House Recommends $41.3 Million Increase for IHS Programs in FY '82

WASHINGTON, D.C.— The House Committee on Appropriations, in completing markup on its FY 1982 appropriations bill here June 25, has recommended that next year's Indian Health Service (IHS) budget be increased $41.3 million over the level requested by President Reagan earlier this year.

The House bill represents the first round of congressional action in the appropriations process. The Senate Appropriations Committee will make its own recommendations later this month, and the differences between the two bills will be resolved in a House-Senate conference.

Increased funding levels are recommended by the House for several IHS programs the Reagan Administration proposed to cut. Two of the more significant such programs, which the Administration recommended phasing out entirely over the next few years, are urban Indian health care and Indian health manpower.

The urban Indian health program, which provides support for 41 urban Indian health projects across the country, would be funded at a level of $9.79 million under the House bill, compared to the Administration's $4.45 million request. The Indian health manpower program, which provides scholarship assistance to Indian students training to be health professionals, was increased by the House to $7.3 million, compared to the Administration's $3.8 million figure.

The House bill also provides for increases in hospital and health clinic programs ($7 million); dental health ($500,000); mental health ($1.8 million), and sanitation services ($500,000).

Although the total additional expenditure for IHS health services amounts to $17.6 million, the bill requires IHS to offset most of this increase through the expenditure

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A GROUP OF NAVAJO CHILDREN watch other youthful Indian dancers while attending a pow-wow at the New Mexico State Fairgrounds. The pow-wow was part of the festivities surrounding the Third National Indian Child Conference in Albuquerque, N.M., May 17-21. For article relating to the conference workshops and presentations see page 6.
Health News Across the Nation

The following is a regular feature of the NIHB Health Reporter. In this section, we present our readers with short briefs on issues and activities from around the country that are related to Indian health care, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on items mentioned here can be obtained from the NIHB Public Information Office.

--- BULLETIN ---

WASHINGTON, D.C. — Dr. Emery A. Johnson, Assistant Surgeon General, announced here July 15 that he will retire from his position as Director of the Indian Health Service (IHS). Dr. Johnson’s retirement will be effective September 1, 1981.

Dr. Edward N. Brandt, Assistant Secretary of Health, stated in a letter to tribes and Indian organizations that Indian leaders will be consulted in the decision to name a new IHS director.

Dr. Johnson joined the IHS as a medical officer in 1955, and served in several medical and administrative capacities prior to his appointment as IHS director in 1969. A more extensive account of Dr. Johnson’s career in the field of Indian health care will appear in the next issue of the National Indian Health Board (NIHB) Health Reporter.

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SACRAMENTO, CALIF. — The California Rural Indian Health Board (CRIHB) filed suit in U.S. District Court here June 17 seeking to overturn an Indian Health Service (IHS) ruling that the organization is ineligible for a contract under P.L. 93-638 (the Indian Self Determination and Education Assistance Act). The IHS ruling, issued last October, states that CRIHB’s membership composition fails to meet the requirements of a “tribal organization” as defined in the act. According to the CRIHB lawsuit, IHS based its decision on the fact that three of CRIHB’s 30-member governing Board, which represents 15 Indian health clinics in California, were not members of tribes recognized by the Bureau of Indian Affairs. CRIHB’s application for a P.L. 93-638 contract was consequently rejected, although the organization remains eligible to contract with IHS under the authority of the “Buy-Indian” Act.

The CRIHB lawsuit charges that the IHS decision “is a gross distortion of Congressional intent and an abuse of discretion” that deprives CRIHB of “the opportunity to take advantage of this unique, long awaited and richly deserved opportunity” to contract under P.L. 93-638.

CRIHB also contends that “the federal regulations and general provisions governing Buy-Indian contracts are substantially less favorable to the contractor than an otherwise identical contract awarded under P.L. 93-638.” The lawsuit requests that CRIHB be declared eligible for contracting under P.L. 93-638, and that IHS be required to enter into a P.L. 93-638 contract with CRIHB in FY 1982.

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SEATTLE, WASH. — The Seattle Indian Health Board is seeking applicants for the position of executive director. Applicants should have at least five years’ administrative experience in a health related field, with a minimum of three years in an executive capacity. Applicants must also have experience in financial management, budget control, and be able to communicate with a variety of groups and agencies. Persons interested in applying for this position should submit a resume and three letters of reference to: Personnel Department; Seattle Indian Health Board; P.O. Box 3364; Seattle, Wash. 98114.

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TUCSON, ARIZ. — The University of Arizona Department of Family and Community Medicine has completed a study and final report on “Trends in Infant Feeding Among Southwest American Indians: 1900-1980.” The report presents information on trends in infant feeding practices, health consequences of current practices, and efforts that might be taken to improve the health status of southwest Indian children in relation to infant feeding. The report is available to the public for $5.00, and can be obtained from: Dr. Cheryl Ritenbaugh; University of Arizona; Health Sciences Center; College of Medicine; Dept. of Family and Community Medicine; Tucson, Ariz. 85724.

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DENVER, COLO. — The American Indian’s holistic approach to healing is the subject of “Good Medicine,” an hour-long documentary film prepared by the Public Broadcasting System. Filmed on location in South Dakota and Arizona, “Good Medicine” sensitively explores the design and effect of highly complex Indian healing ceremonies never before recorded on film. The documentary examines the differences between modern Western medicine and the centuries-old healing art of Native Americans. The film’s narrator and host is John Bellino, former executive director of the National Indian Health Board. While the film has already been shown by public broadcasting stations in some cities, other stations will air the documentary this month. Persons interested in viewing the film should contact their local stations for dates and times of the broadcast in their area.

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WINDOW ROCK, ARIZ. — The Navajo Vocational Rehabilitation Program (NVRP) has been awarded a

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The grants range from $650,000 to $40,000, with Washington, D.C., issuing a request for proposals in awarding the ten grants to tribes. According to Elmer Guy of NVRP, the money was made available through a Rehabilitation Act of 1973 grant and will be the first time an Indian tribe has received direct funding for its handicapped and disabled. The object of NVRP, says Guy, is to provide culturally relevant comprehensive vocational rehabilitation services to Navajo people living on or near the reservation.

FORT COLLINS, COLO.—Health educational materials on the nutritional aspects of infant feeding, diabetes, and the promotion of traditional foods have been prepared by the NIH Science Center here, and are available for sale. The packages of materials are designed for use in a number of settings, including WIC nutrition programs, schools, Community Health Representative programs, hospitals and clinics, diabetes control projects, and programs for the elderly. Each package contains: “radio play” cassette recordings, artwork, and complete scripts of the radio plays. The cost of each package is $50. To order the materials, or to obtain additional information, contact: Dr. Alan Ackerman; NIH Science Center; Department of Food Science and Nutrition; Colorado State University; Fort Collins, Colo. 80523. Phone: (303) 491-5798.

WASHINGTON, D.C.—The Environmental Protection Agency has awarded funds to ten Indian tribes to enable them to establish their own air quality control programs. The grants range from $40,000 to $125,000 apiece and total more than $740,000. Although such grants have historically been directed to only state and local governments, EPA issued a policy paper last November stating that tribal governments should have a key role in implementing pollution control programs affecting their reservations. EPA then issued a request for proposals from tribes interested in establishing air quality programs. The agency worked closely with the Council of Energy Resource Tribes (CERT) in awarding the ten grants to tribes.

WASHINGTON, D.C.—Alaska Area guidelines for obtaining resolutions of support for Indian Health Service contracts under the Indian Self Determination Act (P.L. 93-638) were published in the Federal Register May 18. The guidelines provide that Alaska Native villages, as the smallest tribal unit under the Alaska Native Claims Settlement Act (P.L. 92-203), must approve any P.L. 93-638 contract that benefits their members. In the case of contracting for programs of the Alaska Native Medical Center that serve all Alaska Native villages, the guidelines require the contractor to show evidence of support from each village throughout the state. Contents required for the village resolutions, as well as different types of resolutions, are described in the guidelines.

WASHINGTON, D.C.—A newly developed automatic data processing system for the Bureau of Indian Affairs’ social services programs will be implemented October 1 in all areas except Alaska, according to Interior Assistant Secretary for Indian Affairs Ken Smith. Smith said the new system will eliminate some emergencies now created by the time lag in delivery of services; will give social workers more time for clients by cutting down paper work; and will provide accurate, timely audit and program reports.

BIA officials expect the new system to enhance the operation of its social services programs, which includes child welfare services in helping with the placement of Indian children in adoptive or foster homes; family services; “workfare” projects; and assistance to Indians to enable them to get needed services and assistance from state and local agencies.
of Medicare/Medicaid collections totaling $15 million. Therefore, the net increase provided for IHS health services is only $2.6 million.

In the area of IHS facilities construction, the House provides for additional funding for building outpatient clinics at Anadarko, Okla. ($3,045,000); Tsaile, Ariz. ($3,757,000); and Huerfano, N.M. ($3.2 million). In addition the House bill calls for an increase of $28.6 million for sanitation facilities construction.

Overall, the House recommends FY 1982 spending levels of $629 million for IHS services and $46.7 million for IHS health facilities, compared to the Administration's request of $626.8 million for services and $81 million for facilities construction.

In a separate bill passed early last month, the House Appropriations Committee provided $4.95 million in FY 1981 supplemental funds, which the Reagan Administration had requested to rescind. The funds will be used to provide for the planning and design of health facilities at the following locations: Anadarko, Okla. ($200,000); Tsaile, Ariz. ($250,000); Huerfano, N.M. ($220,000); Browning, Mont. ($1,05 million); Kanakanak, Alaska ($1.2 million); Crownpoint, N.M. ($1.3 million); and for personal quarters at Lodge Grass, Mont. ($650,000).

Other congressional action that will affect certain Indian health programs not directly supported by IHS involves the upcoming House-Senate conference on the Omnibus Reconciliation Act of 1981. The conference will set funding authorization levels for numerous federal programs over the next few years, and will determine whether certain federal health programs will be consolidated into block grants to the states.

Tribal leaders and Indian organizations have expressed concern over the block grant concept, contending that state-administered programs have generally excluded tribes from services.

Legislation adopted by the Senate provides for three different health block grants in the areas of Maternal and Child Health, Health Services (which includes funding for alcoholism, drug abuse, mental health, and Community Health Center programs), and Health Prevention (which includes funding for Family Planning programs).

The House, on the other hand, has practically rejected the block grant concept and is basically recommending categorical funding for federal health programs. This difference must be resolved in the House-Senate conference.

In the event the Senate version is adopted and health block grants become a reality, there are provisions to protect tribes from being excluded from their share of the funding, according to NIHB General Counsel Daniel Press.

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Indian Food and Nutrition Programs Likely to be Reduced in FY '82

WASHINGTON, D.C.—The sweeping cutbacks proposed by the Reagan Administration in food programs threaten to reverse the modest successes made in improving Indian nutrition in recent years.

Presently, more than 100 Indian tribes and urban Indian organizations are administering one or more federal food programs. About 50 tribes now administer food distribution programs on their reservations, while another 20 tribes are in the process of completing applications to do so. In addition, some 70 tribes and urban groups are managing projects under the Community Food and Nutrition Program, including self-help, outreach and food bank programs. And, finally, tribes and urban groups are sponsoring summer food and child care food projects.

These projects, which in recent decades have helped thousands of Indian families exist above the starvation level, are now being threatened by Administration proposals that would reduce funding for most federal food and nutrition programs. Moreover, it appears that Congress will support many of the Administration's proposed cuts.

Approximately 400,000 Indian people are currently depending on three programs alone: Food Stamps (265,000), Commodity Food Packages (75,000), and the Women, Infants and Children (WIC) Program (75,000). This does not include the thousands of older Indians receiving food assistance through specific feeding programs for the elderly, or the tens of thousands of children from low-income families receiving a free school lunch.

According to Kathleen McKee, attorney for the Food Research Action Center (FRAC) here, the impact on Indian reservations due to the proposed federal nutrition budget cuts will be felt on a tribe-by-tribe basis, depending on how large and how poor the Indian communities are. McKee also says that the impact on the food stamp cuts really hasn't been brought home yet.

"Many tribal communities are subsisting on federal grants and will not only be affected by the food cuts, but also will be affected by housing, social service, CETA, and legal service cuts," said McKee. "When you look at the overall cuts in Indian programs, the effect will be devastating."

McKee also stated that it is anticipated that once the CETA public service jobs are eliminated, unemployment on the reservations could go as high as 60 percent, resulting in more Indian people having to rely on food stamps and commodity packages.

"We are finding that most people cannot assume that their congressional representatives are going to support social service programs. Native Americans need to communicate with their congressional representatives to inform them of the disastrous effects the cuts in food stamps and child nutrition will have for Indian people," said McKee.

In the area of food stamps, Congress has basically supported Administration cuts which amount to $1.65 billion. Adoption of the President's proposed reductions in income eligibility would eliminate thousands of low-income Native Americans from participation in the program.

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Teenage Suicide, Mental Health Issues Addressed at Indian Youth Conference

ALBUQUERQUE, N.M.—Alarming statistics which indicate a rise in teenage suicides, increased alcoholism and substance abuse as well as inadequate mental health services for Indian children were among several significant factors that surfaced during the Third National Indian Child Conference here May 17-21.

The conference also addressed many of the needs and sentiments of Indian youth and their families and offered its 1,200 conferees more than 40 workshops that focused primarily in three areas: health, education and mental health. These areas reflected some growth in services provided to Indian youth and a noticeable return to traditional cultural values, particularly in the areas of mental health and education.

A wide variety of "Youth Issues" workshops were also offered to many of the participating Indian youth who attended from various parts of the country. The workshop topics included: teenage sexuality, family communications, Indian youth awareness, self-esteem and teenage suicide.

The idea for an annual conference to address special needs of Indian children took root in 1977, and through the sponsorship of the Save the Children Foundation three conferences have been held specifically for the purpose of identifying the needs and developing services for Indian children.

According to conference Chairperson Effie Dressler (Washoe), the conference's intent is to provide attendees with a better understanding of behavioral problems among Indian youth; identify available resources in the areas of social service and mental health; and explain how Indian communities can get their fair share of those resources. "Many Indian parents don't know where to go for help and don't know what to do when it comes to mental health problems," said Dressler.

During the opening session, mental health issues and programs were addressed and included presentations by Indian Health Service (IHS) mental health officials and fourteen workshops focusing in areas such as cultural conflicts and delivery of mental health services to American Indian children and families; therapeutic foster home programs; and issues concerning suicide and self-destructive behavior among Indian youth.

According to Dr. Jerry Meketon, chief of quality assurance and training for IHS mental health programs, severe funding problems in IHS mental health programs have caused a serious backlog of services. "We can't make any commitments to existing programs because we don't even know what this year's budget consists of," Meketon said. Other barriers to the full provision of mental health services to Indian youth and their families include the lack of adequate mental health facilities, prevention programming and recreational therapy.

In the area of suicide and self-destructive behavior among Indian youth, a workshop concerning these issues was most candidly presented by Dr. Irving Berlin, director of the Child and Adolescent Psychiatry Department of the University of New Mexico. Dr. Berlin presented data that indicated a sharp rise in attempted suicides among Indian children, especially adolescent girls, and a corresponding rise in drug and organic solvent (glue sniffing) abuse.

But, according to Berlin, the attempted suicide rate is not the real measure of the depression and anxiety felt by young people. "It is more likely that if you put the attempted suicide rate plus the accident rate (related to alcohol and drug abuse) together, you would come closer to a real understanding of the feeling of hopelessness and helplessness that these young people are feeling," said Berlin.

Berlin, also an IHS consultant for the Indian Children Programs, continued that "it appears very clear that substance abuse and alcohol abuse are very early signs of feeling unwanted and uncared about. Most young people involved in suicide attempts are young people with feelings that nobody is really concerned about them. Many young people studied were from pueblos and reservations who had parents who were heavily alcoholic and were, themselves, severely abused and neglected as young..."}

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Teenage Suicide...
Continued from Pg. 5

children and could not cope with many of the demands of the world."

The workshop also revealed that studies of Native American teenagers indicate drug and alcohol abuse is starting at earlier ages, particularly among children aged 8-10. Signs of depression are also starting to show up among Indian children in elementary school, said Berlin.

The signs of depression among Indian youth are also evident as they get older and can be directly related to economic pressures, said Berlin. "This type of depression, which seems to be widespread among Indian youth, is caused by and large by the realization and risk of not finding a good job. Indian youth are at a terrible risk at not being able to find work that is meaningful to their Indianness. Almost all of the young adults involved in drinking is the result of not being able to find any stability on or off the reservation," said Berlin.

The workshop also identified an IHS project where youths that were arrested could not be placed in a jail cell without a tribal elder accompanying them. Berlin explained that through the night, the elder would talk in their native tongue to the youth about the teenager's importance to the tribe.

"This program was successful because it cut sharply into the suicide rate among several Northwestern Tribes," said Berlin. He noted that because of this community effort, the suicide rate dropped off 80 percent during the program's first year. "These teenagers who had become so alienated and heavily into drugs and alcohol changed dramatically as long as these elders continued their relationships with them," said Berlin.

Community mental health approaches, especially in the areas of emotional disabilities, abuse and neglect among Native American children were thoroughly examined in many of the conference workshops.

Included in the "Prevention: A Community Mental Health Approach" workshop were discussions of methods for preventing the occurrence of emotional disabilities in children. These methods ranged from parenting skills to peer counseling to community action programs.

According to panelist Dr. Michael Biernoff, the primary prevention concept specifically identifies high-risk groups which have not been labeled "mentally ill." "Special actions are directed at specific populations (elders, children, etc.) for specific purposes to help provide a support group for people, and particularly youth, with mental health problems," said Biernoff. "Clearly defined goals toward community problems requires community support at attacking underlying symptoms."

Biernoff stated that community-based prevention projects must be aware that Native American communities are small, rural and conservative, and that the social unit of organization is the extended family. "Attention must constantly be paid to the impact of the changes that will occur in the community," said Biernoff. "The community's health goals must be constantly revised, processes challenged, with an outcome of an effectively functioning Indian community."

An example of a community's mental health approach was provided by panelist Joseph Rael, who discussed Picuris Pueblo's new holistic health center. "At Picuris, the holistic center is designed with the community in mind and will deal with all aspects of the patient," said Rael. According to Rael, the holistic health center will combine old and new ways of healing.

"Our culture allows for both to occur simultaneously," said Rael. "Our health programs have not been too successful because we have never looked at the underlying...
Next NIHB Conference Set for Tucson in '82

OKLAHOMA CITY, OKLA.—The Fifth National Indian/Alaska Native Health Conference will be held in Tucson, Ariz., April 19-23, 1982. The site was chosen by the National Indian Health Board (NIHB), which will serve as conference sponsor, during its recent quarterly board meeting here.

Preparations for the conference will begin next month, and NIHB is encouraging tribes, Indian organizations, and individuals to submit recommendations for subject areas they wish to see covered at the conference general assemblies and workshops. Recommendations might include topics in the area of legislation; health administration; treatment of certain diseases and illnesses that are prevalent among Indian populations; mental health, and other aspects of Indian health care. All suggestions will be considered by the conference planning committee, and should be sent to the NIHB central office as soon as possible.

NIHB is also seeking nominations for persons or organizations whose contributions to the field of Indian health care merit special recognition. Nominees will be considered for recognition awards that will be presented during the conference.

Nominations for these awards should include an explanation of how the person, tribe, or organization contributed to:
- furthering the goal of Indian Self Determination in the area of health care for American Indians and Alaska Natives
- improving the health care services and benefits to American Indians and Alaska Natives as provided under treaty rights and/or laws of the United States
- providing the public with a better understanding of matters and problems of health affecting American Indians and Alaska Natives
- promoting the education of members of American Indian tribes and Alaska Native villages in matters pertaining to their health and welfare
- seeking an equitable adjustment of public health services among participating Indian tribes and Alaska Native villages
- otherwise promoting the common welfare and health of American Indian and Alaska Native people.

Persons or organizations that may be considered for these special recognition awards include (but are not limited to): physicians, nurses, Community Health Representatives, and all other health professionals serving Indian people; health administrators; tribal council members; health educators; researchers; elected officials; health boards and other health organizations; and any other individual, tribe, or organization whose work has helped improve the health care of Indian people.

In addition, NIHB is seeking Native American artwork for use in publications related to the conference. All original work will be returned to the artist following completion of the publications.
Regional Training Sessions

IHS Contracting Process Under P.L. 93-638

OKLAHOMA CITY, OKLA.—A major segment of an Indian Health Service (IHS) initiative to simplify and improve its contracting process under P.L. 93-638 (the Indian Self Determination and Education Assistance Act) was completed at a fifth and final training session for IHS management personnel here June 11-12.

According to Leah Exendine, chief of the IHS Indian Resource Liaison Staff that has been coordinating the training effort, the five sessions were held around the country to familiarize IHS contracting and project officers, as well as other IHS administrators, with the new IHS policy regarding P.L. 93-638 contracting (for a detailed report on this new IHS policy, see the NIHB Health Reporter, February 1981; Vol. 2, No. 10).

Attendees of these five training sessions will be involved in implementing this policy in their respective area offices and service units, Exendine said. Separate training sessions on P.L. 93-638 proposals and contracts are being planned for tribal officials and other interested persons, she said.

In her introductory remarks at the June 11-12 training session here, which was attended by IHS and tribal officials from service areas of Oklahoma, Navajo, and the United South and Eastern Tribes (USET), Exendine explained that the training focuses primarily on the development of new P.L. 93-638 contracts, rather than dealing with revisions or renewals of existing contracts. Future IHS efforts will address other aspects of tribal contracting and management, she said.

Exendine briefly reviewed the efforts of the IRLS, which was established nearly one year ago to serve as a focal point for IHS policy development. Their first major task, she said, was to develop a policy to simplify and improve "638 contracting" and to provide some uniformity in contracting practices among different IHS area offices.

"After nearly six years of experience, IHS found there were a number of discrepancies among area offices in the way 638 contracts were processed," Exendine said.

The establishment of a uniform, simplified 638 contracting process, and the need to impress upon IHS personnel the meaning and importance of Indian Self Determination, are two of the primary objectives of the IHS training effort, Exendine said. The workshop was designed to provide attendees with a thorough review of P.L. 93-638 and its regulations, as well as the new IHS 638 contracting policies outlined in four separate IHS policy directives referred to as Indian Self Determination Memoranda.

Presenting a legal overview of the P.L. 93-638 contracting process was Sid Edelman, IRLS legal resources specialist. Edelman explained that the intent of P.L. 93-638, as stated in the law, is to provide for "the establishment of a meaningful Indian self-determination policy that will permit an orderly transition from Federal domination of programs and services to Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of their programs and services."

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**PL 93-638 TIME LINE FLOW CHART FOR CONTRACTING**

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<th>I</th>
<th>II</th>
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<td>5</td>
<td>10</td>
<td>60</td>
<td>45</td>
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</tr>
<tr>
<td>(Receipt)</td>
<td>(Resolve Threshold Issues)</td>
<td>(Approve/Disapprove Notice)</td>
<td>(To Complete Contract)</td>
<td>(Hqtrs.)</td>
<td>(HSA)</td>
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- **I.** 5 days to acknowledge proposal receipt.
- **II.** From time of receipt, 10 days for acceptance notification. (First 5 days part of this 10.)
- **III.** Allow 10 days to resolve threshold issues — if any.
- **IV.** 60 days for Area Director to notify Tribe of approval or disapproval of the proposal.
- **V.** From receipt of RFC, contracting has 45 days to complete and award the contract.
- **VI.** If proposal over $200,000, 5 days for IHS Headquarters contracts & grants branch to approve.
- **VII.** If HSA OC&G review required (i.e. CAB), another 5 days required.

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125 days if contract less than $200,000

135 days if contract over $200,000
Designated to Institutionalize Indian Self Determination Act

The contracting mechanism provided for in P.L. 93-638 differs from normal federal contracting procedures. Edelman said, because tribes have the right to contract for federal programs serving Indian people, and that right must be recognized at all stages of the contracting process.

He also noted that some IHS officials are concerned about contracting programs to tribes because, in the event a tribe fails to adequately administer the program, the federal government is required by law to reassume control of the program and provide the services to the tribe. “But this is a risk IHS officials have to take. Self-Determination gives tribes the right to fail as well as the opportunity to succeed,” he said.

Edelman added that while some federal employees may disagree with P.L. 93-638, it is still their responsibility to carry out the intent of the law. “It’s important that we all understand what the law and regulations say, and that we understand the Indian Health Service policy regarding 638 contracting,” Edelman said.

IHS 638 Contracting Policy

The IHS 638 contracting policy was reviewed in detail at the training session by Joe Moran, Director of the Health Services Administration’s Office of Contracts and Grants.

As stated in Indian Self Determination Memorandum No. 81-1, which was issued February 1, 1981: “It is the policy of the IHS that the right of Indian tribes, acting through tribal organizations, to assume responsibility for the operation of programs of the IHS must be fully recognized at all stages and at all levels of the contracting process ...”

The policy also restricts the discretion of federal officials in the 638 contracting process by providing that “no administrative articles other than those included in the ‘Sample Contract’ or ‘Contracting Desk Reference’ ... shall be used in any ‘638’ contract unless agreed to by the contractor.”

The “638 Sample Cost Reimbursement Contract,” which is referenced in the policy statement, contains the provisions necessary for most 638 contracts: a cover letter; 11 administrative articles; and 41 general provisions for cost reimbursement contracts under P.L. 93-638. Moran noted that several of the general provisions are inappropriate and are currently being reviewed and modified.

The IHS policy also establishes a specific time frame for the approval or disapproval of a 638 contract proposal (60 days after receipt of the contract); and for the award of a new contract (45 days from the date the Request for Contract is received by the contracting officer — see chart for specific time frame requirements).

Several IHS contracting officers attending the training seminar voiced their skepticism over these time guidelines. Bill Millar, director of tribal health program development for the USET Area Office in Nashville, Tenn., contended that the 45-day requirement was unrealistic for certain tribal contracts (those contracts exceeding $200,000) that must be reviewed and approved by IHS headquarters and the HSA Office of Contracts and Grants.

This review at the headquarters level, which Millar said has taken as long as 30 days, excludes contracting officers from control over the time factor in processing the contract.

Moran responded that headquarters personnel will also be working under strict requirements to stay within the 45-day time frame, and that 638 contracts will be given priority consideration for review. “The headquarters cost advisory will not be a factor in meeting these time requirements,” he said.

Contracting Process Under P.L. 93-638

The actual “nuts and bolts” procedures of contracting under the Indian Self Determination Act were discussed by Thomas J. Harwood, Director of the Albuquerque Area Indian Health Service.

Harwood explained that the Albuquerque area office has established a 638 contracting program utilizing the procedures specified in Indian Self Determination Memorandum No. 81-3, “Contracting Process Under the Indian Self Determination Act,” which was issued April 17.

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ALBUQUERQUE AREA DIRECTOR T.J. Harwood reviews details of P.L. 93-638 contracting process during training session in Oklahoma City June 11-12. Harwood has been instrumental in initiating a model IHS 638 contracting program in the Albuquerque area.
Regional...

Continued from Pg. 9

(Note: This document outlines procedures for new 638 contracts, and does not address revisions or renewals of existing 638 contracts).

The purpose of this policy is to establish specific stages and procedures for developing new contracts under P.L. 93-638, and to identify the roles and responsibilities of IHS officials in the 638 contracting process.

With respect to 638 contracting, Harwood said that "the time is here for change, and the Indian Health Service must maximize its efforts to have tribes participate in this process." He noted that in his own area "tribes have been able to pick up some 638 contracts and operate the programs better than we did."

Harwood also stated that this contracting process was used in recent negotiations with a tribe in the Albuquerque area. Following the award of the contract, Harwood said the tribal chairman expressed his satisfaction with the contracting process, saying that "at last we've got something that really works."

As detailed in ISDM No. 81-3, there are six stages used by IHS in the preparation of a new P.L. 93-638 contract with a recognized tribal entity. Briefly, those six stages are:

Stage 1 — Preparation: The IHS Area Director prepares a system and staff to implement the 638 contracting process. This includes appointing a "638 leadership team" and designating a Contract Proposal Liaison Officer (CPLO) to assist tribes and tribal organizations interested in submitting 638 proposals, and to coordinate 638 contracting activities within the area.

Stage 2 — Preproposal: IHS personnel work to identify and resolve all issues relating to tribal 638 proposals. This includes scheduling conferences with the proposed contractor to assist in the preparation of the 638 contract proposal, and to provide technical assistance as needed.

Stage 3 — Contract Proposal Assessment: Upon receipt of a 638 contract proposal, IHS personnel work to identify and resolve any possible “threshold issues” (items that do not raise a declination issue under section 103 of the Act, but nevertheless preclude acceptance of the proposal by IHS); designate a Proposal Assessment Team comprised of appropriate personnel to assess the proposal; obtain further information as needed; attempt to resolve any declination issues that are raised; and prepare a report to Area Director recommending approval or disapproval of the proposal.

Stage 4 — Decision: Within 60 days after acceptance of the contract proposal, Area Director approves or disapproves the proposal. If disapproved, proposed contractor has 30 days to appeal the decision.

Stage 5 — Contract Award: Contracting officer prepares documents and files necessary to award the contract.

Stage 6 — Contract Administration: Contracting officer convenes a postaward conference to review specifics of the contract. Project officer monitors contractor’s performance, providing technical assistance and evaluation as needed.

Although the recent IHS training efforts for P.L. 93-638 contracting focused primarily on the development of new 638 contracts, according to IRLS Chief Leah Exendine, future undertakings will deal with problems related to personnel management; property and supply; grants management; financial management, and other areas of administration.

Additional information about the IHS training session on P.L. 93-638 contracting, and the Indian Self Determination Memoranda, can be obtained from IHS Area/Program Office or from the NIHB Public Information Office. ■

Indian Food...

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and reduce the allotments of thousands more.

Also affected by the proposed budget cuts is the Food Distribution (or Commodity) Program on Indian reservations, which provides food to households living on the reservations or near the reservation of a tribe of which they are members.

While the Food Distribution Program which is strictly for Indian people has not been cut directly, the same eligibility guidelines for Food Stamp programs apply for the Food Distribution Programs. Therefore, the commodity eligibility criteria will suffer many of the same effects and cutbacks.

With the Indian working poor now on food stamps likely to be cut out of the program, on many of the reservations the Food Distribution Program is the only food program the Indian people will have to fall back on.

The Special Supplemental Food Program for Women, Infants and Children (WIC) is funded and administered by the Department of Agriculture (USDA) through state health departments and Native American tribes, and run locally by public or nonprofit health facilities and organizations. WIC provides extra food for pregnant women, new mothers and young children who cannot afford an adequate diet.

The program serves pregnant women, new and nursing mothers, or children under five who are at nutritional risk and whose incomes are below the reduced-price meal guidelines. Nutritional risk means a poor diet, inadequate growth patterns (under/overweight, stunting) or a medical history of nutrition-related problems in the family, such as anemia (low iron), miscarriages, and premature births.

According to an FRAC publication, out of 8.3 million women, infants, and children who need and are eligible for WIC benefits, only 2 million receive them at just over 1,000 clinics.

Both the House and the Senate have "capped" program spending at estimated amounts needed to maintain current services. The funds recommended will be enough to allow for current caseload levels, but does not allow for more people to come into the program.

The Community Food and Nutrition Program provides funds for projects that help poor people get more food. Among the projects funded by the Community Services Administration (CSA), which operates CFNP, are food banks, food cooperatives, outreach services, and self-help food production enterprises. About $3 million has been set aside for projects to help Indian people, and currently about 65 tribes are operating such projects.

CSA has instructed its regional offices not to obligate any General Community or Indian CFNP second year monies. These monies are essentially frozen but may be released by CSA "sometime in the spring." The monies represent funds for the second year of operation (October 1, 1981 to September 30, 1982) of approved programs and amount to $2.9 million for Indian CFNP programs. These funds must be released or current projects will expire September 30.

Final budget figures for most of the federal food and nutrition programs serving Indian people will be determined by congressional action in the coming months. ■
Participation Seen As Key Element For Successful Youth Programs

Perhaps no single aspect of Indian health care is as important to the future of Indian people as the physical, mental, and emotional well-being of Indian children and young people. In the following article, Patricia D. Mail, M.P.H., reviews some of the problems faced by today's Indian youth, and discusses some unique approaches for dealing with those problems. We invite our readers to comment on Mail's discussion.

One's youth, particularly one's adolescence, is supposed to be a time of growth, learning, exploration, adventure, and the beginning of adult freedom. It is not a time associated with illness or loss of life. Indeed, the tragedy of death is particularly poignant when a child or young person is removed from the community.

Youth is a time of activity, of health, of new awakenings. It is in the youth of the community that a Tribe invests its future. Hence, the emphasis on "child welfare," on maternal and child health services, and most especially, on education. The heritage and history of The People are repossited in the Elders, while the Future is vested in the Youth.

Normally, youth is a time of health. Childhood infectious diseases can be prevented by immunization, and in the last several years, the Indian Health Service (IHS), in cooperation with major initiatives from the Department of Health and Human Services, has worked toward establishing and maintaining a 90 percent or better immunization in all the Indian communities served by the IHS.

Well-Child clinics help in the screening and early identification of disabling or potentially handicapping problems, so that by the time a child is ready for school, serious conditions affecting eyesight, hearing, coordination and navigation should have been identified and referred for treatment.

The Women, Infant and Children's Supplemental Feeding Program (WIC) has provided a sound nutritional start for many Indian children, with the improvement in health being evident to all medical personnel dealing with infants and children. The IHS has, for years, placed a high priority on services to mothers, infants and young children resulting in an increased life expectancy, improved dental health, and less disability overall.

However, there are areas of unmet need, as well as significant areas in which problems still exist. In an IHS publication detailing health trends and services, it was noted that in the area of dental services alone, there is a considerable backlog of work which is yet to be provided to Indian young people. This is made more difficult, in part, because these are individuals in ages which do not routinely use clinical services and often have dropped out of school, so that locating adolescents for services is difficult at best.

While the physical health of Indian youth is, in general, excellent, there are enormous needs in the area of mental health. All too familiar are the grim statistics relating to alcohol abuse, drug abuse, solvent sniffing, suicides, accidents and homicides.

In a recent newsletter of the American Indian Alaska Native Nurses Association, it was noted that the infant death rate for Indians was 1.1 times higher than the infant death rate in the general population, while the age-adjusted death rate due to accidents was 3.7 times higher for Indians than the general population. Deaths from alcoholism rose 59 percent between 1966 and 1975, and the suicide rate for Indians is 20.1 deaths per 100,000 population, while the homicide rate is 24.6 deaths per 100,000 population.

While these figures reflect statistics overall for Indian people, it becomes more serious when we examine the age-specific suicide and homicide death rates for young people between the ages of 5 and 24. The grim reality is that suicide and homicide are killing Indian young people, thus destroying the future of the communities.

What makes these figures so alarming is that the population of Indian young people we are discussing is a rapidly growing population. The great majority of Indian people are under age 30, so that death rates which have increased in young people are particularly alarming.

The question of illness has not been addressed, in part because death is a final fact, and in part because Indian youth is usually a fairly physically healthy population. However, although we lack data, we do know that the mental health of young Indians is in jeopardy. We are also seeing troubling increases in adolescent pregnancy, obesity, and increasing injury from accidents and injuries (many of which are associated with alcohol abuse).

The causes are complex for the problems which we can observe: cultural shock, cultural assimilation problems, discrimination, values conflicts, disruption of the home from alcohol abuse, dependency on erratically funded federal programs, self-identification problems, few professional role models, destruction of traditional roles, and community disorganization. The child and teen-age Indian is uncertain, so feigns indifference and indulges in risk-taking behaviors.

The solutions are scattered, and several projects have initiated innovative, new approaches to these problems. For instance, the October 1980 Listening Post, the newsletter of the IHS Mental Health Programs, reported a special pilot project involving Indian young people in a sixty-day wilderness experience to help put them back in touch with their ancestry and spirituality. The project is designed to emphasize personal development and includes tutoring to improve academic performance.

Another program, the Native American Rehabilitation Program in Portland, Oregon has developed some Self-Actualization scales and conflict diagnostic charts to help clients, including young people, identify areas of their lives in which problems arise, and help them to understand the complexities of self and seek spiritual and cultural reintegration.

Other innovative treatment and prevention approaches to dealing with adolescent health problems, such as being overweight, might be dealt with similarly to the Tacoma-Pierce County Health Department's residential summer

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Develop and the child’s counselors. Perhaps the most salient list of positive actions which can be planned and implemented within the Indian communities comes from observations and remarks of Dr. James Andre, former IHS specialist in the alcoholism community. Dr. Andre suggested the following actions be taken for prevention of problems, as well as treatment and rehabilitation for substance abusers:

- Commit more resources than what are currently available, since what is currently being done is widely accepted to be inadequate. This is especially true for programs directed at the youth, for which there is virtually nothing.
- Do something innovative, entirely different than expected. For example, in spite of the fact that few clinicians can see the relationship between athletics and health, try a well-funded and staffed tribal recreational program, and give it time to have an impact (e.g., more than one summer’s funding).
- Encourage and support those programs that emphasize early identification of a variety of problems, from parenting to alcohol abuse to suicides, and provide a wide range of treatment and counseling services. These services should have the goal of evaluating which modalities work best, with which patients, thus developing a profile of programs that are effective based upon fact and not biased impressions.
- Develop programs which seek to integrate and coordinate available community services, as well as resources outside the community, into a network of services which can provide the continuity currently lacking in many places. Adding more services without adequate coordination only makes the delivery and receipt of services more chaotic from the client’s point of view.
- Provide education based on sound educational principles, not just showing movies and handing out pamphlets. Indian young people have questions which require

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Therapeutic Foster Home Program Helps Disturbed Indian Children

BILLINGS, MONT.—Emotionally disturbed children who have been unable to form relationships with their peers or adults, who physically abuse themselves and others, who lack trust, discipline and most of all love, are presently being helped through a unique foster home program located on the Ft. Peck reservation.

According to Margene Tower, mental health service branch chief for the Indian Health Service (IHS) in the Billings area, the Therapeutic Foster Home Program came into existence because of an extreme lack of mental health services geared toward the severely disturbed Indian child.

“Our mental health field workers were reporting more and more cases involving Indian children who were setting fires, pulling the legs off of small animals, violently beating up other children, and generally displaying varying psychotic behaviors,” said Tower.

As a result of the realization of inadequate services for these children and as an outgrowth of the interest and concern expressed by the tribes and the Montana Indian Health Board (MIHB), the Therapeutic Foster Home Program and a series of training workshops and clinics on disturbed children were developed.

Through an IHS grant, the MIHB and the Ft. Peck Health Board began the first phase of the program by setting up a community education training project that included tribal judges, welfare workers, school teachers and counselors. The training examined the dynamics of the child’s first two years of life; what happens when things go wrong during that time; behaviors of the unattached child; and the principles and techniques of a particular type of therapy called “confrontation therapy”.

The second part of the program included providing the foster parent with training. A Child Mental Health Specialist, who coordinates program policies, eligibility requirements, and state and tribal program activities is also part of the program, says Tower.

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Navajo Project Coordinates Indian Child Custody Proceedings

ALBUQUERQUE, N.M.— The Indian Child Welfare Act (P.L. 95-608), signed into law in 1978, was designed to protect the most critical resource of American Indian tribes — the Indian child.

The underlying premise of the Act is that Indian tribes, as local governments, have a vital role to play in any decision about whether Indian children should be separated from their families.

Inspired by constant reports from Indian families and tribes that public and private agencies were removing Indian children from their homes and reservations in an arbitrary manner, the Indian Child Welfare Act (ICWA) mandated that such practices were to come to a halt. The Act also expresses a clear preference for keeping Indian children with their families or extended families and that the tribal courts be recognized as the most suitable forum for passing judgment on matters concerning the custody of tribal children. The legislation also authorizes the awarding of grants to Indian tribes and organizations in the establishment and operation of child and family service programs.

Since the passage of the Act, tribes have begun to develop and set standards so that Indian child custody proceedings will run smoothly and fairly. These initial guidelines and models have pulled together tribal governments and other Indian organizations in the planning and delivery of Indian child welfare services, with a goal of preventing large numbers of Indian children from being removed from their homes.

According to Anselm Roanhorse, director of the Navajo Indian Child Welfare Project, upon passage of the Act, the Navajo Tribe has brought together several resources in order to establish a workable process to expedite the intent of the ICWA. The model adopted by the Navajo Tribe includes the development of specific procedures for notification, intake, social services investigation, response, transfer of legal jurisdiction, custody and permanent placement planning.

"What we needed was one single point of implementation," said Roanhorse. Thus, the formation of the Navajo Indian Child Welfare Project and an ICWA Implementation Handbook took place. The project, according to Roanhorse, is located within the administrative structure of the Division of the Navajo Social Welfare Office and coordinates closely with the already functioning ICWA delivery network. This network consists of resources which include a Bi-State Social Service Department, BIA Social Services, state courts and other tribal, state and private social services.

The objectives of the project consist of serving as the official contact office for the tribe; verifying and monitoring all Indian Child Welfare Act cases received; acting as a liaison for the Navajo Tribe; and assisting in the identification and solicitation of resources.

The tribe, which has been awarded a $47,000 grant under the Act, has already processed 95 cases, involving 15 states and 133 Navajo children, according to Roanhorse. "Each case is unique. Sometimes all we have to go on is a name and the effort to track down more information, especially in the area of tribal eligibility, is a tedious one," says Roanhorse.

In one particular case the project office was notified by the State of California that they had in their custody a one-year-old child who was abandoned by his mother and believed to be of Navajo descent. According to Roanhorse, the name of the mother could not be verified by the tribal census office.

"Since the mother's name was from her past marriage, we didn't know if she was a Navajo, but her name was eventually tracked down and her tribal eligibility verified," said Roanhorse.

The eventual outcome of the placement proved to be a happy one. The child's grandparents were found to be living on the Navajo reservation and custody of the child was awarded to them, said Roanhorse.

In special circumstances, an agency advisory team is called in for mediation purposes, particularly in cases involving child behavioral problems, says Roanhorse. "Each case calls for a thorough assessment from a legal, medical and social service perspective. We want to be sure that the child will be given every chance to receive special services offered on the reservation."
WASHINGTON, D.C. — The impact of proposed Reagan Administration budget cuts on the future of this country's 41 urban Indian health projects was the primary focus of participants at the Fifth National American Indian Health Care Association (AIHCA) Conference here June 2-5.

According to AIHCA, the Administration's combined reductions in health programs "serve to place urban Indian health organizations and their clientele in a most precarious position. The cumulative effect of these cuts may be crippling and would reverse the substantial gains made in the last four years." It is estimated that approximately one-half of the American Indian population resides in urban areas.

Under the Administration's budget proposal, Indian Health Service (IHS) funding for urban Indian health projects, which is authorized by the Indian Health Care Improvement Act (P.L. 94-437, and reauthorized under P.L. 96-537), would be reduced 50 percent in FY 1982 and eliminated entirely in FY 1983. (Editor's note: The House of Representatives has recommended that FY 1982 funds for these projects be restored. See related article pg. 1.)

Funding for the projects would be further reduced by the Administration's proposals to block grant programs in the areas of mental health, alcohol and drug abuse, Community Health Centers, family planning, and maternal and child health care; and to cut back programs for community food and nutrition, CETA, WIC, Medicaid, and the National Health Service Corps.

Addressing the issue of the Administration's budget cuts, Congressman James Jones (D-Okla.), Chairman of the House Budget Committee, said that Indian programs are taking a disproportionate share of the cuts. "The Indian population, which represents less than one percent of the national population, is being asked to absorb roughly two and one-half percent of the total cuts in the Reagan Administration's budget," he said.

This appears to contradict the Administration's promise to protect the "truly needy," he continued. "I've had a hard time figuring out who the Administration would consider in that 'truly needy' category if not the Indian people of the United States."

Jones said that evidence of the need of Indian people is detailed in report by the Senate Select Committee on Indian Affairs, which shows that American Indians have a lower life expectancy than the rest of the population, and experience higher rates of suicide, diabetes, alcoholism, nutritional deficiencies, and mental health problems.

Because his home district includes the city of Tulsa, Okla., which has a successful Indian health care project, Jones said he is "well aware of the unique problems of urban Indians and the genuine need for the continuation of these health services."

"In spite of the theoretical availability of other health services, urban Indians simply were not receiving adequate health care prior to the establishment of urban Indian health projects," he said.

Despite Administration efforts to phase out these programs, there is still an opportunity to have Congress provide support to those programs most in need, Jones said. He urged conference participants to work together to educate congressional policymakers about the health care needs of Indian people. "If you do that, I think you will find a number of House and Senate members who are very sympathetic to what you are trying to achieve," he said.

The need for Indian people to work together to try and minimize the impact of budget cuts on Indian health programs was also emphasized by Navajo Tribal Chairman Peter McDonald.

In his keynote address to the AIHCA conference, McDonald cited the need for unity and cooperation between tribes and urban Indians. "We must not let intertribal differences affect our efforts toward improving the level of health care for our people," McDonald said. "I think if we all unite — reservation Indians and urban Indians — and begin to address the total health need of Native Americans we will be able to speak with one voice and be effective," McDonald said.

The chairman of the nation's largest Indian tribe

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criticized the Administration's proposed cuts in urban Indian programs and said it was unrealistic to assume that urban Indians could receive adequate health care from other sources, as proposed by some Administration officials.

"It's a false assumption that just because Indians relocate to urban areas that they are somehow welcomed into the arms of the town, county, and state in which they live — it just doesn't happen," he said.

McDonald commended the work of AIHCA conference participants in providing adequate health care services to Indians in urban areas, and he urged them to continue their efforts. "Good health care really is fundamental to the survival of our culture, our religion, our tradition, and our very way of life," McDonald said.

If the Administration's budget cuts are implemented, the loss of health services to urban Indians will be devastating, according to AIHCA President William Memberto. He said the resultant cut in services at the Michigan Urban Indian Health Council facility, of which he is director, would probably lead to increased illness and loss of life among the Indian population in Detroit, Mich.

Memberto also noted that existing Indian health projects have fully demonstrated their competence in delivering health care services, and said that several studies have shown the projects to be highly cost effective.

In addition to the major presentations at the AIHCA Conference, attendees took part in workshops dealing with Board Management, Quality Assurance, Management Information Systems, Parliamentary Procedures, and an Orientation to Capitol Hill. A report on the conference proceedings is under preparation and can be obtained by contacting the American Indian Health Care Association; 245 East 6th St., Suite 818; St. Paul, Minn. 55101 Phone: (612) 293-0233.

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Wichita Center Illustrates Success Of 'Title V' Initiative

WICHITA, KANSAS— When Congress passed the Indian Health Care Improvement Act (P.L. 94-437) in 1976, one of its major commitments was to improve the health status of Native Americans residing in this country’s cities.

As a result of that congressional intent, health care services for urban Indians have improved significantly over the past five years, largely through the efforts of 41 urban Indian health centers located throughout the country.

The Wichita Urban Indian Health Center here illustrates the success many of these Indian health projects have experienced in providing health care services to urban Indian populations.

Like many of the other urban projects, the Wichita center started practically from scratch with only two staff persons working in a one-room clinic. The center is now housed in a 6,000 square foot complex and employs 15 full-time staff, and provides the city’s Indian population with a full range of comprehensive health care services. The center utilizes a variety of resources in its operation, generating $2.50 in local support for every federal dollar it receives, according to executive director Bert Steeves.

The center offers 32 hours of medical clinics per week. Family practice, obstetrics and gynecology, pediatrics, and well child clinics are held weekly, and a diabetes clinic is offered each month. Physicians and other health professionals donate their time to these clinics under an arrangement with the local hospitals.

Dental services are also provided at the center’s fully-equipped dental facility, which is staffed by a dentist, dental assistant, and dental hygienists. The center also provides outreach and transportation services through its Community Health Representative and Community Food and Nutrition programs.

In addition, the center contracts with local health professionals to provide off-site health service for prescriptions, medical and dental lab work, and optometrics. Dental care and off-site health services are provided on a sliding scale, depending on the patient’s income. No one is refused service at the center due to an inability to pay.

Staff at the center also work to increase the community’s awareness of the special health needs of urban Indians by participating in such projects as the Mayor’s Task Force on Child Care, the local health fair, the local Health Systems Agency Sub-Council, the White House Conference on Families, and the Board of Directors for the American Indian Health Care Association.
conditions causing problems such as alcoholism and suicides. Culturally we are trying to bring into the community new ways and incorporate them with the traditional values of our culture.

In the area of Indian child abuse and neglect, Charlotte Goodluck, co-facilitator for the “Meeting the Needs of Abused and Neglected Indian Children” workshop, cited actual case examples in order to define short and long term needs of abused and neglected children. Also provided in the workshop were examples of problems encountered in attempting to meet these children’s needs in Indian settings and possible solutions through community activism on behalf of Indian children.

Goodluck stressed throughout the workshop that the needs of an abused and neglected child were as important as the needs of the family. “We need to look at the whole situation. Sometimes all the focus is on the child as the victim. We can’t leave out the natural parents or the extended family, or clan.”

Goodluck said that some of the reasons a child may be abused and neglected is because the parents may be frustrated, angry or sad, and take it out on people who live with them. Sometimes the parents get no help or support from their family, said Goodluck. “We should use more of our knowledge of the clan systems and use available role models in situations like these,” she said.

The workshop concluded with new program ideas in the areas of tribal day care centers, the development of a community-extended family center and the development of a child task force. “We must gear our interest to strengthen the families and look at the whole aspect of abuse and neglect. We must look inside our communities — what we have is very precious and very valuable,” said Goodluck.

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Therapeutic...

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Tower reports that the children placed into the foster homes are doing well, and she noted the experience of one child who had severely attacked a fellow classmate and feared getting close to anyone is now able to give and receive love and has dramatically improved his school performance and his relationships with friends.

Even though the program has been quite successful, Tower says she doubts it will be able to continue in 1981. “The continuance of this program is vital to the children involved and even though the commitment of the IHS staff, the NIHB and the Ft. Peck Reservation is very strong, due to the severe budget cuts, IHS will not be able to fund the project,” said Tower.

Tower did say that alternative funding sources are presently being examined, but as yet no future monies have been obtained.

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