President Signs Child Welfare Act

WASHINGTON, D.C.—On the final day of the 95th Congress last month, Rep. Morris Udall (D.—Ariz.) rose to the floor of the House to urge passage of the Indian Child Welfare Act of 1978. Citing the Indian child welfare situation which has reached crisis proportions, Udall asked, "...because of the trust responsibility owed to the Indian tribes by the United States to protect their resources and future, we have an obligation to act to remedy this serious problem. What resource is more critical to an Indian Tribe than its children? What is more vital to the tribe's future than its children?"

The measure was adopted virtually unopposed.

Later, on November 8, over four years of effort by congressional supporters and an untold number of concerned private citizens met with success as upon the signature of President Jimmy Carter the Indian Child Welfare Act of 1978 became the law of the land. (No statement accompanied the President's action.)

In the past, Indian families have often been victim to the inability or unwillingness of state officials to understand their cultural and social norms. The new law, which is geared toward strengthening and preventing the breakup of Indian families, makes it clear that jurisdiction over child welfare matters will rest with the tribes.

Title I of the law clarifies the allocation of jurisdiction over Indian child custody proceedings between Indian tribes and the states. More importantly, it establishes minimum federal standards and procedural safeguards to protect Indian families when faced with child custody proceedings against them in state agencies or courts.

Among these, the standards for notification of a custody hearing for a child not domiciled or residing on a reservation have been tightened up. And upon the request of either the child's parent(s) or tribe, in absence of "good cause to the contrary," the state court must return such a proceeding to jurisdiction of the tribe.

In any state court proceeding for the foster care placement of, or termination of parental rights to an Indian child, the child's tribe or Indian custodian had a right to intervene at any point in the proceedings.

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Med School Rejected by Califano

WASHINGTON, D.C.—The end of a long wait for HEW Secretary Califano's report to Congress on the feasibility of establishing an Indian school of medicine has proved disheartening.

In a letter to Congress dated October 23, Secretary Califano wrote, "While I am deeply committed to increasing the number of Indian health professionals and improving Indian health services, I do not support the establishment of an American Indian School of Medicine."

Califano's letter accompanied a report mandated under Title VI of P.L. 94-437. The Feasibility Study to Determine the Need for an American Indian School of Medicine was originally the result of an amendment substituted for original legislation calling for the establishment of an Indian medical school. A Feasibility Study Group composed of representatives from several Indian organizations, a representative of traditional Indian medicine, an Indian medical student and four medical educators monitored the study throughout its course.

The study was conducted for the Secretary by DHEW's Bureau of Health Manpower. It found an Indian school of medicine to be both necessary and feasible.

Nonetheless, the Secretary believes that "the nation already has more than sufficient capacity to train doctors" and that increased Indian representation in the medical profession should come from "bringing Indians and other minority students into the mainstream of medical education and practice" rather than through the construction of another medical school.

And while the feasibility study found numerous barriers which in large measure deter Indians from entering with legal counsel. The law also provides that strict preference for foster or adoptive placement be given to the child's extended family and then to another Indian home.

Dealing more specifically with Indian needs, Secretary Califano announced in his letter that he has directed Dr. Julius Richmond, the Assistant Secretary for Health, to identify ways in which existing programs can increase the numbers of Indians and other minorities in the health professions. Dr. Richmond was also asked to develop a proposal for increasing the number of health personnel who serve reservations.

According to IHS Director Dr. Emary Johnson, Dr. Richmond has since designated Dr. George Lythcott, Director of the Health Resources Administration as his lead person for the research. A task force composed of representatives from IHS, HEW's Bureau of Health Manpower and Intra-Departmental Council on Indian Affairs and the Administration for Native Americans has been formed and is to present its findings to Dr. Lythcott by the end of December.

It is expected that among other recommendations which might come out of the group, strong possibilities are that full funding for Title I of P.L. 94-437, Indian Health Manpower and an IHS exemption to the current federal hiring freeze will be asked.

In light of the Secretary's rejection of the Indian medical school idea, were the efforts of the Title VI Feasibility Study Group wasted? Not according to its chairman, NIHB Executive Director John Belindo, "We knew from the start that for Congress to even consider the school would require a complete reversal of Congressional and Departmental thinking," he says. But he adds, "All of the data, input from the tribal community and Indian medical students proved very valuable in assessing options for establishing an Indian medical school, and we would hope that the group's efforts will lay the groundwork in future advocacy of an AISM."

Meanwhile, efforts to establish a proposed American Indian School of Medicine on the Navajo reservation continue. With spirits only slightly dampened, Dr. Taylor McKenzie, president of the proposed school which has been in the planning stages for several years, says, "In general terms, I don't think the Secretary's action will stop our efforts to start the school."

The biggest obstacle to establishment of the AISM on the Navajo reservation, according to McKenzie, has been the lack of long-term federal funding. "There is no question but that the Secretary's decision has hurt our chances," he admits.

But with determination to keep going, he adds, "It's going to make our job just that much more difficult."

Dr. McKenzie says his group doesn't have a strategy yet but will devise one as soon as they have a better chance to review the feasibility study as finally submitted to Congress by the Secretary.

He is skeptical of the measures suggested in Califano's letter. For he claims, as proven by both P.L. 94-437 and 93-638 in the past, "when Congress makes a mandate the bureaucracy doesn't necessarily carry it out."

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President . . .

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Parents are also entitled to legal counsel.

The law also provides that strict preference for foster or adoptive placement be given to the child's extended family and then to another Indian home.

Reiterating an already existing (though sometimes overlooked) authority of tribal courts, under the law, an Indian tribe shall have exclusive jurisdiction over any child custody proceeding involving an Indian child residing or domiciled within its reservation, except where such jurisdiction is otherwise vested in the state by existing federal law.

Even in '280' states tribes will now have a chance to control their own child placements. A tribe in such a state wishing to reassume child placement jurisdiction must submit a plan to the Secretary of Interior. If it is determined that the tribe has a "suitable mechanism" for exercising jurisdiction the state must return it.

And the standards to be applied in foster or adoptive placements are to be those social and cultural standards of the relevant Indian community.

Recognizing that while tribal jurisdiction is a vital aid, it alone cannot prevent the breakup of Indian families,

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Hearings Unlikely

WASHINGTON, D.C.—With the 95th Congress having drawn to a close, oversight hearings on the Indian Health Service are now only "a remote possibility," according to staff of the Senate Select Committee on Indian Affairs.

Although the hearings remain high on the committee staff's list of priorities it hopes to accomplish before the next congressional session, at the time of publication committee chairman James Abourezk (D.-S.D.) was campaigning back in his home state as were other members of the committee (Abourezk himself is retiring from the Senate at the end of the year) and prospects for the hearings appeared dim.

IHS Budget Gets $17 Million Markup for FY '79

WASHINGTON, D.C.—IHS officials here appear to have mixed feelings over the appropriations act which funds IHS activities and P.L. 94-437 (the Indian Health Care Improvement Act) programs for the upcoming fiscal year.

Although the appropriations act, signed into law by President Carter October 17, adds more than $17 million to the budget originally proposed by the president last January, the funds are still far less than the amount requested by IHS Director Dr. Emery Johnson to adequately fund 94-437 and the backlog of unmet Indian health needs.

However, the appropriations act does restore funds to several major IHS programs that were severely slashed by the president's proposed budget, including Titles I, III, and V of 94-437.

Almost $6.8 million will be returned to Title I, Indian Health Manpower, to continue current programs of recruitment, preparatory and professional scholarships, externs, and education allowances. These programs would have been eliminated under the president's original budget.

While obviously pleased to see Title I money restored, IHS Indian Health Manpower Director Dr. George Blue Spruce recently indicated the funds could not adequately meet the demands of the Indian community. For example, Blue Spruce said that of the 18 applications approved last year for organizations to recruit and assist Indian students in the health professions, only 9 could be funded. Although the number of applications will probably increase next year, the funding level will remain the same, he said.

"Until Indian students are allowed the same opportunities for leadership training as others, true Indian self-determination in the health sector won't come about," Blue Spruce said of the need to fully fund Title I programs.

Another area where funding was restored was Title V, Health Services for Urban Indians, which will receive $3.7 million. Under the president's budget this money would have been deleted, forcing IHS to discontinue new urban projects in FY 1978.

"We're happy the money has been restored, but it's somewhat short of what we asked for," said Luana Reyes, president of the American Indian Health Care Association. "Congress was willing to authorize $10 million for FY '79, but they're not willing to appropriate that amount," she added.

The appropriation for Title V means that there will be "no new business" in FY 1979, according to Wes Halsey, IHS P.L. 94-437 Title V Coordinator. IHS plans had called for the development of 10 new urban projects a year under 94-437, but funding for next year will be limited to the 41 programs currently in operation.

Largest of the markups over the president's original budget is the $7 million increase in Title III construction funds. However, the conference committee of the Senate and House appropriations committees, which recommended the increase, indicated in its report that IHS must change certain procedures in its construction policy before future building funds will be appropriated.

Specifically, the committee report requests that IHS establish a system of controls to prevent future cost overruns.
IHS Develops Format for TSHP Report to HEW

ROCKVILLE, MD.—IHS activities for Tribal Specific Health Planning (TSHP), including the format for the final IHS report to be submitted to the Secretary of Health, Education, and Welfare next year, were outlined by IHS officials here September 26-27.

Representatives from national Indian organizations met with IHS officials to review the progress of tribal health planning across the country and discuss the procedure for bringing TSHP’s together for the final report.

Of the 293 tribal entities that could potentially take part in the TSHP process, 246 are committed to developing a tribal health plan, said Tim Shea, IHS Health Services Planning Branch Chief. He added that this figure is not final and he expects that more tribes will become involved in the near future.

As envisioned by the developer of the concept, IHS Director Dr. Emery Johnson, the plans will provide Congress with a logical tool to determine comparative needs for health services and facilities among the nation’s tribes — something Congress has been asking for of late.

TSHP’s must be submitted to IHS headquarters by August 1, 1979. These documents will be drawn into a single IHS plan that will be submitted to the Secretary, who will hopefully use it as the basis for his report to Congress on the progress of the Indian Health Care Improvement Act (P.L. 94-437).

The final IHS plan will be similar in format to the San Carlos Sample TSHP developed earlier this year by IHS, according to Shea.

A prelude will open the report and will consist of three parts: an introduction, background, and progress report.

The introduction will highlight statements from the most current budget hearings, including a description of general IHS responsibilities and its available resources. The background will provide a summary of 94-437 to date and the resources appropriated to fund the act.

Following the prelude will be six sections describing the different circumstances of Indian people across the country and detailing their different health needs.

The first section will outline the purpose of the plan and identify Indian populations that will be served. This will include a breakdown of all service areas and an outline of existing services in those areas.

Section two will provide more descriptive data on service areas, such as climate and topography of different regions and the economic and educational status of Indian people living there.

Under section three, demographic and health data will be presented for population distribution, birth and death rates, and the major health problems of Indians nationwide.

The fourth section will present the process used for identifying additional resources needed in the final four years of 94-437, FY ’81 through ‘84. Two major tables will be used to specify the amount of funding and the positions required to address unmet health needs. The tables will present data in year-by-year and tribe-by-tribe schedules, with the information to be taken directly from individual TSHP’s, Shea said. Tribes will also be allowed to use alternate population figures if they feel the official government statistics are inaccurate, Shea added. Both sets of figures — governmental and tribal — will be represented, he said.

This section will provide Congress with a practical means for assessing Indian health needs through statistics brought together from all TSHP’s. The actual plans will remain on file intact with IHS and be available to anyone that wishes to review them for additional information.

Section five will detail the approach to be used for overcoming Indian health problems by detailing the kinds of health care activities (such as nursing care, ambulatory needs, etc.) required by tribes.

Finally, section six will offer recommendations to Congress on the legislative action needed to address the health concerns stated in the plan.

Shea stressed that the final IHS document will be a summation of all TSHP’s and will accurately reflect individual tribal health needs specified in the plans. A detailed description of how TSHP’s will be condensed into this final IHS report will be completed next month, he said.

In addition, IHS officials heard concerns about the TSHP process from national Indian organizations representatives. A list of those concerns and IHS’ responses to them will be made available to IHS area offices and tribes sometime in December, Shea said.

IHS Budget . . .

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similar to the $916,000 one that occurred for a Red Lake, Minn. health facility.

IHS must also submit a priority list for hospital construction, along with the criteria for developing that list, before future construction monies will be approved, the report states. In addition, funds already appropriated for the planning stages of six new IHS health facilities remain under a congressional freeze pending final approval of an acceptable bed planning methodology, which predicts inpatient care needs in specific areas.

A proposal for controlling future cost overruns is now being developed, according to Jim Neifert, P.L. 94-437 Title II Project Manager. Also, a hospital construction priority list is 80 per cent complete and a system for bed planning is finished, he said. All three reports will be submitted to Congress by the end of the year, he added.

In addition to markups for 94-437 activities, Congress appropriated an increase of $3.1 million for implementation funds for P.L. 93-638, the Indian Self-Determination and Education Assistance Act, which includes planning assistance funds for Tribal Specific Health Planning. Community Development programs will also receive an increase of $2.5 million.

While the appropriations act does not provide the funds needed to adequately fund all IHS programs, IHS Financial Management Branch Chief Sol Orden indicated there was some cause for optimism. IHS will not experience the drastic cuts slated for some other federal agencies, and in light of the cutback in overall government spending Orden said, “I feel we did exceedingly well in the budget process.”

The total IHS budget for FY 1979 comes to $484 million for services and $77 million for facilities.
PHOENIX, ARIZ.—With perhaps only 60 per cent of Indian children under the age of five fully immunized, the Native American community is one of several specific populations targeted by the U.S. Department of Health, Education and Welfare's nationwide Childhood Immunization Initiative.

The nationwide program was launched last April by HEW Secretary Joseph A. Califano, Jr. The secretary set a goal of full immunization for 90 per cent of U.S. children under the age of 15 by the time the program concludes next September, according to assistant coordinator for Indian Health Service efforts in the initiative, William Smith.

While striving to meet this overall goal, IHS is concentrating its special efforts on babies. Under the direction of George E. Bock, M.D., Acting Director of the Phoenix Area Indian Health Service, IHS has set its own goal at full immunization for 90 per cent of the children under age two within 95 per cent of its service unit areas.

In a survey of all reservations in the country at the end of last year, IHS found that only 60 per cent of Indian children under age five had been given protection (in the form of immunizations) against measles, mumps and rubella. These and other preventable diseases including polio, diphtheria, tetanus and whooping cough have become increasingly common among school-age children in recent years because of carelessness or neglect in providing needed immunizations.

In addition to providing shots, IHS is also aiming at increased education to parents as part of its effort. Specifically, according to Smith, IHS hopes to institute cooperative agreements with Community Health Representatives in reservation communities. The CHR's are being urged to encourage parents to bring their children in for immunizations and to provide information to them on the diseases and procedures involved. Upon agreement of community CHR's, Smith said IHS might further assist them by supplying each with a list of children in their area who have not been fully immunized.
NCAI Delegates Support Nine Major Indian Health Positions

RAPID CITY, S.D.—In addition to supporting resolutions on such highly emotional issues as the Indian backlash movement in Congress and apparent White House apathy toward Native American concerns, delegates to the National Congress of American Indians (NCAI) 35th Annual Convention here endorsed nine recommendations of its Health and Social Welfare Concerns Committee.

As presented to the NCAI general assembly September 21, the recommendations, developed in position papers by the health committee chaired by NIHB Executive Director John Belindo, including the following topics:
- P.L. 94-437, the Indian Health Care Improvement Act;
- and P.L. 93-638, the Indian Self-Determination and Education Assistance Act;
- P.L. 93-641, the National Health Planning and Resources Development Act;
- National Health Insurance
- The Indian Child Welfare Act
- Title XX Social Services Amendments to the Social Security Act
- The provision of services to American Indian and Alaskan Native elderly
- Mental health
- Sterilization
- The American Indian School of Medicine

Along with the adoption of these positions, Native health activities at the NCAI convention included a presentation by Indian Health Service (IHS) Director Dr. Emery Johnson and a workshop on Tribal Specific Health Planning.

P.L. 94-437 and P.L. 93-638

Calling for full recognition of these two laws, which were enacted "to establish a framework within which the Indian people can effectively decide their role in health programs," the policy paper specifies three basic issues needed to improve the health status of Indian people: (1) that P.L. 94-437 goals and intent be fully recognized, (2) that P.L. 93-638 concepts be fully embraced by IHS and (3) that IHS request maximum appropriations authorized in both these acts.

IHS' "failure to fully implement these concepts" has led to inadequate funding for the two laws, according to the position paper.

NCAI encouraged IHS to maintain good relations with congressional appropriations committees. "The concepts of P.L. 93-638 and P.L. 94-437 are hollow promises if full funding is not achieved," the position states.

Directly related to these basic issues are the many health concerns expressed to IHS during 1977 by NCAI and Indian consultant groups on P.L. 93-638 and P.L. 94-437. These concerns remain largely unaddressed, the position states, and as a result NCAI reaffirmed concerns expressed in 1977.

Among these concerns is the allegation of IHS failure to carry out its role as advocate for "other health resources," and the general lack of training provided to area Indian health boards.

P.L. 93-641

Tribal groups continue to experience problems with the National Health Planning and Resources Development Act (P.L. 93-641), particularly with the uncertainty over their relationships with Health Systems Agencies (HSA's), the primary mechanism for implementing the act.

In an effort to alleviate these problems, NIHB has worked diligently at providing tribal planning agencies with information on the activities of HSA's and how they affect Indian people.

Because the federal government has not clarified the relationship between HSA's and the Indian health care structure, there is a continued need for this kind of information, the position maintains.

NCAI delegates therefore voted to support NIHB in its efforts to monitor P.L. 93-641 activities, provide tribes with information, advocacy, and technical assistance, and recommend legislative changes needed to make the law more responsive to Indian needs.

National Health Insurance

Recognizing the increasing possibility that some kind of National Health Insurance (NHI) policy will be adopted by the federal government within the next few years, NCAI delegates voted to support the position that any NHI legislation must recognize the special status and health needs of Indian people.

Tribal sovereignty and tribal Self-Determination must also be recognized and preserved in the legislation, the position continues, and because of the unique aspects of the Indian health system NHI legislation will require a separate

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section dealing specifically with Indians based on the following six principles:
- NHI legislation must support the continuation of the IHS-tribal-urban Indian health program and ensure that NHI will become an additional financial resource to this system, rather than supplanting it.
- Indian people must be exempted from any compulsory NHI financing charge.
- The following three elements of NHI should be incorporated into IHS: the guaranteed benefit package, the individual's entitlement of that health package, and the funding needed to provide those guaranteed services.
- Recognition must be given to Indian tribal governments as the appropriate entity for administering health programs on their reservations.
- Tribal Self-Determination must be incorporated into NHI legislation.
- Urban Indian Health Programs must be eligible for reimbursement from both IHS and NHI.

Indian Child Welfare Act

With the Indian Child Welfare bill slated for a congressional vote two weeks after their convention, NCAI delegates voted to give their full support to the bill and urged Congress to pass it.

The NCAI position also condemns Justice Department criticism of the bill, and denounces as “irresponsible and inexcusable” the lack of support given the bill by the Bureau of Indian Affairs. (NOTE: The President signed the Indian Child Welfare Act on November 8. See separate article.)

Title XX

Difficulty with the funding formula, interference with tribal Self-Determination, and administrative problems have plagued tribes since enactment of the Title XX Amendment to the Social Security Act in 1975.

The National Tribal Chairmen's Association (NTCA) has developed a draft to Title XX for the purpose of making it more amenable to Indian concerns.

However, the NCAI position finds the draft amendment unacceptable for several reasons, including its limitation of direct funding to only recognized tribes and its provisions for funding. Efforts must be made to coordinate NCAI concerns with the NTCA project, according to the NCAI position.

Provision of Services to American Indian and Alaska Native Elderly

With the inclusion of “direct funding” to Indian tribes as an amendment to the 1978 Older American’s Act, efforts of the National Indian Council on Aging (NICOA) will be geared toward influencing Congress to appropriate funds necessary to meet the needs of Indian elderly.

In keeping with these efforts, NCAI delegates supported a position urging Congress to appropriate at least $25 million in FY 1979, $30 million in FY 1980, and $35 million in FY 1981 to improve services to Indian elderly.

The position also supports NCAI efforts to establish an Indian desk within the Administration on Aging and work with the agency to develop regulations that will implement the direct funding section of the Older Americans Act.

Mental Health

Noting that services for mental health are “virtually non-existent” at the reservation level, the NCAI position on Indian mental health called for the establishment of a “coordinating system” capable of delivering adequate mental health treatment to Indians.

The NCAI position also supports the recommendations made by the Task Panel on American Indians and Alaska Natives to the President’s Commission on Mental Health, and urges the President to act on them immediately.

Sterilization

In acknowledgement of growing concern over IHS sterilization abuse — as specified, for example, in a 1976 general Accounting Office report — NCAI delegates voted to adopt the NIHB position on sterilization. “No sterilization procedures should take place without the informed and voluntary consent of the individual” states the position.

While the NCAI position acknowledges the use of sterilization as a medically accepted means of permanent contraception, it recommends that trained Indian counselors be provided by IHS to explain the full range of consequences to Indian patients considering the procedure.

AISOM

The final NCAI position concerns the establishment of an American Indian School of Medicine (AISOM).

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PHOENIX, ARIZ.—In its last minute scramble to recess last month, Congress merely extended the National Health Planning and Resources Development Act (P.L. 93-641) for another year at its present level of funding. None of the amendments which has been proposed were included although it is widely expected that they will be reintroduced next session.

And so the threat of planning agencies infringing on tribal sovereignty in health matters still lingers for among those amendments which failed to receive consideration in the House were those addressing Indian concerns.

But aside from this setback there are hopeful developments on a national level which should ultimately aid tribes here and elsewhere struggling to determine an appropriate role for themselves within 641.

Participants at the symposium held here September 16 by the Intertribal Council of Arizona heard of recent cooperative efforts between the National Indian Health Board and the Bureau of Health Planning (BHP), the agency charged with 641 implementation.

NIHB and IHS staff and a number of other Indian representatives with 641 expertise met with BHP senior staff in early September. At that time, it was recommended that BHP establish a national policy statement for Indians in relation to HSA’s; that the statement should reflect protection of tribal sovereignty and at the same time allow cooperative assistance between tribes and HSA’s; and that BHP should make a special effort to aid tribes in health planning and management.

And in an effort to keep in touch with all major agencies involved with Indian health, Neufeld said the BHP also desires to establish communications with, among others, the Administration for Native Americans, the Bureau of Indian Affairs, the National Congress of American Indians, the Association of American Indian Physicians and the Association of American Indian Social Workers.

Neufeld also mentioned that his agency has agreed to meet periodically with NIHB to discuss common concerns.

"Every HSA is to coordinate its activities with everybody else in sight working on health matters."

and promised that NIHB will be involved in writing any new regulations required should “Indian amendments” to the planning law be adopted.

The focus of this ITCA symposium (under its project with the Health Resources Administration titled “P.L. 93-641 and American Indians in Arizona”) was on coordination, public involvement and education activities of Health Systems Agencies established under the planning law.

Speaking specifically of the coordination activities required of HSA’s, Neufeld explained that there are three “organizations” in their local areas with which they must coordinate: Professional Standards Review Organizations, primarily for cost containment purposes; local and statewide A-95 clearinghouses (although Arizona tribes are not subject to the A-95 review process); and adjacent HSA’s, particularly within urban areas.

In addition, said Neufeld, every HSA is to coordinate its activities with “everybody else in sight working on health matters.” This means that HSA’s are to be concerned with what is going on on reservations and around their periphery, he commented, in what might be viewed warily as a mixed “blessing” for tribes. He added that “we are working at a national level to make sure this happens at the local level.”

Planning Law Extended as ITCA

Ben Neufeld, BHP program analyst, gave the group here a good indication that his agency is following up on these suggestions. He announced that the BHP has begun discussions with its 10 regional centers for health planning in an effort to make technical assistance available to tribal health planners.

BHP also wants to get useful written information out to tribal health planners and is working on this aspect with NIHB.

BUREAU of Health Planning program analyst Ben Neufeld (center) discusses the possibilities for future cooperation between his agency and ITCA with project director Alberta Trippeconnic and project consultant William Mack.
DURING symposia held by ITCA over the past several months, tribal representatives from throughout Arizona have heard the options for participation in 641 available to them as well as of the experiences of those tribes which are involved in 641 activities. At a final symposium to be held November 26 tribal representatives will address HSA members and staff as their audience.

So for those tribal groups wishing to tap 641 resources for assistance with their own health planning it is a most encouraging sign. For those somehow hoping to escape any involvement with the law it might be taken as a warning.

This latter stance is viewed as impractical by many 641 experts. Should a tribe choose to receive all of its services through IHS and to submit proposals only for funds appropriated through IHS, it is not required to submit to the "review and comment" process as mandated under 93-641.

However, the HSA "review and comment" authority, as it will apply for at least another year, is in effect for any tribal proposals submitted for programs such as drug abuse, mental health, alcoholism, family planning, EMS, health education, etc. covered under the Public Health Service Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

And those tribes which have been fearful that "review and comment" authority might have the same practical effect as "review and approval" received another encouraging sign from Neufeld. He told the group that regulations issued to date have dealt primarily with review but not with final decisions. "We (BHP) must get a statement out to the funding agencies saying that when we say there is a difference between 'review and approval' and 'review and comment' we mean there is a difference and not to regard a comment as a decision," he stated.

Neufeld also tried to encourage those tribal people present about an aspect of HSA activity unique to tribes, that of providing information regarding the availability of federal funds. In the past, he explained, not knowing what type of information to make available has prevented HSA's from doing this part of their job. BHP has now issued a notice to all 205 of the country's HSA's detailing the types of information to be made available along with a tribal listing to insure that HSA's are aware of the tribal groups in their areas.

Perhaps the most distasteful aspect of HSA participation to many tribes is the prospect of dealing with possibly insensitive non-Indian local residents. One idea which has been bandied about as a possible alternative is formation of tribal or inter-tribal HSA's, such as that on the Navajo reservation.

Asked his opinion of the idea, Neufeld said he doubts that there will be a provision in future regulations for any tribal HSA's other than the Navajo one. Apart from the Navajo, no reservation in the country is large enough to justify a separate HSA, he maintained. It also doesn't make sense to group together several groups in a state because an HSA must deal with problems common to an area's population, he said. Such an approach would also not make sense economically considering the long distances between reservations in some states, argued Neufeld.

His latter argument prompted a reminder from ITCA project director Alberta Tippeconic of one of the HSA's in this state which presently covers an area hundreds of miles wide.

Aside from desiring some sign about BHP's willingness to cooperate, throughout the course of the ITCA study begun last December, tribes here have repeatedly expressed their frustration at receiving no strong indication of IHS' stance on the health planning law. They got one here from Dr. E. S. Rabeau, Director of the IHS Office of Research and Development.

He said, "Our (IHS') role in 641 should be a passive one. We're there to provide technical assistance to tribes upon their request." He added that while he concurs that an understanding between the Health Resources Administration (of which BHP is a part) and IHS is desirable he is "very reluctant" to see IHS take an active role.

At the local level, said Gordon Jensen of the Phoenix Service Unit, "When it comes to the service unit providing services there is no real involvement by the HSA." "Yet," he argued, "we must become involved to prevent perversion of the law."

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Planning . . .

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Jensen maintained that there is good reason for service unit involvement with HSA’s because when it comes down to contract health services “we are buying services from the same sources as the rest of Phoenix and must be concerned with receiving them at a reasonable cost and making them available to tribal people.”

“Our (IHS’) role in 641 should be a passive one. We’re there to provide technical assistance to tribes upon their request.”

Although the ITCA study is geared to Arizona tribes, its findings are being looked to for the applications they may have for tribes elsewhere as well. Part of the final product to be offered HRA upon completion of the study will be recommendations regarding Indians and the law. Tribal representatives at the symposium here heard some of the preliminary ones prepared to date.

As has been emphasized by tribes throughout the study the recommendations stress their need for continuing technical assistance. The greatest need in this area is to aid individual tribes and groups of tribes within an area to solidify the relationships they may have begun with HSA’s or make a final, reasoned judgment not to participate.

One of the vital aspects of a tribal-HSA relationship, states the recommendations, is possible coordination in “plan development.” Most tribes are now developing Tribal Health Plans and will need technical assistance for coordinating this planning with the HSA and determining how to relate the tribal plan to the area-wide plans required under 641.

PROGRAM ANALYST Howard Bad Hand (right), NIH’s 641 liaison person, chats with Phoenix Area Indian Health Board Director Jim Porter.

Other recommendations stress the need for an on-going “communication system” between tribes and 641 planning agencies, with tribes participating (or not participating) with their area HSA’s fully aware of their options and the need for an improved communication system to be “forged at all levels involved in 641 implementation.”

The recommendations applaud BHP for having “clearly shown its awareness and concern for improved communication” while chiding IHS. “To date, there has been only minimal involvement and none of the leadership expected of Indian people by the IHS,” they state.

ITCA suggests that the two agencies establish a closer working relationship on P.L. 93-641. As a minimum, they

From the Top

Despite our publication of remarks by IHS Director Dr. Emery Johnson over the past year and a half pertaining to IHS’ roles both in Tribal Specific Health Planning and P.L. 93-641, tribes continue to ask how the agency views these responsibilities.

In addition, as revealed by the related story in this issue, they also wonder how Tribal Specific Health Planning which will hopefully serve as the basis of a report to Congress from the Secretary on a one-time basis can coexist with the National Health Planning Act, under which state health plans are to be reviewed annually.

In an effort to clarify these things, we decided to ask for an answer straight from the top and found Dr. Johnson more than willing to provide us with one. He encourages tribes to at least “test the waters” of their local HSA’s. For, he explains, while IHS is available to assist tribes with their health planning activities, since 641 resources are available to tribal members as a result of their dual status as U.S. citizens and since the resources available in the private sector “will ultimately have an impact on our facilities, we must do all we can to get our position known.”

As tribes are entitled to their usual services from IHS in addition to being eligible for HSA funds for planning and proposed facilities, says Dr. Johnson, “in this situation Indian people can have their cake and eat it too.” He advises tribes leery of any participation in HSA activities, “You can still participate and disagree with everything they do. But if you don’t participate you will be affected anyway so you better know what’s going on.”

He admits that in many instances tribal participation with HSA’s may prove a waste of time. “But a tribe won’t know unless they try,” he remarks.

Regarding its own role, Dr. Johnson recalls that prior to the law’s enactment, IHS worked in cooperation with tribal spokesmen to help prevent HSA’s from having authority over tribal health planning. But now that it has been enacted, he says, “it’s not our job to actively push tribes into participating. It’s more a job of providing them with information so that they can make their own choices.”

As for those concerned that Tribal Specific Health Planning is only a “one shot deal” while planning under 641 is subject to annual review, says Dr. Johnson, although the use of TSHP’s as the basis of a report to Congress by the Secretary may happen only once, he is hopeful that once tribes have begun the process they will continue it annually. This will present the Administration and Congress with a logical tool for determining where health funds are needed most, he says.
Full Designation for Navajo HSA

WINDOW ROCK, ARIZ.—The Navajo Health Systems Agency (HSA) has received “full designation” from the U.S. Department of Health, Education and Welfare after operating with conditional designation for the past two years.

Of the five HSA’s in Arizona, the Navajo is the second to receive full designation status.

John Hubbard, Jr., Executive Director of the Navajo HSA, explained that full designation means in part that the agency has met all criteria under P.L. 93-641: the National Health Planning and Resources Development Act. These include the development of a Health Systems Plan, a community-based Governing Body, an Annual Implementation Plan, hiring of a professional planning staff and adoption of an Agency Plan of Operation (by-laws).

Dr. Taylor McKenzie, Chairman of the Navajo HSA Governing Body remarked that “we have worked strenuously to establish a Navajo Health Systems Plan and develop an agency that is responsive to the health planning needs of the Navajo Nation. The full designation is a vital tool toward Navajo self-determination in the health field.”

The Navajo HSA was created by Navajo Tribal Council resolution in June, 1976 and is unique in several respects. It is the only Indian HSA out of 205 HSA’s throughout the country. Because of the size of the Navajo Tribe, its unique health problems and health service delivery agency (IHS), it was felt that there was sufficient justification for a Navajo area HSA designation. The agency operates as a single unit of general local government under the Navajo Tribal Council.

The Navajo Health Systems Plan, published by the NHSA in May represents the first comprehensive health plan for the Navajo area. This plan will form the basis for the Tribal Specific Health Plan to be developed by July, 1979, by the Navajo HSA in cooperation with the Tribal Division of Health improvement Services and Navajo Area IHS.
DENVER, COLO.—When the Indian Health Service established the Office of Alcoholism within its central office earlier this year, members of the National Indian Board on Alcoholism and Drug Abuse (NIBADA) expected that Indian alcohol projects across the country would have immediate and direct access to IHS headquarters. Unfortunately this has not been the case, due mainly to inadequate funding, time constraints and staff limitations at IHS.

Members of NIBADA met here October 25 to review activities of the IHS Office of Alcoholism and to discuss policy recommendations for the future transfer of Indian alcoholism projects from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) to IHS.

NIAAA was established in 1970 to administer all federal alcoholism programs but its financial support to such programs is limited to six years. In an effort to continue operation and funding for Indian alcoholism projects, Congress agreed to the transfer of “matured” programs (those under NIAAA for six years) to IHS beginning in 1977.

Under the transfer agreement, IHS created its Office of Alcoholism to coordinate transfer activities and develop project grants and contracts to continue funding Indian alcohol programs. As each project changes over, IHS assumes the responsibility of supervising and evaluating services provided to Indians suffering from the effects of alcoholism.

The transfer, provided for under P.L. 94-437 (the Indian Health Care Improvement Act) brought 36 Indian alcohol projects to IHS control in FY ‘78. An additional 52 programs will be transferred in FY ’79 and IHS will have a total of 154 alcohol projects when the transition is completed in 1980.

Three areas of concern about the transfer process were addressed by NIBADA at its meeting: (1) the responsibility of the central office (IHS Office of Alcoholism) to communicate with local alcoholism staffs and to provide them with direction during the transfer; (2) the appointment of area alcoholism coordinators; and (3) the option for contracts or grants in applying for project funding.

Changes are needed in each of these areas in order to improve Services to Indians suffering from the problem of alcoholism, said NIBADA President Wanda Frogg.

No Standardized Format

Lack of direction and guidance from the central office is “the most serious problem we’ve faced,” said Frogg. “Right now, if you have any problems you can’t go to the central office and get any results,” she said.

One of the main purposes of the IHS Office of Alcoholism is to “direct and coordinate” transfer activities, according to the NIAAA-IHS memorandum of agreement that governs the transfer. Under this agreement, and verbal assurances from IHS, NIBADA members hoped that the central office would provide direction and develop specific guidelines for transferring alcohol projects.

Instead, the initial 36 transfers were completed without the benefit of formalized procedures. While many of the transfers went smoothly, a few project directors ran into difficulty because of the absence of necessary official forms and applications.

For example, the Salt River Indian Alcohol Program in Scottsdale, Ariz. experienced problems for this reason, according to director James Butler. After first being told that there was no official format to follow, Butler said his application for funding was rejected as improper. Although the transfer was eventually completed funding was delayed for several months, he said.

“There is a definite need to set up policies and guidelines for project transfers,” said Mary Crazy Bear, director of an alcoholism halfway house in Miami, Okla. She termed the transfer of her program as “chaotic” due to the confusion caused by the absence of a transfer format.

Deliberate Wait

But according to IHS Office of Alcoholism Director Bud Mason, his office deliberately refrained from developing such guidelines until the first group of transfers was complete.

This was done for two reasons, Mason said: First, to avoid the impression that IHS was dictating policy and secondly, to acquire a real understanding of the transfer process and the various problems confronting alcohol projects.

With the experience gained from the initial transfers, area offices and alcohol program directors are currently in the process of submitting recommendations for IHS policy guidelines that will be used for future transfers. Responses are due in the central office by November 30, where they will be used to develop a standard transfer format. This document will then be sent to local alcohol programs for review and comment.

“This is the kind of process we have to go through to get input from the local level. This way, we will get recommendations that mean something,” Mason said of the decision to wait in the development of official transfer procedures.

“Congress wants proof...”

In an effort to provide guidance to local alcoholism personnel, the IHS Office of Alcoholism has established six major objectives that will help to evaluate and improve the quality of services offered by local alcohol programs, according to Mason.

The goal of the six objectives is to develop a methodology that will allow local alcohol programs to justify their needs for positions and funding with concrete, factual data, Mason said.

“We’re past the point where emotional appeals have any effect. Congress wants proof that programs are effective and needed, and we have to be able to supply that proof,” he stated.

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The first objective is to develop standard procedures for future project transfers. The key to an acceptable format is the input from local alcohol projects, Mason said.

Secondly, an evaluation mechanism to measure the relative effectiveness of Indian alcohol projects will be completed later this month and field-tested early next year. IHS Director Dr. Emery Johnson has told the Office of Alcoholism that the evaluation system should be made operational before the appropriations hearings next March.

Mason stressed that the evaluation system will not be punitive or designed to defund programs that are found to be experiencing trouble. Rather the evaluation will be used to identify difficulties the alcohol projects may be having and determine what steps are necessary to eliminate the problems.

"The evaluation system will let us know what we’re getting from NIAAA and how we can assist those projects that need help," said Lawrence Berg, associate director of the IHS Office of Research and Development, who sits on the committee that is developing the evaluation policy.

Thirdly, a Resource Allocation Criteria document will be completed and distributed to local alcohol programs to allow them to identify needs in their respective areas.

Fourth, a small working group of Indian research people will be appointed — hopefully next month — to conduct a study that will indicate the prevalence of the Indian alcohol problem nationwide. Data from the research project would be made available by FY ’80, Mason said.

Fifth, a system for data collection will be established to gather reliable statistics on Indian alcoholism nationwide. Most of the available data on Indian alcoholism is inconsistent, according to Mason, and accurate information is needed "to show Congress the magnitude of the problem and show them the effectiveness of our programs in treating the problem," he said.

Finally, a program will be started to train medical staff and Indian alcoholism counselors on the most effective means of treatment for alcoholism. The training program will also strive to encourage a positive attitude among personnel working with Indian alcoholics, Mason said.

All six objectives will be formalized and sent out to area offices as soon as details for their implementation are worked out, Mason said. He is hopeful that distribution of these materials will begin before the end of the year.

Direct Access

Another concern expressed by members of NIBADA centers on the difficulty alcohol program directors have exercising their option to work directly through the central office rather than IHS area offices.

"The original intent (of establishing the central office) was to give Indians direct access to the upper hierarchies of IHS without having to go through the bureaucracies," said Dave Vallo, NIBADA member from California. Although that access is technically available, Vallo argues that it is ineffective because the central office encourages alcohol project directors to go through area offices if they want more expedient results.

Although the option to work directly with the central office is guaranteed by the IHS-NIAAA memorandum of agreement, NIBADA contends that contracting responsibility has been designated to IHS area offices and thereby effectively eliminates the central office option.

While the directors of many transferring alcohol programs may prefer to work with their area office, an alternative is needed for those who feel problems may arise at the local level, Vallo said.

Area Coordinators

NIBADA also expressed dissatisfaction with the manner in which IHS chooses its area alcoholism coordinators.

As specified in the IHS-NIAAA memorandum of agreement IHS was to identify area coordinators to monitor progress and provide technical assistance to transferred projects. Members of NIBADA believed the area coordinators would be full-time, Indian workers with a strong background in alcoholism. But in most cases the designated coordinators are non-Indian and already employed by IHS in another capacity, so that supervision of alcohol transfers became at best a part-time responsibility.

"We were told verbally that we would have a say in the choice of an area alcohol coordinator," said Robert North, NIBADA representative from the Seminole Tribe in Florida. Although he has been pleased with the individual chosen as coordinator for his area, North said he was upset that recommendations from local Indians were not requested for the choice.
Coordination of Indian Mental Health Resources is ‘MIN’ Goal

By Trudy Wilmoth
NIHB Board Coordinator

ROCKVILLE, MD.—Approximately 12 million U.S. children under 18 years of age suffer from mental health problems. Two million of those are afflicted by a combination of mental and physical problems and many fail to gain access to the full array of services they need.

The most devastating aspect of these statistics is that an estimated 10 to 15 per cent of the 2 million children are Indian. It is this population, defined as the “Most in Need,” which is the focus of a program planned to begin next summer, the “Child and Youth Mental Health Service Systems Initiative.” More often referred to as the MIN program, it was developed by the National Institute of Mental Health (a component of the Department of Health Education and Welfare) to increase coordination between existing human service resources on local, state and federal levels that are designed to respond to the needs of underserved children and adolescents with mental health problems.

Acknowledging recommendations made in the final report of the President’s Commission on Mental Health in which was included “A Good Day to Live for One Million Indians” a “Report of the Special Populations Subpanel on Mental Health of American Indians and Alaska Natives,” the MIN program allows for individual communities to define (within broad general cultural, social and economic guidelines) the group of children or adolescents it considers “Most in Need.” For some Indian communities this group may be the alcohol abusing, destructive adolescents, for others it may be children and adolescents labeled depressed or schizophrenic by the “Anglo” medical system.

The ability of Indian adult family members to perform their culturally accepted functions is considered one of the key factors in an assessment of a child’s normal growth and development. Therefore each child’s family is to play an important role in the long-range goals of the program.

The program will provide funds to allow each community to combine the following resources:

1. existing medically-oriented services such as those provided by the Indian Health Service, state, local and private sources.
2. existing social services such as the Bureau of Indian Affairs, Indian Health Service, community voluntary agencies, tribal, state and local government agencies.
3. community based groups such as religious, social, educational organizations.
4. traditional healers as desired and willing.

Over the years, out of the political process many program services for children and adolescents with mental health problems have developed independent of one another. At present only 12 per cent of the federal dollars allocated for maternal and child health is used in actual service delivery. The primary objective of the MIN program is to create a more efficient interrelated network of these services. Although it will not offer direct services, it is geared toward helping Indian communities make better use of their current allocations.

Because the major concerns of this program fall in the mental health or deviant behavior area, the plan in many situations for cross-linking the various services would likely be developed through an Indian group or organization with already existing concerns in the mental health area. However, an Indian community may wish, because of its particular situation, to designate some different group as the responsible party for cross-linking the existing human service systems.

From the individual’s perspective, the goals of this program are to provide him/her easy entry into a human service system — access through one source to all available quality help within the community.

From a community perspective, the program will hopefully focus all of its available resources through a coordinated effort directed at the largest number of individuals in the “Most in Need” population. It is anticipated that current community and family distress over the behavior of these children will be reduced as those behaviors become modified through the mobilization of resources to aid these children.

The program monies can be used only to coordinate and improve existing traditional and non-traditional human services. They cannot be used to provide direct services.

The financial resources for the MIN Program’s first year of operation are modest. For FY ’79 only American Indians, Alaska Natives, and Native Hawaiians will receive funding for coordination and cross-linking of services. In subsequent years, as the budget increases, this amount will also increase, allowing not only for further funding of Native American programs but also of state programs.

Specific requests for contract proposals will be sought during the winter months of 1978-1979 with projects, hopefully, to be initiated next summer.

For more information contact either Trudy Wilmoth, National Indian Health Board, Denver, Colorado or Dr. Stephen Hersh, Director or Dr. Larry Platt, Assistant Director, Most in Need Program, Office of Children and Youth, National Institute of Mental Health, 5600 Fishers Lane, Room 4A30, Rockville, Md. 20852, Phone (301) 443-3304.

NIBADA . . . .

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To alleviate these kinds of problems, NIBADA Executive Director Albert Pooley said IHS must appoint full-time area alcohol coordinators that report directly to the IHS Office of Alcoholism. Preference should be given to Indians with alcoholism experience, and job descriptions should be uniform and consistent, he said. NIBADA should also be allowed to make recommendations on the selection of these people, Pooley argued.

Staff Limitations

Unfortunately, there is very little IHS can do about the appointment of area coordinators at the present time according to IHS Office of Alcoholism Deputy Director Orville Mestes. Of the $8.7 million appropriated for the funding of alcohol projects in FY ’79, only $199,000 can be used for administrative costs.

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As required by Title VI of P.L. 94-437, the Secretary of HEW is to report to Congress on the need and feasibility for an AISOM based on the recommendations of two studies which support an AISOM. (NOTE: Secretary Califano recently sent his report to Congress but his comments were not supportive of AISOM. See separate article for details.)

Need for Planning

IHS Director Dr. Emery Johnson addressed the NCAI general assembly September 19.

He spoke briefly of the importance of P.L. 94-437 and P.L. 93-638. The laws should be viewed as components of a single process, he said, that is designed to improve the health of Indian people while strengthening tribal sovereignty.

In reviewing the past year of IHS activities, Johnson pointed to the more than 300 Indian students involved in health professions studies, the transfer of 36 alcohol programs from the National Institute of Alcoholism and Alcohol Abuse (NIAAA) to IHS, and expanded urban projects as major accomplishments for the year.

As for the upcoming year, Johnson pointed to the need for competent planning in health programs, especially with the prevailing mood in Congress to require more accountability for federal spending.

"If someone in Congress says our programs are failures, we want to be able to say 'here are the successes, here is the progress, here is how the programs are benefiting Indian needs,'” Johnson told the delegates.

TSHP Workshop

"If you look at this like a football season, we've been in preseason," Tim Shea, IHS Health Services Planning Branch Chief, told some 200 participants attending the NCAI workshop on Tribal Specific Health Planning (TSHP) of IHS orientation activities during last year. Over the next year, IHS will bring together TSHP's from across the country into a single plan to be presented to the Secretary of HEW. (NOTE: Details for the process were outlined at an IHS meeting September 26-27. See separate article.)

SEVERAL MEMBERS of the NCAI Health and Social Welfare Concerns Committee review committee resolutions; from left: Perry Sundust, NIHB Phoenix representative; Violet Hillaire, Northwest Washington Service Unit Board Chairperson; John Belindo, NIHB Executive Director and Committee chairman; Margie Montgomery, NCAI staff person; Larry Curley, Indian Liaison Specialist for the National Indian Council on Aging, and Patti Marks, staff person for the Senate Select Committee on Indian Affairs.
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But more important than this is the ceiling placed on IHS positions by Congress, Mestes said. Although the Office of Alcoholism has requested ten full-time positions for area alcoholism coordinators, the positions have not been approved, he explained.

Once Congress agrees to the need of additional staff for alcoholism programs the positions can be filled on a full-time basis. But in light of the freeze on federal hiring this approval will be difficult to obtain, Mestes said.

**Funding — Grants or Contracts?**

The last area of concern discussed by NIBADA is that of the funding mechanism available in the transfer process. Although alcohol projects have the option to apply for either grants or contracts under the IHS-NIAAA memorandum of agreement, several NIBADA members are worried that IHS will pressure most projects into using contracts. Depending on how it is written, a contract can be restrictive to the point of inhibiting working conditions, said NIBADA Executive Director Albert Pooley.

"I’ve seen contracts drawn up so that every piece of paper and pencil used had to be accounted for," he said. It is this kind of prohibitive accounting requirement that alcohol transfers can avoid if they are allowed to choose between contract or grant, Pooley contended.

When asked about the restrictive nature of contracts and how it applies to transferring alcohol projects, Phoenix area alcoholism coordinator Tom Burns replied that it depends on the area. While not as "loose" as a grant, contracts from his area office are not designed to hinder program operations, Burns said.

"It’s our feeling that these programs are mature, that the people know what they’re doing. We just want some indication of the progress that’s being made. We’re not interested in the number of pencils someone is buying to get the job done," he said.

**NIBADA-IHS Meeting**

NIBADA will meet with the IHS Office of Alcoholism to review these concerns about the transfer process and discuss procedures for the FY ’79 transfers. In addition, NIBADA will present IHS with its own recommendations for a plan to evaluate Indian alcohol programs.

The NIBADA-IHS was scheduled for Nov. 14-16 in Rockville, MD.

**Section 103 . . .**

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health professions school. There is a service obligation based on one year of service for each year of scholarship award with a minimum obligation of two years. Deadline dates for filing Section 104 applications for the spring, summer and/or fall semesters of 1979 have not yet been established.

However, those planning to file an application for either Section 103 or 104 are urged to begin assembling three copies of each of the following documents: at least two letters of recommendation, high school and/or college transcripts, Indian preference documentation.

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