Reagan Administration Likely to Support Indian Health Programs

WASHINGTON, D.C.—While it is still too early to identify the specific Indian program strategies of President-elect Ronald Reagan, early indications are that the incoming Administration will not make any drastic changes in the present direction of federal Indian policy.

Among other things, Reagan has voiced his support for tribal sovereignty, Indian Self-Determination, strengthening tribal management capabilities, and providing Indian leaders "with an open channel of communication in the White House."

In the area of health care, most existing services will likely continue under the Reagan Administration, according to Indian Health Service (IHS) Director Dr. Emery Johnson. Because Indian health care policy is based on two landmark pieces of legislation — P.L. 94-437 (the Indian Health Care Improvement Act) and P.L. 93-638 (the Indian Self-Determination and Education Assistance Act) — that received overwhelming bipartisan support from Congress and were signed into law by Republican administrations, Johnson maintains that "one would not anticipate major changes in the direction of that policy" under the Reagan Administration.

However, Johnson cautions that any optimism about the new Administration's support of Indian programs must be tempered with the realism of budget constraints in the upcoming years. He predicts that future restraints on federal spending will lead to an increased emphasis on program accountability under the Reagan Presidency.

On the matter of accountability, Johnson asserts that the Indian Health Service's record of delivering "quality services that are cost-effective" is as good as, if not better than, most federal agencies. "Indian health programs can clearly document the improvement of health services to Indian people. This can be said of both government and tribally-run health programs," he says.

Reagan's insistence on program accountability should not be construed as a reluctance to support programs that provide genuine assistance to people who need help, according to Timm Williams, California representative to the National Indian Health Board. Williams is former director of the California Indian Assistance Project, where he served as Governor Reagan's special assistant on Indian affairs in the early 1970's.

"Governor Reagan initiated several efforts to help the Indian people of California, and he's never really received credit for that. I believe he will support programs that can demonstrate benefits for the people, instead of having costs eaten up through administration," he says.

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WASHINGTON, D.C.—President Jimmy Carter recently signed two important measures that affect the delivery of health care services to Indian people.

On December 17, the President signed a measure to amend and extend the Indian Health Care Improvement Act (P.L. 94-437) for four years. The new law contains several important amendments in addition to extending funding authorization levels through FY 1984. (See related article Pg. 5.)

President Carter also signed the Department of Interior Appropriations bill (H.R. 7724), which contains funding provisions for the Indian Health Service for FY 1981. The new law provides for $594,119,000 in Indian health services, and $84,469,000 for facilities construction in FY 1981.
Examples of Reagan's support of Indian programs during his tenure as governor of California, according to Williams, are evidenced by his approval of funding for the California Intertribal Council, his work in preventing dam construction on the Round Valley Indian reservation, his support of the California Indian Assistance Project, and his state Indian Day proclamation.

Williams noted that Reagan "is very thorough in his decision-making. He surrounds himself with a strong staff that can present different viewpoints on complex issues." Reagan will probably make a careful review of present Indian policies and programs before seeking any changes, he added.

As for health care services, Williams agreed that IHS probably has a stronger record of accountability than most federal agencies, which he attributes to the active involvement of Indian communities in their health care programs. Since current health service programs have shown demonstrable achievements in improving the health status of Indian people, and because there is an obvious need to continue such programs, IHS and tribal health care services will likely be supported, and maybe even strengthened, under the Reagan Administration, Williams said.

Responding to specific areas of federal Indian policy, Reagan has stated that he supports tribal sovereignty and Indian Self-Determination. "The Indian Self-Determination Act (P.L. 93-638) was proposed by a Republican Administration and enacted by Congress to provide the legal and administrative vehicle for the tribal governments to secure control and management of federal programs designed to serve their constituencies. I believe that the tribal governments, as they decide they are able to administer it, should have that control," Reagan stated during his campaign.

Reagan further indicated that his Administration would thoroughly review P.L. 93-638 to seek ways of "improving the legislation and the Federal administration of it; and of removing those aspects which cause anxiety and reluctance on the part of the tribes to participate."

With respect to urban Indians and non-federally recognized Indian groups, Reagan said he is "aware of the unique nature of their situation and of the fact that their problems have been largely ignored in the past. The situation of urban Indians, the off-reservation rural Indian communities, and the tribes not recognized by the federal government must be looked into with the goal of establishing ways and means of securing better opportunities for them."

"However," he continued, "this must be done in a way that will not threaten or compromise the treasured trust relationship of the Federally-recognized tribes, nor diminish the financial commitment of the Federal government to them."

In addition, Reagan stated that he supported "government to government relationships between the federal government and tribal governments"; favored decentralizing program responsibilities "from the federal government to the state and local governments, including tribal governments, along with the tax resources to pay for them"; endorsed the development of tribal court systems; and supported a stronger role for tribes in Indian government policy development.

Although Reagan did not promise to establish a White House coordinator of Indian affairs, he indicated that such a position would be considered. "However, I can assure the Indian tribes that their leadership will have strong advocacy and an open channel of communication in the White House," Reagan said.
Health News Across the Nation

The following is a regular feature in the NIHB Health Reporter. In this section, we present our readers with short, concise 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. Further information on items mentioned in these short reports can be obtained from the NIHB Public Information Office.

WASHINGTON, D.C.—President-elect Ronald Reagan named retiring Sen. Richard Schweiker (R-Penn.) as the Secretary of Health and Human Services for his incoming Administration. Schweiker, 54, Reagan’s running mate for the Republican presidential nomination in 1976, has been actively involved in Senate health-related activities for the past 10 years. He is the ranking Republican on both the Senate Labor and Human Resources Committee, and the Labor-Health and Human Services Appropriations Subcommittee, the two Senate units which control both authorizing legislation and appropriations for health, education, aging, and public welfare matters.

Schweiker has worked in drafting and sponsoring legislation to combat heart disease, sickle cell anemia, lead paint poisoning, and has been especially active in the fight against diabetes. With respect to his appointment to the Reagan Cabinet, Schweiker stated that he was “deeply honored” to be chosen for the position, and that he is “delighted and enthusiastic about this new challenge ahead.”

WASHINGTON, D.C.—On December 11, the Senate gave unanimous consent to extend the life of the Senate Select Committee on Indian Affairs for another three years. The committee will be expanded to include an additional two senators, bringing its membership to seven. Over the past year, the Senate Select Committee was particularly active in the area of Indian health care, holding several field oversight hearings on the Indian Health Service and reauthorization of the Indian Health Care Improvement Act.

MINNEAPOLIS, MINN.—The Minneapolis Indian Health Board is operating a special short-term project to screen local Indian people for high blood pressure. The program will continue for 8-10 weeks, with door-to-door screening to be done in an effort to reach as many Indian residents as possible. The screening service is provided at no charge, and it is hoped the project will help provide needed information about high blood pressure in the Indian community.

HONOLULU, HAWAII—The School of Public Health at the University of Hawaii is seeking Native American applicants interested in studying for a Master of Public Health degree. Under funding provided by a P.L. 94-437 (the Indian Self Determination and Education Assistance Act) grants, students will receive a monthly stipend of $480, travel, book allowance, and tuition. Deadline for receipt of all documents for the 1981-82 academic year is March 31, 1981. For further information, contact: Director, Special Educational Opportunities Programs; School of Public Health; University of Hawaii; 1960 East-West Rd.; Honolulu, Hawaii 96822.

TOPPENISH, WASH.—In an effort to control and treat diabetes among residents of the Yakima Reservation, the Yakima Indian Health Center operates a program to determine the needs of local diabetic patients. The clinic is attempting to screen all reservation residents over the age of 35 who have not been checked for diabetes within the last two years. Efforts are also being made to educate local residents of the serious consequences of diabetes, and to encourage as many people as possible to take part in the screening. Persons identified as having a high risk of becoming diabetic will be asked to undergo yearly examinations for the disease.

BERKELEY, CALIF.—The University of California, Berkeley, is seeking Indian applicants for its School of Social Welfare for the 1981-82 school year. Beginning in 1981, the School of Social Welfare will offer a master’s degree program geared to the needs and concerns of Indian populations. For further information, contact: Elaine Walbroek; School of Social Welfare; 120 Haviland Hall; University of California; Berkeley, Calif. 94720. Phone (collect): (415) 642-3228

SACRAMENTO, CALIF.—The California Rural Indian Health Board (CRIHB) will hold its annual meeting here January 16, 17, and 18 at the Point West Motor Lodge. The meeting will include a film entitled “Colliding Worlds”, which reflects the changing societal values of the Mono Indian tribe of California. Keynote speaker for the meeting will be Ralph Zotigh, Director of the National American Indian Safety Council. For further information contact: the California Rural Indian Health Board, 2020 Hurley Way, Suite 155, Sacramento, Calif. 95825. Phone: (916) 929-9761.

KYAKOTSMOVI, ARIZ.—The Hopi Health Professions Development Program has been reinstated following a shutdown due to termination of funding in late August. The program provides a number of important services to students interested in careers as health professionals, including financial aid assistance, higher education placement, training trips, workshops, and social and educational activities. Approximately 60 students currently participate in the program.

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DENVER, COLO.—Evelyn Lance Blanchard, community development specialist for the Portland area Indian Health Service (IHS), was recently honored as one of the top ten graduates of the University of Denver graduate School of Social Work. Blanchard received the award during ceremonies here November 1 marking the school’s fiftieth anniversary. In her capacity with IHS, Blanchard has worked extensively to help improve services for Indian families. She was designated Outstanding Role Model in 1979 by the North American Indian Woman’s Association and currently serves as president of the Association of American Indian and Alaska Native Social Workers.

ROCKVILLE, MD.—The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is currently recruiting to fill the new position of Chief, American Indian/Alaska Native Branch. Persons interested in applying for the position should contact: Lois R. Chatham; Acting Associate Director for Program Operations; NIAAA; 5600 Fishers Lane; Rockville, MD 20857.

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LOS ANGELES, CALIF.—The Bureau of Indian Affairs (BIA) recently awarded a grant to the Indian Child and Family Resource Center here to implement the Indian Child Welfare Act (P.L. 95-608). Projected services to be provided by the center include: legal representation to Indian families involved in child custody proceedings; recruitment of Indian foster and adoptive families; a training program for professionals involved in Indian child placement; documentation of child abuse and neglect, and information and referral services.

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**Key Health, Legislative Issues Focus of NIHB Conference Agenda**

SAN DIEGO, CALIF.—Two major general assembly presentations and 16 health-related workshops make up the tentative agenda for the Fourth National Indian/Alaska Native Health Conference, to be held here April 7-10, 1981. Approximately 2,000 people are expected to attend the conference, which is designed to examine many of the important health care problems affecting American Indians and Alaska Natives. In keeping with its conference theme “The 1980’s: A Decade of Indian Health Initiatives,” the conference will particularly focus on the role of Indian Self-Determination for tribes and Indian organizations in the management and delivery of health care services to Native Americans.

While this focus is certain to be evident in most of the conference workshops, it will receive special attention during a panel discussion on “Issues and Answers to P.L. 93-638 (the Indian Self-Determination and Education Assistance Act)” which will take place before the conference general assembly on April 8. Several top legal attorneys and government officials will examine how the law specifically applies to the delivery of health care services to Indian people.

The following morning, April 9, a panel of Indian medicine men will address the topic of “Traditional Indian Medicine and Holistic Health.” The sessions on P.L. 93-638 and traditional Indian medicine have been scheduled before the conference general assemblies to allow as many conference attendees as possible to attend.

Following the general assemblies on April 8-9, conference participants will break into smaller workshop sessions that will address issues related to health legislation, human services, and health management. Workshop attendees will be encouraged to participate in these sessions and share their views and experience with others. Each workshop will be held twice — once in the morning and once in the afternoon — to allow attendees to take part in as many of the sessions as possible.

As presently scheduled, workshops on the following topics will be held April 8: the Mental Health Systems Act (P.L. 96-396); Nutrition; Health Maintenance Organizations; the Indian Health Service Budget Process; Funding Alternatives; Urban Health Concerns; the National Health Service Corps, and Environmental Health Concerns.

On April 9, workshop topics will include: Community Health Concerns (which will include a presentation on Alaska’s unique Community Health Aide program); Alcohol and Drug Abuse; Emergency Medical Services; Diabetes; the Elderly; Indian Youth; Otis Media, and Indian Health Manpower Development.

Other conference activities will include a banquet, a pow-wow, a dance and other entertainment. A report on all conference presentations and recommendations will be published and sent to all conference attendees.

The conference will be sponsored by the National Indian Health Board (NIHB), with the California Rural Indian Health Board (CRIHB) serving as host organization. Related information on preregistration, hotel accommodations, exhibits, conference speakers, agenda, and other materials will be distributed in mid-January.

Conference posters will be available upon request in early January. To obtain a poster, or additional information about the conference, contact: Thomas Allen; Deputy Director; National Indian Health Board; 1602 S. Parker Rd.; Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931.
Carter Signs Bill to Amend Health Care Improvement Act

WASHINGTON, D.C.—A measure to amend the Indian Health Care Improvement Act (P.L. 94-437) and extend the act’s funding authorization through fiscal year 1984 was signed into law by President Carter here December 17.

The Indian Health Care Improvement Act was passed in 1976 to raise the health care status of American Indians and Alaska Natives to a level equal to that of other Americans during the act’s seven-year scope. Congress authorized specific funding levels for the first three years only, with the intention of making further authorizations for FY 1981 - FY 1984 after reviewing the accomplishments and progress of the act.

That review was completed several months ago, and the new law represents a compromise between two bills (S. 2728; H.R. 6629) passed by the House and Senate earlier this year. In addition to establishing funding authority for P.L. 94-437 programs through FY 1984, the law includes major amendments to Title IV (Access to Health Services), Title V (Health Services for Urban and Rural Indians) and Title VII (Miscellaneous).

The major new provisions of the law, along with the authorization levels for the next four years, are summarized below:

**Indian Health Manpower**

An amendment to Section 103(b) will expand the Indian Health Manpower scholarship program to allow for up to four years of pregraduate study (in the areas of pre-medicine, predentistry, preosteopathy, pre-veterinary medicine, preoptometry, or pre-podiatry) in addition to the previously authorized two-year preparatory scholarships.

In the conference report language, the House-Senate conferees expressed their concern over the timeliness of scholarships awarded under Title I and urged IHS to “make scholarship awards in as timely a fashion as possible.”

The law authorizes the following funds to be appropriated for Title I programs: $15.8 million for FY 1981; $18.04 million for FY 1982; $20.73 million for FY 1983; and $23.91 million for FY 1984.

**Health Services**

No major amendments were made in Title II programs, which includes provisions for patient care, field health, dental care, community mental health, inpatient mental health, model dormitory mental health services, therapeutic and residential treatment centers, training of traditional Indian practitioners in mental health, treatment and control of alcoholism, and maintenance and repair services. Total authorization levels for these programs are: $56.3 million for FY 1981; $64.5 million for FY 1982; $74.4 million for FY 1983; and $81.8 million for FY 1984.

**Indian Health Facilities**

Rather than identifying specific amounts for the construction of new health facilities and sanitation facilities under Title III, the extension authorizes “such sums as may be necessary” for those purposes for FY 1981-1984.

**Access to Health Services**

An amendment to Title IV establishes a program to provide grants to tribal organizations to assist individual Indians and Native Alaskans in enrolling in Medicare and applying for medical assistance through Medicaid. Authorizations to carry out this program are: $5 million for FY 1981; $5.75 million for FY 1982; $6.6 million for FY 1983; and $7.6 million for FY 1984.

**Health Services for Urban and Rural Indians**

A major amendment to the law is the Title V provision establishing a “rural Indian” program in addition to the previously-authorized “urban Indian” health program, with each program having its own authorization level. As defined in the act, “rural Indian” means any Indian individual who resides in a community that is not located on a federal Indian reservation or trust area; is not an Alaska Native village; is not an urban center; and has a sufficient rural Indian population with unmet health needs to warrant assistance under Title V.


For rural Indian health projects, the law authorizes $3 million each year for FY 1981-FY 1984.

**Miscellaneous**

Amendments to Title VII constitute the most extensive change to the act. Under the new provisions, the Department of Health and Human Services will be required to conduct, in conjunction with tribes, Indian organizations, and other federal agencies, a study of health hazards to Indian miners and residents of Indian communities that result from nuclear resource development.

In another amendment, IHS will have the authority to establish a demonstration project in two IHS areas where personnel ceilings will be lifted and the area program will be managed through fiscal controls. The National Indian Health Board has testified in support of such a program, contending that it will allow for better IHS management and will improve health care services for Indian people.

The new provisions also make California Indians who are members or descendants of former federally-recognized tribes eligible for IHS services, and designate the state of Arizona as a single contract delivery area. These provisions for Indians in California and Arizona become effective in FY 1982.

Other amendments to Title VII provide that:

- the Department of Health and Human Services submit to Congress a resource allocation plan that will explain the future allocation of funds and services among eligible Indian populations, and that will provide a schedule for reducing present resource deficiencies
- property leased by the Department of Health and Human Services from an Indian tribe may be reconstructed or renovated by the Secretary, provided such work is approved by the tribe.
NIHB EXECUTIVE DIRECTOR Jake Whitecrow (right) accepts a $1,000 contribution from Gulf Oil Company, presented here by Kent Ware III, Director of Gulf's Indian Affairs program.

Notes From the Executive Director:

Here we are at the end of another calendar year. It is a time when most of us look back and think about what we've accomplished during the preceding twelve months, and try to determine where we hope to go in the upcoming year.

This past year has been one of growth and change for the National Indian Health Board. We have had many fine accomplishments that will ultimately help improve the health care of our Indian people, which in turn will help us develop stronger Indian Nations.

Over the past year, NIHB worked diligently to extend and improve one of the most important laws Congress ever passed for Indian people — the Indian Health Care Improvement Act (P.L. 94-437). We also worked through administrative channels to reverse or nullify the U.S. Comptroller General's decision about Indian Health Service contracting that would have created havoc for many of our Tribes' health programs. We advocated that the Indian Health Service be exempted from federal freezes on hiring and travel, because those restrictions hurt IHS' ability to deliver quality health care to our people.

NIHB fought to get equal pay benefits for Public Health Service doctors, who make up such a vital part of the Indian health care delivery system. We supported efforts to improve and expand Indian food and nutrition programs, because proper nutrition affects overall health care in so many ways. We initiated a process to train and encourage tribes to become involved in the federal budgeting process. And we worked to secure provisions in the new Mental Health Systems Act (P.L. 96-398) to help improve mental health services to Indian people. In all these endeavors as well others, in which we worked with the support of tribes and other Indian organizations, we were fortunate to succeed.

But accomplishments such as these are meaningless unless they provide a stepping stone to further achievements. Significant steps have been made in improving the health care of our Native people, but we still have a long, long road to go before all of our people are truly healthy in body and spirit.

NIHB is approaching this new year with these thoughts in mind, and we seek your continued support in our efforts. Over the past year, NIHB has received resolutions from Tribes, and Indian organizations representing Tribes, that reflect strong support for NIHB throughout Indian Country. Depending on population estimates, NIHB has the support of between 75-85 percent of the Native population. We will work to expand upon this support, and we will speak to every important health issue affecting American Indians and Alaska Natives.

One of NIHB's most important initiatives in the upcoming year will be to work with Tribes and IHS officials to change the IHS P.L. 93-638 contracting process, to make it easier for tribes to contract for their own health care services. We hope to see some major changes in this process in the near future.

In order to make any serious inroads to improving our lives and our Indian communities in the next year, we must be willing to help each other. Tribes, Indian organizations, Indians, and non-Indians — we must all work together as best we can. We are looking at a potentially tough year but I firmly believe that if we are each accountable for our operations, then we will have the support we need to continue and grow stronger.

On behalf of the National Indian Health Board, its members, its alternates, its staff, and all twelve area health boards, I wish each of you a very happy Holiday Season. May our Creator shine his blessings upon you and yours, and may 1981 bring to each of you a fulfillment of your dreams and ambitions.

J.W.

NATIONAL INDIAN HEALTH BOARD
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March 1 Deadline Set for Health Conference Resolutions

SAN DIEGO, CALIF.—The National Indian Health Board (NIHB) is now accepting resolutions from tribes, Indian organizations, and individuals for the Fourth National Indian/Alaska Native Health Conference to be held here April 7-10, 1981. The NIHB conference planning committee is asking that such resolutions be submitted by March 1, 1981.

Resolutions at past conferences have served as an important mechanism to address crucial issues affecting Indian health care, and to give focus and direction to NIHB, which serves as sponsor for the conference. Past resolutions have addressed such areas as health legislation, Indian Health Service (IHS) policies, request for support of local issues, identification of special health problems, and other matters affecting the health care of Indian people.

The March 1 deadline has been established to facilitate the conference resolutions process and to allow conference participants an opportunity to have an active part in that process. The NIHB conference resolutions committee will review the resolutions for clarity and accuracy, and to determine whether the resolution conflicts with NIHB operating procedures. Resolutions will be considered for adoption at the NIHB quarterly meeting following the conference.

Upon completion of this review and adoption process by NIHB, the conference resolutions will be distributed to proper government agencies and other organizations, with a request for response. NIHB will also draw up appropriate strategies to address the resolutions and provide for additional followup where needed.

In order to simplify the conference resolutions process, the NIHB planning committee is asking that resolutions be submitted according to the format identified below. Resolutions may be submitted to area NIHB representatives or directly to the NIHB central office in Denver, Colo. Copies of past conference resolutions have been printed in conference proceedings reports, which are available from the NIHB Public Information Office.

To submit resolutions for the conference, or to obtain further information, contact: Thomas Allen, Deputy Director; National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931.

### National Indian Health Board Conference Resolution Format

- **Resolution Title:**

- **This Resolution Will Affect the Following Health Issue:**

- **WHEREAS,**

- **WHEREAS,**

- **WHEREAS,**

- **NOW THEREFORE, BE IT RESOLVED THAT THE NATIONAL INDIAN HEALTH BOARD**

- **Resolution submitted by**

- **Location of Contact Person:**

- **Telephone:**

- **Other Information:**
PROFICIENCY IN CHAIRSIDE assisting skills is gained in the modern classrooms and training laboratory at the Southwestern Indian Polytechnic Institute (SIPI). The eight-chair clinic at the SIPI Dental Center provides field experience and helps to provide excellent opportunities for developing chairside dental assisting skills in the real world environment.

Indian Dental Programs Changes, Improvements

DENVER, COLO.—One of the fastest growing health priorities among the American Indian and Alaska Native population is the concern with good oral health and comprehensive dental care.

In the early 1900's, the oral health status among American Indians had evolved into a "backlog of neglect" due to the virtual non-existence of dental care. This neglect, resulting in oral diseases that caused pain, disfigurement and loss of function, prompted the federal government to take a significant course of action in treating dental problems of Indian people.

In 1913, the Bureau of Indian Affairs (BIA) assigned five dentists to travel among Indian reservations and boarding schools to provide dental care that consisted mainly of extraction services. Portable equipment was used by the dentists and travel was frequently on horseback. Over the years, as roads were constructed and more money became available, mobile dental trailers were used.

By 1955, when Congress established the Indian Health Service (IHS) within the U.S. Public Health Service, fixed dental clinics had been built in several locations near larger reservations. Gradually, additional field clinics, mobile dental units and portable dental equipment were added.

Today, the IHS dental program has grown to 124 dental facilities and more than 250 contract providers throughout the United States. The facilities, located in hospitals, health centers, and health stations, provided dental services to 227,000 individuals in 1979, according to IHS statistics. IHS also reports that American Indians and Alaska Natives continue to receive an increased number of services through the dental care delivery system and through its 252 dentists, 362 dental assistants and four public health dental hygienists.

But despite these accomplishments, IHS statistics report several major problems in the delivery of dental services to Indian people. In the most recent IHS Dental Services annual report, it was stated that in fiscal year 1979, 31 percent of the eligible American Indians and Alaska Natives were provided care through the direct or contract care dental delivery system. This percentage is low when compared to the 49 percent of the total U.S. population visiting a dentist at least once in 1979, the report states.

The report also reveals a significant shortage of adequate resources, resulting in only 34 percent of "required" dental services being provided to the Indian population.

In spite of inadequate resources, significant program progress has been made during the past 24 years, states IHS Director Dr. Emery Johnson. "While most oral health services are provided by IHS dental staff or private dentists on contract with IHS, care is also provided through the cooperation between the Indian Health Service and a variety of other resources including dental schools, state health department, Head-Start, Medicaid programs and voluntary organizations. Another major reason for accomplishments to date has been the active participation of Indian and Alaska Native people in their dental programs," Johnson said.
The success and steady progress of the IHS dental program over the years can also be attributed to the mission of the program, says IHS Chief of Dental Services, Dr. Robert Mecklenburg. According to Mecklenburg, the policies and activities of the program are guided by three basic principles: first, dental services must be convenient to people both in time and place so that preventive measures can be employed; second, dental staff must be given broad responsibility and strong administrative support so that they can be flexible in responding to variations in the needs of Indian people; and third, Indian people themselves must be encouraged to develop a strong sense of responsibility for their own oral health and well-being.

According to Mecklenburg, the Indian Health Service's encouragement of responsibility lies in the promotion of community involvement in the dental health programs. The active participation of community groups, tribal governing bodies and local health authorities is encouraged in planning, decision-making and implementation of oral health programs, states Mecklenburg.

Another program priority over the past year has been in the area of community fluoridation, says Mecklenburg. With the establishment of a dental community development position responsible for oral disease prevention and fluoridation, a vigorous and renewed commitment was made to involve the community sector in health services delivery.

"Community water fluoridation is advocated by the IHS as the primary means of preventing dental problems, especially when you consider that it can prevent tooth decay up to 60 percent or better," Mecklenburg said. Communities that are not amenable to community water system fluoridation due to technical or mechanical barriers are often good candidates for having school water systems fluoridated, added Mecklenburg. In such cases, the benefits of fluoride are gained even though the children are not exposed to fluoride prior to school age, he says.

Specific training in dental disease prevention is also provided to Community Health Representatives, tribal health workers, and IHS dental officers, so the benefits of prevention can be extended to as large a group of people as possible, Mecklenburg said.

Other areas of community responsibility cited are the organization of care for special populations such as the handicapped, Head-Start children, group prevention programs and the development and management of training programs for tribal and IHS employees in community development, program management and oral health care delivery.

Emphasis on American Indian and Alaska Native involvement is reflected through a variety of shared arrangements for the management of dental care delivery.

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Reflect Significant Over Past 25 Years

THE EMPHASIS ON Native American community involvement and preventive dental techniques is illustrated here by two Zia Pueblo children. Most of the health education materials are provided by the Indian Health Service Dental Branch and are distributed to IHS clinics, area and program offices and community groups.
PROVIDING DENTAL CARE in Alaska presents special problems because of the vast territory and remote areas that must be served. Dentists Kenneth Crooks (left) and Kevin Craig (middle), and dental assistant Rene Sims (right), work at the dental clinic at Kanakanak Hospital near Dillingham, AK, which serves 32 villages in the 40,000 square mile Bristol Bay service region. During winter months, dental teams from Kanakanak travel to many of the outlying villages to provide residents with a variety of dental care services.

Indian Dental Programs

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systems. There are 53 programs which utilize various management relationships between IHS and tribes, ranging from complete tribal ownership of facilities and tribal management of health programs pursuant to the Indian Self-Determination and Education Assistance Act (P.L. 93-638), to different types of shared contractual arrangements for services and personnel.

A further look into the IHS dental programs reveals a diversified level of services which include hospital dental clinics, area service units and separate tribally-run dental service programs.

Dr. Regis Nairen, Chief of the Service Unit Dental Program in the Phoenix area, reports that the Phoenix Indian Medical Center dental clinic served a total of 17,000 patients last year. Besides the hospital dental facility, the service area includes two other clinics providing full dental services to the Salt River and Gila River reservations, Nairen said. In addition, the Phoenix area provides an orthodontic clinic located on the hospital grounds and dental training programs for dentists and dental auxiliary personnel.

The Phoenix hospital clinic, one of the largest in the country, employs the services of 11 dentists, 15 dental assistants (all Native American), one administrative assistant and 16 dental auxiliaries which include several dental therapists, said Nairen.

According to Nairen, several dental problems experienced at the hospital and the service areas are related to the delay in getting specialized dental services to the population. "Patients with more complex dental problems such as gum disease, orthodontia and denture work, plus those needing specific surgical procedures usually have to wait longer, with treatments strung out over a longer period of time," he explained. Other dental care complications, asserted Nairen, can be traced to the high incidence of diabetes among the Indian population in the Phoenix area. "The high incidence of diabetes in the Southwest causes complications affecting the whole circulatory system which contributes to many cases of gum disease and overall oral health degeneration," he said.

In Ada, Okla., Dr. David Schrupp, Chief of the Ada Service Unit Dental Program, supervises three dental clinics: one located at the new Ada Indian Health Service Hospital; one in Wewoka, which consists of eight chairs, four dentists, and eight dental auxiliaries; and the third located in Tichomingo, which includes five chairs, one dentist and one dental auxiliary.

According to Schrupp, despite the Ada hospital clinic, which has ten chairs, two general dentists and one dentist specializing in denture work, and the other two clinics outside Ada, there are still not enough services being provided based on the demand of the area's population.

"We have a large backlog of adults waiting for specialized services, even though we are steadily building up the program," said Schrupp. But, even with the backlog of required dental services for his area, Schrupp said he remains pleased with the overall acceptance and participation in the Ada dental services.

According to Schrupp, another aspect of the Ada service unit has been the training and promotion of dental auxiliaries to dental therapists. Dental therapists, says Schrupp, fill in cavities and perform restorative work in place of the dentist. Continued on Pg. 11
Indian Dental Programs

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"After six months, the dental therapists go through another evaluation and if they are doing well they can receive further training and an increase in their salary level," he said.

In addition to IHS clinics such as the ones in Phoenix and Ada, more than 50 tribes are involved in the operation and management of Indian dental programs.

In Tacoma, Wash., for example, the Puyallup tribe has managed its own community dental clinic for five years. According to Sherry Horner, dental program manager for the tribe, the clinic consists of five chairs, two full-time dentists and a part-time orthodontist, a dental hygienist and four dental assistants. The clinic, which also has its own lab technician, serves both the urban and suburban areas surrounding the reservation, says Horner. "Most of our funding," said Horner, "is provided from a P.L. 93-638 contract and additional third-party billing." According to Horner, IHS acts only as an "overseer" of the tribal program.

Problems cited by Horner centered primarily on the backlog of dental services. "We try to get the children in to see the dentists first, but a good portion of our adults have to wait for more complicated dental service work to be completed over a longer stretch of time due to the shortage of personnel," Horner said.

In Old Town, Maine, another tribally-run program is successfully meeting most of the tribe's dental needs, according to Dr. Fenn Welch, dentist for the Penobscot Nation's dental services program.

"The Penobscot population is now receiving more comprehensive oral health care because of the nature of the program," says Welch. "With our smaller population, the availability of the dentist and several community prevention programs, the dental services are more than adequately serving the people."

Emphasis on American Indian involvement appears to be the way of the future, says Mecklenburg. "With more tribal participation, our best service to the population will be in the area of an 'overseer'. We would then help to supervise and make sure the tribally-run programs get the best out of their dollar for dental health care," said Mecklenburg.

Dental services for Indian people will continue to improve with more tribal participation, continued Mecklenburg.

"When the Indian population runs their own programs, there is a general tendency to put the money where the need is felt the most. To me, this is an indication that community programs probably get a better balance of care through their own self-determination as compared to determination outside the community," said Mecklenburg.

"We are clearly moving in the right direction as compared with two decades ago. The development of the IHS dental service program has been an evolutionary, maturing process," Mecklenburg concluded.

Indian Dental Assistants Play Vital Role In IHS Dental Programs

ALBUQUERQUE, N.M.—A large and important work force within the Indian Health Service (IHS) dental branch has been its 362 dental assistants, most of whom are American Indian and Alaska Native.

As auxiliary personnel, their value is enormous to the IHS dentist and to the dental program, according to IHS Dental Services Chief Dr. Robert Mecklenburg. "Not only do they perform chairside duties, prepare patients for treatment, process dental X-Rays, and provide oral health education — they also provide a significant degree of sensitivity that acts as an important link to the community," Mecklenburg says.

A good example of the unique role of the dental assistant can be found at the Zia Pueblo Dental Clinic. Ida Gachupin, a dental assistant for more than 15 years, says that sometimes patients come into the clinic frightened and unsure.

"I try to make them feel more comfortable by speaking in their native language. This way, someone in great pain can communicate more easily to the doctor and myself."

According to Gachupin, there are advantages in being part of the community. "Most of the people living in the pueblo know me, especially the children. When I drive by them, they always wave and run to my car to show me their teeth, with most of them admitting to giving up eating candy bars," laughed Gachupin.

Another important aspect to the dental assistant's role is in the area of preventive care. Gachupin reports that several of her dental assistant's activities involve teaching classes in oral hygiene to children in Head-Start programs, as well as classes in nutrition, diet and maintenance care in the schools.

The importance placed on the dental assistant's role is also recognized in the academic and training areas, says Dr. William Bird, Director of the IHS Dental Staff Development and Special Services. "Approximately 250 dental auxiliaries

Continued on Pg. 12
Autumn's short training courses and gaining additional skills above general assistant duties. For example, a Dental Program Coordinator training program, recently inaugurated by IHS, trains assistants in the overall direction and management of a tribal or area dental care program.

Other examples of academic training include a one-year certificate program and a two-year associate arts degree in dental assistance from Haskell Institute in Lawrence, Kansas. The one-year certificate program, according to Bird, is designed with time options to accommodate tribes that cannot afford to have someone gone for long periods of time. A four-month intensified clinical and academic dental assistance program is also offered in Albuquerque.

For individuals who have not had formal training in a particular dental area, a rich variety of personalized and time-designed training programs are offered. These programs include correspondence-type instruction where specific learning packages can be requested and worked on either at home or on the job, said Bird. "The continuing education programs are most valuable, especially when funds do not allow for travel to the designated training areas," said Bird.

According to Dr. Mecklenburg, IHS's view is that "no matter what the person's situation we try to arrange a program that will fit into their life. On-the-job training and home study can produce a person with the same knowledge as those who attend formal academic institutions."

Future dental assistant programs will consist of computer management instructions and courses, a wider range of video tapes and records, training films and booklets.

and 190 dentists received a formal accredited course of instruction at one of six staff development centers throughout the IHS. Clinical specialty consultants provided many additional hours of instruction for individual facility staff, service units and area functions," said Bird.

Health professionals in the Dental Branch are also encouraged to further their skills in several ways, according to Bird. Auxiliaries can advance to more responsible positions by completing short training courses and gaining additional skills above general assistant duties. For example, a Dental Program Coordinator training program, recently inaugurated by IHS, trains assistants in the overall direction and management of a tribal or area dental care program.

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NCAI Adopts Strong Stands On Alcoholism, Health Issues

SPOKANE, WASH.—With a vigorous focus on present and future issues in the areas of health, education, social welfare and economic development, combined with a determined effort to form a persuasive legislative plank on these issues, the 37th annual convention of the National Congress of American Indians (NCAI) convened here October 26-31.

Over 1300 delegates and conferees gathered to draw up a legislative package that will be presented to key committees and federal offices in Washington, D.C., says NCAI Executive Director Ronald Andrade.

The convention's delegates and tribal representatives worked long hours reviewing and adopting recommendations from committees established to examine areas of health, alcoholism and drug abuse, economic development, housing, human resources, Indian preference and natural resources. Andrade stated that NCAI is hopeful the recommendations will form a working platform for the incoming Reagan administration policy toward American Indians and Alaska Natives.

Keynote speaker Senator John Melcher (D-Montana), chairman of the Senate Select Committee on Indian Affairs, told the NCAI delegates to "use your own clout" to achieve full self-determination. Tribes should be more aggressive, he added, because the federal government has not had a "good sound policy for Indian people."

Melcher went on to explain that "money talks, especially with tribes controlling large portions of natural resources in this country." According to Melcher, tribal control of resources, specifically energy resources, is the key to achieving tribal goals. He encouraged tribes to be "wise and prudent . . . and to use the best technical advisors available to help carry out economic development. In economics, money and power talk," Melcher told the convention.

The senator also discussed the Senate Select Committee's belief that Indian Health Service (IHS) should give more time and attention to the number one health problem affecting Indian people — alcohol and drug abuse. Melcher said present governmental efforts are now fragmented, and he suggested an increase in broader-based substance abuse programs.

"a symbolic action"

A strong focus and commitment in fighting the frightening reality of alcohol and drug abuse among American Indians was also evident by NCAI's declaration of war on alcoholism and drug abuse — the first such declaration in the organization's 37 years of existence.

According to Caleb Shield, Assiniboine-Sioux council member from Fort Peck, Mont., and former NCAI Billings Area Vice President, the declaration of war is a symbolic action stressing the seriousness of Indian alcoholism and drug abuse. Shield cited government statistics which reflected high mortality rates among Native Americans in the areas of homicide and accidental deaths — most of which were alcohol-related.

Included in NCAI's declaration were 10 Articles of War which are intended to utilize every available resource, such as the President of the United States, the Congress, the National Indian Board of Alcoholism and Drug Abuse (NIBADA), Indian Health Service, and a new inter-agency

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DELEGATES AT THE
37th Annual National Congress of American Indians (NCAI) con-
vention Oct. 26-31, in Spokane, Wash., go over positions and
resolutions during the Tuesday general
assembly. Also included
at the convention were
committee meetings,
exhibits, political forums
and presentations of
major NCAI positions.

NCAI Adopts . . . .
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A major concern of the NCAI Health Committee was in
the area of IHS funds distribution. According to
the committee, appropriation measures for FY 1981 both in the
House and the Senate call for the creation of an “equity
health care fund.” This fund of almost $7.9 million was
established in response to a federal court decision in the
case of Rincon Band of Mission Indians v. Califano, which
held that the distribution of federal funds by IHS violated
California’s Indians constitutional right to equal protection.
The court’s decision also required IHS to develop criteria for
a more equitable distribution of funds nationwide.

The equity health care fund was created by the House
and Senate Appropriations Committees to provide added
funding to tribal entities in the lowest level of health care
(defined as Category V, health care deficiency 61-100
percent). Distribution of these funds, according to the NCAI
Health Committee’s recommendation, should be made only
after IHS consults with officials from tribes and Indian
organizations.

NCAI also adopted a recommendation that the tribes
develop an equitable distribution formula with a weighting
factor for remoteness and accessibility to ensure fair and
equitable distribution of FY 1981 funds with a review of this
method by IHS.

Major health positions recommended by the Health
Committee and adopted by NCAI are as follows:
— a cabinet level Indian agency be created as a focal point in
the Executive Branch of the government to consolidate all
Indian programs, including health and environmental
services
— a basic health care guarantee package be made available
to all Indians, to provide services recommended in the Tribal
and Urban Specific Health Plans
— a preventative and environmental health program be
developed to provide proper health education as well as
engineering services for the provision of safe water, sewer
and waste disposal facilities
— all health services from IHS be made available to urban
Indians, regardless of place of residence
— lines of authority and areas of responsibility between
central, area and service unit IHS offices be more clearly
defined, and that unified program planning, monitoring and
evaluation systems be implemented throughout IHS
— Indian health boards be strengthened to make them more
effective with respect to policy making and the
establishment of priorities at all levels

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Indian Social Workers Seek To Improve Indian Family Life

SPOKANE, WASH.—A strong concern with current social work practices and the development and promotion of social welfare programs that meet the needs of American Indian people were among several important issues addressed at the annual meeting of the Association of American Indian and Alaska Native Social Workers here October 24-26.

According to the association's new president, Evelyn Lance Blanchard, a member of the Laguna-Yaqui tribes, the membership is particularly interested in preserving the integrity of Indian family life. Most of the members are Indian or Native people involved in the provision of services to their people, says Blanchard. "Their work spans the modes of assistance from direct contact and consultation to purely legislative concerns," Blanchard said.

Founded in 1970, the 60-member organization received the Distinguished Service Award from the National Conference on Social Welfare in 1974 for the "courageous and concerted effort made by its small number of individual members to create a national image, and produce an impact on the mind and heart of America . . . and for its leadership and guidance in bringing an awareness of the needs of American Indians to other social welfare institutions, and to its government and public at large."

One of the principal issues addressed at the three day annual meeting centered on the Indian Child Welfare Act (P.L. 95-608) and the possibility of creating new amendments to the present law.

The association's concern over implementation practices of the Indian Child Welfare Act is a result of the "disregard of some states" for the law, said Blanchard.

"The implication of various actions of federal and state governments has been that American Indian children are better off if they are removed from the influence of their tribal environment where the environment is assumed to be deprived," Blanchard said. "The insidious consequence of this view is that one out of every four American Indian children is not living with his or her family and 85 percent of these children are living in non-Indian homes without access to their tribal home and relationships."

According to Blanchard, a community development specialist for the Portland Area Indian Health Service, changing this attitude requires social workers to be familiar with the American Indian perspective. One way to enlighten the Western establishment and the Indian population, she says, is to develop a field of social work that concentrates on the American Indian family.

"We need to develop a broader framework in Indian and Western thought that would help both cultures develop a better understanding of the American Indian perspective," Blanchard said.

Blanchard explained that future activities of the association will focus on building their membership and stressing the need for American Indian and Alaska Native students to enter the field of social work.

NCAI Recommends Increased Research on Indian Cancer Problems

SPOKANE, WASH.—Included among the many recommendations of the National Congress of American Indians (NCAI) Health Committee was a resolution supporting the formation of a Native American Cancer Society to look into problems associated with cancer and leukemia among American Indians and Alaska Natives.

The resolution was passed by the NCAI Executive Committee October 31, according to NCAI staff person Ella Mae Horse. "NCAI is encouraging the Indian Health Service and the American Cancer Society to join in the effort of support," she said.

A similar resolution was adopted by the National Indian Health Board (NIHB) at its recent quarterly meeting in Anchorage, Alaska, encouraging both IHS and the American Cancer Society to research the possible reasons for the increase in cancer and leukemia among the Native American population and to determine methods that would help decrease the rate of those diseases.

The NIHB resolution states that there is presently no process to document statistical information pertaining to American Indians suffering from various forms of cancer, and advocates an extensive screening program that would help detect the diseases as early as possible.

Other recommendations made by NIHB were to develop a system for documenting data on the prevalence of cancer among Indian populations, and to support the formation of a Native American Cancer Society that would address the special health needs related to cancer in Native American people and in Indian communities.
AITI Workshops Focus on Alcoholism, Drug Abuse

SACRAMENTO, CALIF.—Two years ago, the American Indian Training Institute (AITI) conducted the first National American Indian School on Alcoholism and Drug Abuse in response to two pressing needs: the lack of schools devoted solely to problems of Indian alcoholism and drug abuse; and the need for trainees to obtain the broadest exposure to Indian instructors in alcoholism and drug abuse.

According to AITI President David Vallo, the project was conducted because "there was very little quality training available for field workers and program coordinators. Few programs provided exposure to the latest information on substance abuse methodologies, Indian instructors and access to current data on alcoholism and drug abuse."

Since 1978, the institute has provided three national training schools, with over 400 participants attending the third school in Albuquerque last spring. Besides specializing in college accredited training to Indian alcoholism and drug abuse programs throughout the country, the AITI staff and consultants deliver workshops and seminars at the national schools on subjects such as: basic management skills, basic communication skills, crisis intervention, prevention of burnout, alcoholism and sexuality, services to alcoholic women, spiritual and cultural approaches to alcoholism treatment, and medical aspects of alcoholism.

AITI is a private, non-profit corporation which receives no federal or state funds and relies solely on registration fees. AITI is currently negotiating with the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the Indian Health Service (IHS) in an effort to seek possible supplemental funding which would help to reduce workshop fees.

According to Vallo, the Fourth National American Indian School on Alcoholism and Drug Abuse will be held in Phoenix, Ariz., April 26-May 1. For further information, contact: The American Indian Training Institute; 2222 Watt Ave., Suite B-4; Sacramento, Calif. 95825.

NCAI . . . .
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— eligibility criteria for contract care be made simply and uniform for all federally recognized tribes
— all available food assistance programs be consolidated into tribally controlled and operated Nutrition Assistance Centers
— preference be given to Indian enterprises for all health related construction projects. Preference should also be given to Indian enterprises in the maintenance and operation of health facilities
— an American Indian School of Medicine be established.

According to NCAI Executive Director Andrade, NCAI will work closely with the Reagan transition team on the major recommendations adopted by the annual conference. "The Reagan people said there will be no appreciable effect on Indian policy," said Andrade, "and we will try to hold him to that promise."

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