I.H.S declined noting that it would be far too expensive to print and distribute informational packets (Carla 2008). M.I.C. now bears the cost, and provides the information to their clients, and also distributes it to urban Indian students at the University.

Cultural Atmosphere

The individual cultural beliefs of American Indian tribes vary greatly, however there a set of core cultural values that are similar for most tribes. In a study by Jerry Stubben (2001), 95% of respondents agreed that maintaining cultural identity and values remained a priority; a value that is reflected in the décor and setting of the clinic. It is common for many American Indians

tribes to conduct business or conversations in a circle, and as a symbolic measure M.I.C. conducts its staff meetings, group therapies and other events in a circle as well. On the M.I.C. website, they chose a quote to describe the importance for most American Indians to conduct business in a circle,

You have noticed everything an Indian does is in a circle, and that is because the power of the world always works in circles, and everything tries to be round.

The sky is round, and I have heard the earth is round like a bell, and so are all the stars. The wind, in its greatest power, whirls. Birds make their nest in circle, for theirs is the same religion as ours...

Even the seasons form a great circle in there, and always come back to where they were. The life of a man is a circle from childhood to childhood, and so it is in everything that moves.—Black Elk, Oglala Sioux (1863-1950)

You will notice that the circle was presented as a pan-Indian symbol, and using symbols that most American Indians identify with is a way for the M.I.C. to promote an inter-tribal community for urban Indians.

Looking around the waiting area, a tremendous amount of American Indian posters are displayed. Some posters have a general message, but most have Native Americans, dream catchers, social service flyers and an array of different knick-knacks depicted. When asked about the décor and cultural items in the clinic, it was clear that Shayna, the receptionist, had never thought about how or why she chose the items in the room. Front desk attendants tend to choose display items because they are responsible for maintaining the atmosphere when the client walks in and because local organization flyers, posters etc. come to them first. After some thought Shayna responded like this,

For the décor I choose things that are inspirational and have a good message, tribal differences don't matter here, I just try to choose things everyone can relate to. But like if I see someone from Browning or something I would probably tend to put it up... [giggles]. (Shayna's tribe is located in Browning, Montana)

Counselors and administrative staff revealed a deeper meaning behind the décor and culture of the clinic;

This place is like a connection spot for urbans, sometimes when you are trying to get treatment it is just hard coming through the front door, it seems like it is easier for people to overcome that here.—Ronnie 2/6/08

For staff members who utilized an urban center when they transitioned from the reservation, the underlying message was that they experienced racism and discrimination. Yet when they walked through the center doors, they knew they were not going to experience such prejudices in the Center.

A Home Away from Home

Norma Ware et.al (2004) found that the top preferences in healthcare delivery for minority and low-income patients were communication, feeling known, and having the opportunity for providing input on treatment. One method M.I.C. uses is making the clinic seem less of a government medical service agency by making the center feel “homey”. Often this homey motif helped low-income individuals, regardless of ethnicity, feel like they belonged in the center; in addition it helped make the search for treatment less intimidating.

At other agencies clients say they feel dehumanized, but that they know that we care here, even the white folks feel that way; maybe its our old building, or that it feels more homey, whatever it is...it is a place where they can come and let their hair down and just be themselves, you know?—Jamie 2/12/08

It should be noted that although Jamie describes the culture of the clinic as a place where both urban Indians and “white folks” feel at home, the center primarily designs the atmosphere with urban Indians in mind. Many of the non-Indian clients that utilize services at M.I.C. are low-income and/or court ordered to attend treatment sessions at the center and often respond positively to many of the same frameworks as urban Indians.

It was important for M.I.C. to maintain a small-scale, homey motif in the center, and to

keep it less “sterile” than western clinics and counseling centers. Miles said:

We don't run things by the book here, each circumstance is assessed with the heart, you know we are homey and we owe it them to keep our doors open and to provide them with a place they can come hang out and just be...Indian.—Miles 2/11/08

Miles made this comment in regard to the strict appointment cancellation policies at other agencies; M.I.C. does not impose policies for missed appointments or cancellations. Instead, M.I.C. staff understands that transportation, and other barriers exist and are determined not to turn their patients away because of it.

Providers at M.I.C. are aware that historical and even contemporary mistrust of service providers may influence the relationship with the client; in addition, the lasting effects of colonial history and mistrust continue to be a constant reality for Native groups (Weaver 1999). Therefore it was important that the clinic remained a social Indian environment; M.I.C. serves as a place where patients can speak their language and network with similar people. The employees and administrators especially, saw M.I.C. as a social hub, where people get together, have a cup of coffee and socialize.

The clinic has a big screen television in the waiting room, a coffee pot that is always brewing, a large fish tank, and an electronic job database system for clients to use at their discretion. M.I.C. also has subscriptions to primary American Indian newspapers and magazines which serve as important resources to A/I living off the reservation. In my own experience, there are few agency waiting rooms where tribal newspapers are available to the patients, and this is an important way for people to feel connected with the community they recently left.

Hub for Cultural Resources

One aspect of M.I.C. that speaks to uniting the community is providing access to cultural

resources that urban Indians find difficult to locate off the reservation. M.I.C. is regarded in the community as the main place where people can access Native resources. Powwows and other cultural activities are often displays of Pan-Indian symbols, which now serve as identity markers for A/I. These activities are defined as cultural patterns that span across tribal boundaries to unite people in a singular regional or national identity (Lerch and Bullers 1996). M.I.C. funds and promotes Indian cultural activities in the community; they organize sweat lodges, powwows, drum circles, contact with tribes, traditional healers and elders, and others. Promoting community activities that are founded on a Pan-Indian identity is another way M.I.C. maintains an inter-tribal organization.

In a survey of American Indian identity markers, Lerch and Bullers (1996) found seventeen markers that involve community acts and events that contribute to the recognition of A/I identity. The results of the survey suggest that Indian identity is linked to active participation in A/I community events. Access to resources and cultural activities is a difficult task off the reservation, and because M.I.C. is a place where A/I can be put in touch with cultural resources, it serves an important role, especially for those who hold culture and tradition very close. Others do not utilize these activities and they are considered assimilated by staff members and the community.

When you move off the reservation, there just aren't enough resources, so people fall out of their culture, they fall out of it. It would be a really big let down if there wasn't anywhere to go, you know people just stop speaking their language and stop practicing their culture if there is nowhere to go. Like on the res. you are surrounded by it, but when you move those activities are hard to find.—Shayna

Most participants discussed the cultural activities in their responses, but mentioned that it seems like the same people show up at every event and they find it difficult to get new people to attend. When asked why, they could not offer an explanation, but it was something they acknowledged

and wanted to change. Strengthening the A/I community within the urban setting is listed as a primary component to their mission statement.

Smudging

In addition to community social events, over half of the respondents listed the importance of a place where clients can smudge as one of the most important cultural elements. Smudging is a Pan-Indian healing technique based on the attributes of gendered plants. A/I philosophy is to live with nature in mind, and American Indians often will draw medicine through the medicinal properties of Native plants. Just as the seasons renew and recycle, they believe that they can renew themselves, too.

Smudging is based on the principle that certain plants, such as sweet grass, are given a female role to play. Sweet grass is a nurturing plant and is used ceremonially after the sage grass has removed negative energy. The sweet grass, like the woman, takes people in. The burning of such sweet grass is thus used to invite the good spirits to come in¹⁰. Others are given a male role like sage grass—given the job of the warrior plant, it is used to smudge and clean the air of negative energy, the forces of darkness. The sage is a warrior plant in that its job is to protect; it is used to protect people from the dark forces and negative energy. These forces are often thought to create illness, and the sage gets rid of the bad spirits that threaten well-being (Meuninck 2006). Although most Native Americans practice smudging, each tribe has variations of the custom. For instance, some of the Arizona Natives rely on the women to smudge, because they are responsible for the group's well-being (Ronnie 4/7/08).

Smudging is used in treatment and it is sometimes used as a social event, although I was told that it can be an individual and personal event, as well. At the Indian Center, smudging

¹⁰Spirit is used as a term here to refer to forces outside of the natural/terrestrial world.

sessions are not scheduled and take place nearly everyday. The staff also notes this as a benefit of employment at the Indian Center, as employees may utilize their group therapy room and smudge when they feel overwhelmed. At the center the counselor who initiates the smudging is responsible for running the session, however in a more ceremonial setting a medicine man might lead the session.

Clients often expressed that they felt discouraged and hurt that they were not allowed to practice smudging in hospitals, group living, shelters or therapy. Fire danger was often the noted as the reason smudging was prohibited but the Native American clients felt this infringed on their right to express themselves culturally and spiritually and often came in to M.I.C. for the sole purpose of smudging.

*One of the struggles is that staff doesn't understand that natives need smudging and family and sometimes need to get home, for support. Many other professionals don't understand that. It is all about understanding how to support them through their culture in order for them to get better. That's something we really utilize here. We give them a support network. We had some people who came from the group home, where they restrict smudging and sweet grass burning because it's a fire hazard. Or like how the hospitals restrict smudging. People feel like they can't be who they are and it's hard when you move into the city—
Kate 2/5/08*

During my observation and interview period at M.I.C., there was only one visit where the smell of sage grass did not permeate the building. I interviewed most of the staff members in the group therapy room where smudging takes place; the smell was strong, and the remnants of that morning's session remained noticeable. This is the only traditional healing method offered at the center, but staff often said they would refer clients to a traditional healer, however only if the client requested.

We don't usually recommend traditional healing options, the patients generally ask for it if they are interested. But patients wouldn't even bring it up in another clinic or like with a doctor because some of the local practitioners have called our healing methods Bull—Carla 2/8/08

Weibel-Orlando (1984) argues that the transitional stage between "at risk" and well is part of a socialization process where the patient must internalize a new role; and many clinics emphasize cultural roles through cultural events or artifacts. Ethnic specific programs help the resocialization process, especially in mental health and addiction counseling, from failing because they reiterate identity rather than the problem; this process helps illuminate an optional identity rather than the one where "risky" behavior is taking place.

In a 1968 study of alcohol use among Native Americans, Frances Ferguson suggests that Native American drinking patterns fall into two basic categories, recreation drinkers and anxiety drinkers. The anxiety drinkers were those who experienced acculturation stresses, meaning they are torn between the traditional ways of the reservations and the expectations of society off the reservation. Recreation drinkers are those that engage in drinking because of the influence from their social group. For anxiety drinkers (as many of the M.I.C. clients are depicted to be), native culture may be a source of comfort and might offer a more suitable framework for the illness experience to take place (Guarnaccia and Rodriguez 1996). Ferguson found that anxiety drinkers often did not succeed in treatment programs, because acculturation anxieties are harder to treat. This suggests, then, that M.I.C.'s attempt to address acculturation stress may play an important role in redressing alcohol abuse.

Utilizing approaches designed with and for a specific cultural audience, consistent with their values and beliefs will show significantly increased behavior change compared with groups receiving non-culturally targeted intervention, and the group receiving no intervention at all (Goode, Dunne and Bronheim 2006). So although the services offered at M.I.C., like counseling sessions, group therapy, alcohol and CD treatment and minor clinical services, fall under the

same names and categories that western clinics often use, the arguments conclude that they do not act in the same way.

Thus the culture of the clinic and the use of Native counselors is a symbolic measure M.I.C. takes to make their clientele feel comfortable. Having familial or traditional options, or at least a way to find them, is also a symbolic measure taken to make the environment a place where A/I can receive successful treatment. Taking into consideration the importance of symbolism in the delivery of healthcare for urban Indians is a primary component missing from other assessments. These symbolic measures are a main reason why urban Indians not only prefer M.I.C. but also have higher rates of success there, as well.

CONCLUSION

Discussion

Despite the concerted efforts of the staff and administration of the Missoula Indian Center and other urban Indian clinics around the U.S., it has become increasingly difficult to justify continued federal funding of health services. Why do urban Indian clinics continue to struggle for recognition? American Indians are entitled to care under agreements with the government as a recognized political identity, yet the status of urban Indians has recently been disputed by the federal administration as not being a valid political identity. Thus urban Indians' right to healthcare coverage will likely become void if congress agrees with suggestions from the administration. Therefore urban Indian clinics will be held accountable to provide sufficient justification, not only for their continued existence but also for the validity and legality of classifying urban Indians as an authentic branch of benefit-eligible American Indians.

Debating Identity and the Provision of Health Services

A great deal of attention has been focused on the meanings, experiences and politics surrounding ethnic identity, both by scholars and health professionals (Song 2003). Ethnicity is a concept that has yet to develop a common meaning and many anthropologists and social scientists have argued that ethnicity has taken on an all too simplistic meaning. Overly simplistic concepts of ethnicity have implied that it exists naturally; nevertheless, such restrictive conceptions of ethnicity are criticized for neglecting the construction of ethnicity through social interaction.

Even if an urban Indian is accepted in the larger community as an authentic A/I, he or she is required to show proof of his/her lineal heritage by proving the percentage of "Indianness in

the blood.” Consequently social status and community acceptance remains an unresolved issue. The ambiguous cultural status of urban Indians results in questions over the continued provision of health benefits administered by the federal government.

The general feeling held by M.I.C. administrators and counselors is that the federal government has essentially set out to diminish the number of Indians who are eligible to draw appropriations for Indian affairs (Churchill 2004). The government continually argues that by limiting the number of people eligible for benefits, funds could be more evenly distributed to the reservations, and result in a higher standard of care. This line of thinking resulted in the restriction of eligibility to those living on reservations, and in many cases, the demand for higher blood quantum requirements. Therefore, people moving off the reservation, whether for higher education or employment opportunities are excluded regardless of the degree of A/I authenticity they possessed (Churchill 2004). Urban Indian health centers continue to receive a small portion of federal aid to serve the urban population and as disputes over funding continue, questions of authenticity remain a central theme. The Missoula Indian center thus plays an important role in countering such arguments, working through advocacy and sponsoring cultural activities to legitimate the authentic status of urban Indians in the Missoula area.

Reinforcing and Promoting Urban Indian Identity

The mission and philosophy of the Missoula Indian Center is to “promote and foster the health, education and general welfare of the urban Indian population in and around Missoula”—and there are two ways the center does this: 1) by providing outreach, referral and advocacy on behalf of urban Indians, and 2) by funding and promoting Indian cultural activities.

Advocacy and Patient Control

Advocacy acts as a form of political action deployed by urban Indian mental health professionals to redistribute public health resources to their clientele (Santiago-Irrizarry 1996). The Missoula Indian Center acts as the primary representative agent for all of the urban Indians in the Missoula area, which constitutes between 1500 and 3300 people¹¹. Susan Shaw (2005) juxtaposed arguments for community access to resources and political control with the emergence of the language for culturally competent care. Through her research, Shaw found that ethnic clinics serve as a source for exercising political control. Data from my research at M.I.C. supports Shaw's argument, and advocacy plays a vital role for the community and will remain an important function of M.I.C., whether it is for their clientele or to maintain funding for its daily operations.

Besides its important role in advocating on behalf of urban Indians, M.I.C. acts as information center. It provides information about health services, assists with access to other government and social services, and often helps guide the client through the application process. These steps help clients understand the lengthy and sometimes complicated application procedures, which gives the client a source for control over their healthcare course. Having significant control and opportunity for contribution to treatment processes ranked among the top reasons staff gave for the center's importance, due to the fact that many of the clients at M.I.C. are low income or minority patients. All staff members who have direct contact with clients noted that many of them often criticized other agencies as treating them as passive agents during treatment; therefore they enjoyed the opportunity for participation in M.I.C. programs.

¹¹ There is a discrepancy between the Missoula County census information and the census data maintained by the Missoula Indian Center. M.I.C says this may be due to a large number of people moving in and out of Missoula County each year.

Promoting Culture and Community

The centers' efforts to maintain an ethnic-specific clinical setting are reflected by their views on the relationship between culture and mental health care. Urban Indian identity is largely reinforced and perpetuated through social networking and outward displays of "Indianness". Cultural activities and displays at the clinic help urban A/I's participate in their culture with other community members and also helps reinforce group solidarity. Identity issues for American Indians can have both legal and personal consequences; a strong sense of identity is shown to be especially important for minorities. Researchers have shown that those with a strong sense of A/I identity were less likely to suffer from depression, less likely to feel anxious and less likely to abuse alcohol and other drugs (Minderhout and Frantz 2008). This portrayal rests at the heart of the notion that culture can cure; interestingly it also marks the contradictory idea that culture can be both the source of dysfunction and also serves as the primary source for curing at-risk behavior (Santiago-Irrizarry 1996).

M.I.C. utilizes culturally-based healing options, such as the White Bison program and smudging, as a way to increase successful treatment outcomes. These programs are based primarily on the idea that transition and loss of culture are the source of mental health or addiction problems; American Indian tradition and culture are then seen as the model that will successfully alleviate those problems. The set of cultural values that underpin health programs seem to be central to all members of the community yet might be construed as an essentializing set of values.

Not surprisingly, all of the M.I.C. counselors described a similar "typical" client, yet interviews revealed that the core set of traits associated with the typical client are not outwardly disclosed to employees of the clinic. Counselors attribute this to knowing and understanding pan-

Indian values, (a set of cultural values that many tribes share) which in turn provide the framework for promoting cultural activities and culturally competent mental healthcare. Thus it seems that cultural competence techniques are not wholly explained in terms of essentialized traits, but can be understood through shared experience.

While culture plays a vital role in the daily operations and justifications for M.I.C., the clinic lacks a clear statement on how to achieve the development of culturally competent healthcare. The guidelines are primarily informal and vary within the clinic; each counselor imposes their own techniques for cultural competence, therefore examining the practices of urban Indian clinics proves especially difficult. Without a discussion with each counselor, it would have been impossible to discern the guidelines by which cultural competence and sensitivity are practiced. Therefore the relationship between patient-and provider takes on a significant importance, as the counselor negotiates cultural values and understanding during individual clinical interactions.

Cultural Connections: Patient Provider Relationships

In a study of over eight hundred A/I participants, Walls et.al (2006) set out to examine CD and mental health service preferences for American Indians. Their research findings suggest that by incorporating an informal and cultural setting with the client's preference for A/I-run services, health outcomes will be improved. Similarly, M.I.C. staff report that many of the cultural issues M.I.C. clients encountered when seeking mental health or CD treatment went unnoticed by mainstream hospitals and social service agencies. This was especially true for the treatment and outreach to elders who tend to be more traditional and have a stronger bond with their cultural identity. M.I.C. employees often recognized these issues simply because they are also A/I and have knowledge of core cultural values and issues, in addition counselors are able to

combat those issues by instituting cultural knowledge. The Indian counselors did not have formal cultural competence training and relied heavily on their ethnic and cultural background to guide decision-making. They were able to pick up on cultural subtleties like communication style and etiquette. Moreover Indian employees said because they identified with the struggles that urban Indians face they were best equipped to institute change and encourage recovery. On the other hand, non-Native counselors attribute their fitness to work at M.I.C. as a product of their personal relationships to A/I culture and heritage.

Although the staff's narratives are framed in terms of shared values, I argue that the element of racism toward Missoula's Indian population--still visible in the community,-- contributes to M.I.C.'s fitness to serve this population. The visible element of racism at other agencies can be attributed as the primary reason urban Indian clients seek treatment at M.I.C, however once in the doors, the cultural elements and competencies of the staff act as the primary reason clients continue treatment programs. Other agencies in the community often have difficulty with patients missing appointments, or neglecting to check in with their counselor regularly, and attending treatment programs only sporadically; however M.I.C. claims that patients regularly keep scheduled appointments and check in with their counselors frequently.

The historic and justifiable mistrust of typically white-run government services is still engrained in many of the clients minds and seems to result in a greater trust relationship with A/I counselors. Although, shared experience and similar personal values may have generally contributed to the establishment of trust relationships with non-Indian staff members, Keith Herman et. al (2007) argue that combining patient-centered care with cultural awareness and sensitivity is shown to have more effective treatment outcomes without over-emphasizing or neglecting culture.

To maintain its status as a non-profit and to maintain funding, M.I.C. is required to maintain an open-door policy. Consequently, the majority of its clients in its CD programs is non-native. However, the general philosophy of the day to day operations of the clinic is centered on the cultural and political status of urban Indians and often fails to recognize the non-Indian clientele. Conversely, all of the mental health and CD counselors emphasized that in conjunction with cultural competence, they used interpersonal communication as the primary method for working with clients ranging from traditional to non-Indian. Yet a discussion of how ethnic-matching and cultural competence influences the relationship between the counselor and the many non-Native clients at the center failed to materialize.

In an organization that serves both A/I and non-A/I the use of patient-centered care is an essential strategy for mitigating cultural differences between provider and non-Indian patients. Based on the interview sessions it is clear that value and ethnic matching are important for both the patient and the counselor. I argue that although shared ethnicity is more easily recognizable to clientele, it is not as important as shared values which were shown to strengthen the patient provider relationship, regardless of cultural background. Patient-centered care is increasingly becoming a popular alternative to cultural competence. With both of these models in effect during treatment programs, it is imperative that M.I.C. administrators are able to differentiate between cultural and interpersonal care.

Moving Forward

The current healthcare system has made it nearly impossible for individuals to be eligible for no or low-cost coverage, and it seems the debate over continued I.H.S funding is a result of high competition for limited funds. The lack of a clear cultural statement and competence

practices can potentially make it difficult to substantiate arguments in support of the distinctive and successful method for treatment offered at urban clinics.

The next important step in the fight for federally funded health services is to develop clear cultural competence guidelines for healthcare delivery. The government is likely to be first and foremost concerned with healthcare programs and although it was a major component and of the utmost importance to the urban Indian community, M.I.C. should rely less on justification based on social networking and cultural resources. If administrators are to continue this fight it will be critical for them to provide legislators with a clear understanding of the link between community and mental health/addiction recovery. It could become an essential part to making a strong argument because providing a hub for resources does not outwardly explain or support the government's concern for culturally competent healthcare.

How will the political legality of urban Indians be determined, if the question falls before a federal judge? Will lineal descent and bloodline be more influential, or will it be enough that the group is a united, organized community? As these questions continue to play out in the U.S. government, urban Indian centers and clinics will serve as an important medium for advocating on behalf of the urban community. Small scale examples might serve as tangible examples for policy-makers and comprehensive reports would provide legislatures with informative resources in order to make decisions that can influence and maintain the current funding agreements. Therefore it is essential that administrators of small-scale organizations, like M.I.C., thoroughly understand the issues as they are played out in the clinic. Debating the authenticity of urban Indians as a legally established AI/AN community has proved to be the result of a healthcare system where resources are scarce, and funding is limited. Until the U.S. adopts a universal

healthcare policy, promoting the recognized political status of urban Indians as a legitimate subset of the nation's first people will prove to be exceptionally significant.

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