



## Tribes Eligible for Direct Funding Under DHHS Block Grants

WASHINGTON, D.C. — One of the major reforms of the Omnibus Budget Reconciliation Act of 1981, which President Reagan signed into law August 13, is the consolidation of 25 separate programs of the Department of Health and Human Services (DHHS) into seven "block grants" that will be administered by state governments.

Because of concerns raised by Indian tribes and Indian organizations, the law contains provisions that allow tribes, under certain conditions, to apply directly to the Secretary of DHHS for funding under all but two of the block grants. The block grants with direct-funding provisions for Indian tribes and tribal organizations are: three Public Health Service programs (Preventive Health; Alcohol, Drug Abuse, and Mental Health; and Primary Care); Low Income Home Energy Assistance; and Community Services. Block grants for Maternal and Child Health (MCH) and Social Services do not contain the Indian provisions.

90 Opportunities for expanding present tribal services under these provisions are limited. For the three Public Health Service grants, the language basically protects those tribal programs already funded directly by a DHHS agency (other than the Indian Health Service). The energy and community service block grants do not contain this "prior grantee" restriction, and both federally and state recognized tribes and Indian organizations may apply for direct funding under these two grants. The block grant program does not pertain to Indian Health Service (IHS) and will not affect tribal health programs funded by IHS.

In a September 22 letter to tribal officials, DHHS Secretary Richard S. Schweiker outlined the application process for tribes eligible for direct funding under the block grants. If a tribe chooses to exercise this option it must submit a letter of intent "to the appropriate Departmental agency . . . by October 1, 1981, or prior to the beginning of the quarter the state begins implementing the block grant program." The tribe then has 75 days to submit a full application, which must meet the same statutory requirements for funding as those made by the states.

### New Federalism

The DHHS block grant initiative is a major part of the Reagan Administration's "New Federalism" policy, which is an attempt to reduce the federal government's role in administering programs and give more authority to the states. "It is the intention of this Administration to pass the baton to the states and let them run with it. They will be

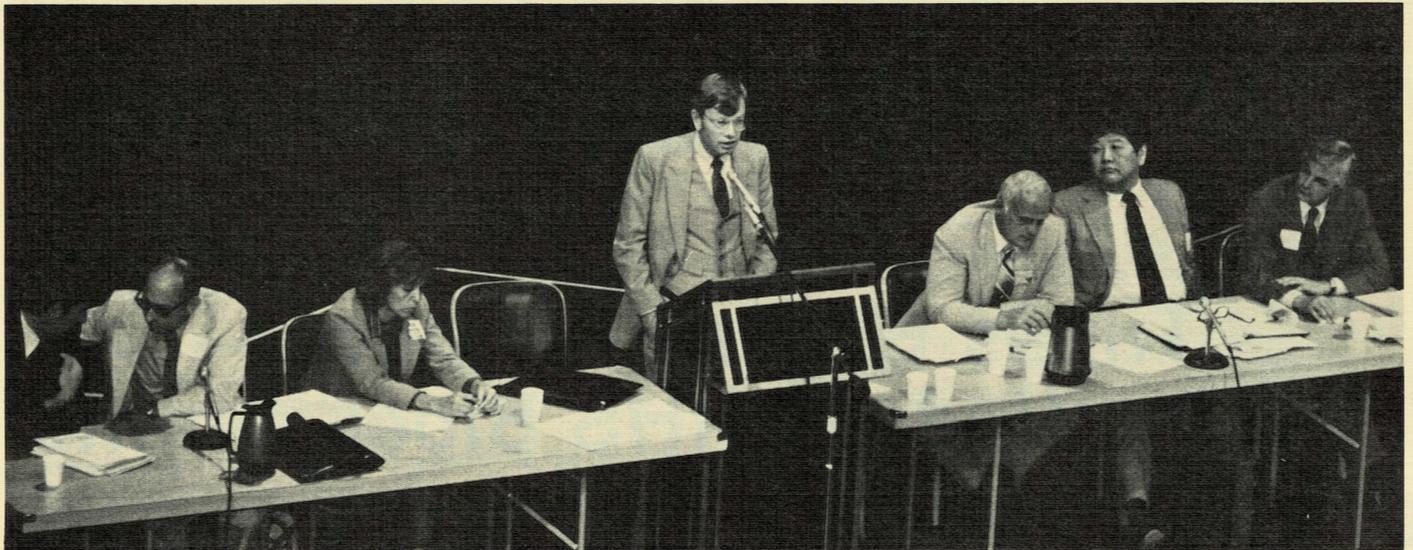
monitored by their own state constituents, and not by a Washington bureaucrat," says James Stockdale, DHHS deputy under secretary for intergovernmental affairs, who has been coordinating part of the block grant initiative.

As provided for in the Omnibus Budget Act, the block grant program is not nearly as extensive as the Administration originally intended. Earlier this year Administration officials proposed to consolidate as many as 88 programs into state block grants, with far fewer restrictions than contained in the present program. The Administration's version encountered much resistance on Capitol Hill, where many congressmen are opposed to the removal of controls over federal program monies. Many state and local officials, while generally pleased with attempts to cut the strings tied to federal funds, are distressed over the impact of the 25 percent budget reduction targeted for the grants.

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*DR. EDWARD N. BRANDT, Assistant Secretary for Health, addressed more than 300 attendees at a retirement dinner for Dr. Emery A. Johnson, who stepped down from the position of Indian Health Service Director on September 1. Brandt commended Johnson for his "dedication, skill, and commitment to improving the health care of Indian people." See article pg. 12.*



*JAMES STOCKDALE (center), DHHS deputy undersecretary for intergovernmental affairs, responds to questions on block grant program during conference in Denver September 16. The conference was one of eight regional meetings sponsored by the White House to explain different aspects of the block grant program.*

### **Tribes Eligible...**

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"The Administration did not get all the program concessions it wanted, and the grants do not have the flexibility that was originally intended," says Judy Peachee, special assistant to the President for intergovernmental affairs. She indicated that "the Administration is committed to more block grants and more flexibility" in coming years.

Indian leaders have expressed their concern about the block grants from the outset. At a May 8 meeting with Secretary Schweiker, representatives from the National Tribal Governments Conference stated that because many states have historically excluded Indians from their services, tribes would likely be denied an opportunity to take part in the block grants if states were given complete, unrestricted authority to administer the program.

Indian representatives at the meeting stressed that tribes' special legal relationship with the federal government gives them the same right as states to deal directly with federal agencies in the block grant program.

In subsequent meetings with Administration officials, tribes and Indian organizations, including the National Indian Health Board, discussed different approaches to provide for acceptable tribal involvement in the block grants.

An initial proposal, based on the so-called "51st state" concept, involved a small percentage of the overall block grant funding being set aside just for tribal programs. When it became evident that Congress would not support this approach, the present provisions for direct funding were developed as an alternative.

As explained in Schweiker's letter to tribal officials, "Indian tribes and tribal organizations may choose to apply for block grants directly from the Department or they may choose to have services or funding provided by the state." The initial request, which need only be a simple statement of intent, is the legal mechanism required to withhold a tribe's funding from the state's block grant allotment. Submission of a letter of intent does not obligate the tribe to make a full application for the program. If the tribe does not submit an application within 75 days, the funding reverts back to the state.

In preparing and submitting an application for direct block grant funding, tribes and Indian organizations must meet the same statutory requirements as states. The application consists of assurances and a plan for carrying out the program; specific requirements for the application are detailed in the legislation. There is no standard application form for the block grants.

In addition, during FY 1982, direct block grant funding to tribes may occur only when the state implements the program. However, if the state decides not to administer the block grant current Indian grantees may apply for a FY 1982 grant under the existing categorical programs.

The amount of funding allotments for states and Indian tribes under the block grant programs has not yet been determined. According to DHHS officials, this information will be made available following completion of congressional action on the FY 1982 budget.

Briefly, the block grants, the programs consolidated, and the authorization amounts are as follows:

- **Alcohol, Drug Abuse and Mental Health** — Combines programs for mental health services, drug abuse projects, and alcoholism projects. Tribes or tribal organizations that received funding directly from the Secretary in FY 1980 for these services are eligible for direct funding under the block grants. \$491 million is authorized for FY 1982.

- **Preventive Health and Health Services** — Combines programs for home health, rodent control, fluoridation, rape crisis, hypertension, health incentive, emergency medical services, health education and risk reduction. Tribes or tribal organizations that received a grant directly from the Secretary in FY 1981 for any program transferred to this block grant are eligible for direct funding. \$95 million is authorized for FY 1982.

- **Primary Care** — Permits states to take over the federal program of running Community Health Centers, beginning in FY 1983. Tribes or Indian organizations that receive a FY 1982 grant directly from the Secretary are eligible to con-

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# Health News Across the Nation

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

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WASHINGTON, D.C. — On September 30, the last day of FY 1981, Congress passed a Continuing Resolution that allows the federal government to continue funding its programs. Under this measure, funding for Indian Health Service (IHS) programs is extended until November 20, or until an Interior Appropriations bill passes Congress and is signed by the President. The continuing resolution provides for IHS funding at the lower of two figures: the FY 1981 appropriations level, or the appropriations level for FY 1982 as recommended by the House of Representatives. Further congressional action on the appropriations bills is likely to be delayed, at least temporarily, until the Administration announces its proposals for additional budget cuts in FY 1982. The Administration is seeking to reduce the FY 1982 federal budget by at least an additional \$13 billion.

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KRESHENA, WISC. — The Wisconsin state attorney general's office has issued an opinion stating that the state will refuse to pay for services for Menominee Indians committed to state mental institutions by tribal courts. The opinion involves serious jurisdictional questions between the state and tribe, according to Menominee tribal chairperson Lucille Chapman. The tribe will meet with officials from the state and the Indian Health Service (IHS) October 21 in an effort to resolve the issue, she said.

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WASHINGTON, D.C. — Recent government statistics indicate that the cost of medical care this year has risen faster than inflation. Not only did escalating medical costs outstrip the general inflation rate for the first seven months of 1981, the Labor Department's Consumer Price Index shows they rose at a faster pace than any of the other six components the government tracks in measuring inflation. Health care costs increased at a seasonally-adjusted annual rate of 12.6 percent for the first seven months of 1981, compared to a 9.4 percent rise in the overall Consumer Price Index for the same time.

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ROCKVILLE, MD. — The Indian Health Service (IHS) has issued a policy memorandum that provides for a "provisional funding level" for tribal contracts under P.L. 93-638

## No Word On New IHS Director

WASHINGTON, D.C. — As we were going to press with this issue, there had been no announcement on the naming of a new director for the Indian Health Service. Dr. Joseph Exendine has been serving as Acting Director of the agency since Dr. Emery A. Johnson retired September 1. Closing date for submission of applications was September 11.

Although it is known that several candidates have been interviewed for the position by Dr. Edward Brandt, Jr., Assistant Secretary for Health, a spokesperson for his office declined to speculate as to when the final decision would be made. Dr. Brandt has indicated that he wants to fill the position "as soon as possible." The selection is expected to be announced sometime in October.

(The Indian Self Determination and Education Assistance Act.) The provisional funding level is made in the absence of an appropriation act "to provide a clear understanding of the funds available for expenditure at the beginning of the contract period," and is made on the basis of the most current budget information available at the time of negotiations. This provisional funding level is subject to adjustment when the appropriations is enacted and a "final funding level" is determined for the contract. According to the memorandum, the provisional funding level helps provide a sound basis for negotiating P.L. 93-638 contracts before an appropriation is enacted. Copies of the memorandum (Indian Self Determination Memorandum No. 81-5) can be obtained from IHS area offices or from the NIHB Public Information Office.

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SHIPROCK, N.M. — Because of the many drownings that have occurred here, the Navajo Emergency Medical Service Program is developing a prevention program that will teach people how to swim and perform rescue procedures. "We estimate that 30 drownings occurred on the reservation this year," says Henry Wallace, director of the program. The new program will begin its efforts against the drownings by marking and posting the estimated 200 ponds, dams and lakes on the reservation which are dangerous to swimmers. The program also hopes to expand to other areas of the reservation, says Wallace.

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OKLAHOMA CITY, OK. — The Association of American Indian Physicians (AAIP) will be holding a Pre-Admission Workshop Nov. 14-15 in an effort to assist Indian students in areas of: selection of a professional school; hints and instructions on how to take tests and how to fill out profes-

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## Health News...

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sional school applications; and advise on professional school admissions. Students will be selected for the pre-paid workshop (by AAIP) on the basis of Grade Point Average (GPA) and year in school. For more information contact: Bill Wilson, Executive Director; Association of American Indian Physicians; 6805 So. Western, Suite 504; Oklahoma City, OK 73139; or phone collect, (405) 631-0447.

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PHILADELPHIA, MISS. — The Choctaw tribe recently initiated a Most-In-Need Children and Youth Project. Program staff will work with tribal youth to address their concerns and needs, and will work with other agencies to establish a network of human services for young people on the reservation.

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INSCRIPTION HOUSE, ARIZ. — Ground breaking ceremonies recently took place for a \$3.9 million clinic here on the Navajo reservation. The clinic will serve Navajos residing in the communities of Inscription House, Kaibeto, Navajo Mountain, Shanto, Cow Springs, and Red Lake. The clinic is expected to be completed by December of next year.

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PHOENIX, ARIZ. — The Indian Development District of Arizona (IDDA) is sponsoring a Rural Emergency Medical Services (EMS) Management seminar here October 19-30. The 10-day seminar will stress the reservation EMS system and the special problems related to EMS within Indian country. Additional information about the seminar can be obtained from Steve Carter, Emergency Services Division; IDDA; 1777 W. Camelback Rd., Suite A-108; Phoenix, Ariz. 85015.

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EDMONTON, ALBERTA — "Indian Health For a Better Tomorrow" is the theme of the first Canadian Indian Health Conference to be held here Oct. 19-23 at the Edmonton Inn. According to planning committee chairman Leo Sasakamoose, the conference will attempt to inform their Provincial Indian community (pop. 40,000) of the vast potential for personal involvement in health programs, particularly through community health boards, committees and other health resource agencies. "We want to involve more of our people in the planning and implementation of their health services," says Sasakamoose.

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OKLAHOMA CITY, OK. — Dr. Thomas S. Whitecloud, III, a member of the Chippewa Tribe and associate professor of orthopedic surgery at Tulane University School of Medicine, has been elected president of the Association of American Indian Physicians (AAIP) for 1981-82. The organization was established 10 years ago to promote health care for the American Indian and Alaska Native and

to encourage Indian people to join medical and paramedical fields.

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WASHINGTON, D.C. — Ray Granbois, a member of the Turtle Mountain Board of Chippewa Indians, has been appointed to the National Advisory Council of the National Institute of Allergy and Infectious Diseases (NAAIDC). In this capacity Granbois will help review grant applications for research training and support, and will help to evaluate programs and make recommendations concerning priorities of the Institute. His term will be effective through 1983. ■

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## Tribes Eligible...

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tinue direct funding when a state opts for a primary care block grant. \$284 million is authorized for FY 1982 categorical grants, with the block grant program becoming effective in FY 1983.

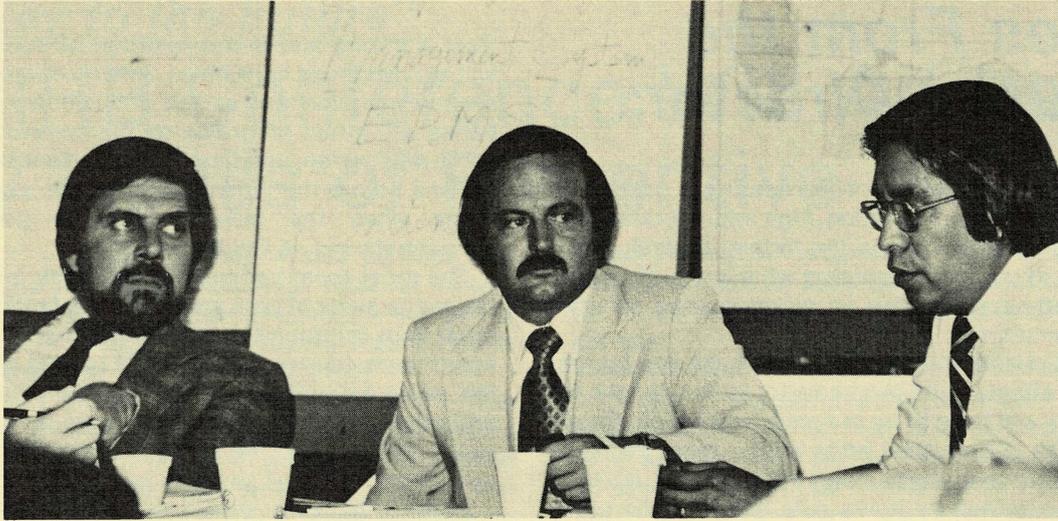
● **Community Services** — Provides block grants for services previously authorized under the Economic Opportunity Act of 1964. This block grant consolidates programs for community action; senior opportunities and services; community food and nutrition, and energy conservation. All federally state and recognized tribes are eligible to apply for direct funding. \$389 million is authorized for FY 1982.

● **Low Income Energy Assistance** — Provides funds to states to help eligible low-income people meet costs related to home energy requirements. Both federally and state recognized tribes are eligible for direct funding. \$1.9 billion is authorized for FY 1982.

● **Maternal and Child Health** — There are now provisions for direct funding to tribes under this block grant, which combines programs for maternal, child, and crippled children services; supplemental income for disabled children; lead-based poisoning prevention; sudden infant death syndrome; hemophilia; adolescent pregnancy, and genetic diseases. \$373 million is authorized for FY 1982, with a fifteen percent set aside for research, demonstration and training projects of national or regional significance. Tribes are being encouraged to investigate these demonstration projects as a possible area for expansion.

● **Social Services** — There are no provisions for direct funding to tribes under this block grant, which provides for a wide range of services under Title XX of the Social Security Act. \$2.4 billion is authorized for FY 1982. Administration officials have indicated that a more expanded version of this block grant will be requested next year, and tribes may try to push for direct funding provisions in this new proposal.

Additional information about the block grant proposal and the Secretary's letter to tribes can be obtained from the NIH Public Information Office; 1602 S. Parker Rd., Suite 200, Denver, CO 80231 Phone: (303) 752-0931. ■



*DR. MICHAEL TRUJILLO, Chief Medical Officer for the IHS Phoenix Area (right), presents his paper on the Critical Issues Facing the Indian Health Service to the Executive Committee of the National Council of Clinical Directors (NCCD). According to Trujillo, the report presents issues which IHS clinicians feel need to be addressed.*

## Clinical Directors Examine Concerns of Reservation Nurses, Physicians

DENVER, COLO. — The executive committee of the National Council of Clinical Directors (NCCD) met here Aug. 26-27 to discuss proposals and recommendations for their upcoming winter conference in Tucson, Ariz.

According to NCCD Chairman Dr. Terry Sloan of Gallup, N.M., a tough approach toward various Indian Health Service (IHS) clinical and managerial policies will be taken by the organization. "I believe that the Indian Health Service can use some input for improved changes at the various service units throughout the country," said Sloan.

The changes and recommendations called for by preliminary reports presented at the meeting included particular areas in nursing, medical systems assessments, physician recruitment and retention, emergency medical services, diabetes, and other important issues facing IHS today.

The basic goal of the NCCD, says Sloan, is to provide a clinical perspective into IHS management to help insure that clinical programs operate as effectively as possible. The members of the organization include mostly physicians who serve as clinical directors throughout the IHS "Service Unit" network. The duties and goals of these directors include representing the IHS administration to local medical staffs and providing insurance that clinical concerns are represented to the Service Unit Director, said Sloan. The clinical directors also have authority and responsibility over all clinical aspects of the Service Unit medical program.

In addition to their responsibility for the quality assurance of any particular hospital function, said Sloan, clinical directors are also active in treating patients and working with tribal governments in planning overall health care services.

Because these physicians are involved in different phases of planning, administration, and evaluation of the IHS service unit (which generally includes a hospital and

several smaller clinical facilities), they are particularly concerned about certain aspects of existing clinical services on reservations.

One area of concern for the physicians is related to problems faced by nursing personnel. According to a position paper written and presented by Dr. Peter Marshall of Alaska, one of the most important assets of any hospital or clinical facility is its nursing staff. But, according to Marshall, there is a growing unrest and dissatisfaction among many of the IHS nurses.

A list of proposals designed to address some of the problems confronting nurses included recommendations that: attempts be made at providing more acceptable accommodations for nurses and their dependents; more rapid and responsive hiring practices be initiated to relieve chronic shortages in nursing staff; and assistance be made available to help finance at least one professional education opportunity per year. "The lack of continuing educational opportunities combined with physical isolation of many clinic and hospital sites increase the nurses' feelings of professional isolation," reported Marshall.

According to the majority of the physicians attending the meeting, nurses were considered one of the most critical resources of a hospital or clinical facility. One doctor even went so far as to say that he would rather take IHS hospital construction money and put it into a "good nursing retention program."

The executive committee also cited critical factors influencing recruitment and retention of IHS physicians. At the request of the NCCD, the IHS Office of Research and Development conducted a survey of all physicians in the IHS in order to identify the major factors affecting physician recruitment and retention. A questionnaire containing 207 items was developed and mailed to each physician, with 88 percent of the physicians responding.

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# Notes From the Executive Director:

I suspect most of you have been hearing a great deal lately about the effects of inflation, high interest rates, and the need for additional cuts in the federal budget. And I suspect many of you are wondering what kinds of impact these proposed cuts will have on programs and services on Indian reservations.

It is difficult to determine exactly how these new budget proposals will affect health programs for Indian people. No doubt, services will have to be reduced, and Indian people will be asked to tighten their belts a little more and take their medicine like everybody else. Unfortunately, many of the programs affected by these cuts will have no place else to turn for alternative funding.

As numerous tribal leaders have pointed out, most of our reservations do not have an adequately developed "private sector" economy to fall back on. Most tribal economies are in the developing stage, at best. It is not hard to see that cutbacks in existing resources are going to make continued development of Indian reservations, and continued improvement in the quality life for American Indians and Alaska Natives, very difficult to achieve.

But it is my hope that the impact from this economic crunch will be only a temporary setback. Indian people

have a strong and proud tradition of surviving, and they will survive these hard times. At a recent meeting I attended, the question was raised about how new budget cutbacks will affect programs on the reservation. There was some discussion, and finally one man spoke out: "We were Indians before the federal dollar came, and we will be Indians when the federal dollar is gone." This, as economists say, is the bottom line.

The most recent economic statistics tell us that costs related to medical care are rising at a faster pace than any other item. Inflation has greatly affected the cost of quality health care; dollars in next year's budget simply won't buy the same amount of hospital services, pharmaceuticals, and other medical supplies that were purchased with last year's dollars. And the costs of contract health care and specialized medical services are rising just as fast.

Some tribally-run programs, in both health and other fields, have struggled through the difficult years of development and are just now approaching a level of sophistication that allows them to offer high quality, cost-effective services to Indian people. The fiscal belt-tightening needed in the coming year will be particularly hard for them.

For those of you that took up my recent "health challenge" and have been dieting with me, I must confess: my own belt tightening has been a little slow. I have only lost six pounds. That's not much — I hope you're having better luck. I'll be trying harder in the coming months. ■

j.w.

## Applicants Sought for NIHB Staff Openings

DENVER, COLO. — The National Indian Health Board is seeking qualified applicants for the positions of health planner, editorial assistant, and executive secretary at its central office here.

The health planner is involved in a number of NIHB planning and research activities, including: technical assistance presentations to tribes and Indian organizations on federal budget, administrative, and legislative issues; health statistics; tribal health planning; NIHB resolutions process, and preparation of reports for the organization. Position requires excellent research and writing skills, with at least two years experience in health planning. A Master's degree preferred, but related experience may be substituted for educational background.

The editorial assistant will be involved in a number of efforts within the NIHB Public Information Office. These duties include assisting in the overall preparation of a monthly newsletter, the *NIHB Health Reporter*; writing articles about particular medical, legislative, or program issues related to Indian health; copy layout and printing of newsletter; photography, and other activities. The position requires typing skills (minimum 60 wpm) and an excellent command of written and spoken English. A B.A. degree in English or Journalism is desired but may be waived with commensurate experience or skills.

Persons interested in applying for the position of executive secretary should have a minimum of two years secretarial experience; have excellent typing (60 wpm

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### NATIONAL INDIAN HEALTH BOARD

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## "The Key to the Future"

# NIHB Conference Will Address Key Issues of Preventive Medicine

TUCSON, ARIZ. — Preventive health care services and their importance in reducing the high rates of certain diseases among Native American populations will be the focus of the Fifth National Indian/Alaska Native Health Conference, to be held here April 19-22, 1982.

The conference theme — "Preventive Medicine — The Key to the Future" — illustrates the increasing emphasis being placed on preventive health measures in treating problems such as diabetes, hypertension, alcoholism and heart disease. The conference will attempt to examine these and other health problems, with particular attention given to the role preventive medicine has in reducing the incidence of those diseases.

"We need to look at why certain diseases occur so frequently among Indian people. And we need to find out what Indian people can do for themselves to help prevent these diseases," says Muriel Ortigas, a Papago Indian who serves as the Tucson area representative to the National Indian Health Board, which is sponsoring the health conference.

NIHB is hoping to utilize speakers from tribally-administered projects that have successfully incorporated preventive health practices into their services. It is also

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### Clinical Directors...

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Physicians indicated in the survey that they were proud of the job they were doing and felt that they were providing high quality health care. Most physicians indicated that they enjoyed the opportunity to be involved in Indian community health care.

But the report also specified particular areas of dissatisfaction such as the lack of educational opportunities for spouses, the lack of opportunities for furthering their clinical skills and problems associated with the isolation of smaller service units. Another area of concern included the extent to which the physicians were expected to perform managerial duties, and many felt that they were unprepared for the administrative responsibility thrust upon them.

In response to the survey, the NCCD developed 28 preliminary recommendations designed to enhance physician recruitment and retention, including suggestions that: there should be a reciprocity agreement between smaller service units and larger medical centers to allow physicians from smaller service units to rotate through specialty services; IHS develop a centralized education program utilizing lecturers, video tapes, etc., to improve the educational opportunities at the smaller service units; the availability of specialists and consultants be increased; improved communication channels with smaller and larger service units be established; more tribal agreements to allow physicians to own their own homes be encouraged; and more educational and working opportunities for spouses be created. ■

hoped that certain programs — such as diabetes control projects — can be featured at the conference as models for tribes that might be interested in developing similar services.

The conference emphasis on preventive health is due in large part to suggestions that have been sent into NIHB. Recommendations for workshop topics, speakers, and other agenda items are still being accepted by NIHB, and all suggestions will be considered in the development of the conference program. Also, any tribal health project interested in participating in the conference should contact the NIHB central office.

In an effort to improve the conference resolutions process, NIHB is requiring all resolutions to first be submitted and approved by area boards. NIHB area representatives will then bring the resolutions before the full board. It is hoped this procedure will streamline the resolutions process and eliminate duplicate resolutions.

NIHB is also accepting nominations for persons or organizations whose contribution to the field of Indian health deserves special recognition. Nominations should include an explanation of how the individual, organization, or tribe contributed significantly to improving the health care of Indian people. Awards based on these nominations will be given out at the conference.

Conference activities will be held at the Tucson Community Center. A number of rooms are being held at government rates for conference participants. Housing arrangements can be made by contacting: Lois Patterson, Housing Coordinator; Tucson Convention and Visitors Bureau; 120 West Broadway; Tucson, Ariz. 85701.

Additional information about the conference agenda, speakers, registration, and other activities will be announced at a later date. ■

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### Applicants...

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minimum) and shorthand skills; have experience in the operation of other office equipment, and have a high school degree. The executive secretary will assist the Executive Director and other NIHB administrative staff in the preparation of reports; correspondence; filing; transcription of tapes; developing minutes of meetings; making travel arrangements, and other secretarial and clerical duties.

To apply for these positions, submit a resume showing personal history, education, work experience (writing samples for Editorial Assistant applicants) and references to the Executive Director at the NIHB central office. Application deadline is October 30. Indian preference considerations will be given to these positions.

Copies of job descriptions for these positions may be obtained from the NIHB central office. For additional information, contact Scott Cull; National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone (303) 752-0931. ■

# Innovative, Community-Oriented to Treatment and Prevention

*Alcoholism is recognized by many tribes and Indian organizations as the number one health problem in American Indian and Alaska Native communities. Statistics indicate that of the ten leading causes of death among Indian people, five are alcohol-related. Both the National Indian Health Board and the National Congress of American Indians have adopted strong positions citing the need for additional resources and improved services for the treatment of Indian alcoholism. And many tribes, inter-tribal councils, and Alaska Native villages have initiated their own alcoholism projects in an attempt to cope with this disease.*

*But despite these efforts, alcohol-related problems continue to plague Indian reservations and remain a primary concern of Indian leaders, health professionals, and others. In the following article, James M. Andre, M.D., M.P.H., discusses some of the factors related to the uniqueness of alcoholism among American Indians, and offers some suggestions for the prevention and treatment of alcoholism in Indian communities.*

*Dr. Andre is former Senior Clinician for Alcoholism with the Indian Health Service, and is widely regarded as an expert in the field of alcoholism. He has been involved with Indian mental health services since 1969, has lectured extensively in this area, and has numerous publications to*

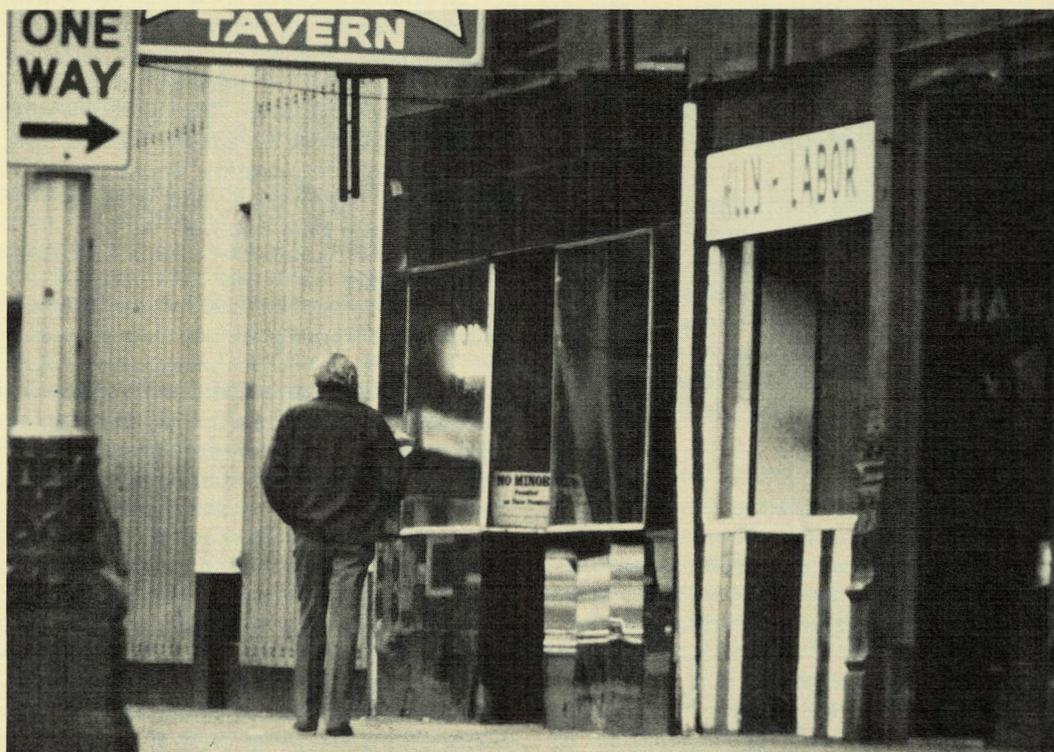
*his credit. He is presently a consulting psychiatrist in Albuquerque, N.M.*

*We invite our readers to respond to Dr. Andre's article. Comments should be sent to the NIH Public Information Office.*

While the history of alcohol use and abuse goes back to biblical times, for the American Indian and Alaska Native it goes back, at the most, 400 years for those tribes in the Southwest and less than 300 years for most other tribes.

It did not take the early colonists long to recognize that American Indians constituted a rare cultural group with essentially no experience with the chemical alcohol, and they turned this observation to their advantage in all dealings with the Indians. Alcohol played a dominant role in the early activities of fur trappers, traders and soldiers, often being used as an enticement of one sort or another. Before long, the whiskey trade among Indians became an end in itself, since the more unscrupulous traders found that a compelling desire for strong drink led many Indians to give up their most valued possessions.

Of real devastation to Indian societies was the fact that they had no system for punishing crimes committed while a man was drunk, no matter how terrible, since the drunken person was not considered in control of his actions. This fact may underlie the phenomenon of using drinking as a



**ALCOHOLISM IS GENERALLY** considered to be the number one health problem of Native Americans, both on reservations and in urban areas. Of the five leading causes of death for American Indians and Alaska Natives, five are alcohol related: accidents, cirrhosis of the liver, alcoholism as a primary diagnosis, suicide and homicide.

# Approaches Seen as Essential of Indian Alcoholism Problems

"ticket to forgiveness" for whatever mayhem the individual may commit while intoxicated.

This uncertainty over how the community should react to drunkenness is a key historical point which is relevant to contemporary attitudes, because the uncertainty prevails to this day that alcohol abuse is still not seen as problematic by some Indian communities, or not critical enough for community leaders to take concerted action against the problem.

In addition to this uncertainty, there are some other factors that have, and still do, contribute to the uniqueness of alcohol use among American Indians:

- Prohibition, which continued from 1832 until 1953 for all Indians and continues yet today for some, has had an affect. Bootleggers still flourish on many reservations with the effect that not only do Indians have to pay more for their drinks, but often they also have to drink fast and in secret. The very illegality of drinking serves to increase its appeal, especially to the young. The need to drink fast may underlie the phenomenon of "blitz drinking," or drinking to the point of intoxication, and the sooner the better.

- Prohibition and bootleggers are also thought to be a factor in current family and extended kin drinking parties, especially among the Navajo where in the old days bootleggers made regular deliveries to the homes of the more affluent Navajos, who would then hold a party for family kin and friends.

- The common Indian practice of sharing with others in need also extends to sharing alcohol. As part of this, accepting what is offered, including alcohol, is just as important a sign of friendship as the offering. Thus, even when one wants to stop drinking, he will often succumb to the expected behavior and drink along with the others. This is recognized as "peer group drinking" and can be viewed as a major factor in recidivism, because if one actively refuses to drink he runs the real risk of exclusion from the group and may wind up with no friends at all.

- Isolation and boredom on some reservations is a real problem especially for the young. It is not difficult to see how drinking, given the danger of being arrested, the long ride to get alcohol, the fighting and occasional sexual adventures may be, by far, the most exciting activity going on many reservations.

- Unemployment and underemployment is still a major problem in many, if not most, Indian communities and it's not difficult to see how this can contribute to both psychological and socioeconomic stress for the individual and his family. But it contributes to problems in a couple of other ways. In terms of alcohol abuse and alcoholism, the high rate of unemployment makes it extremely difficult to find meaningful work, even with job training, for the Indian alcoholic trying to regain his sobriety. Again, in terms of drinking patterns, some have observed that many Indian alcoholics rarely show any attempt to gain control over the hours when they drink (e.g., only after 5:00 p.m. or only on weekends — a symptom said to be common among non-Indian alcoholics).

Rather, the tendency to drink at any time of the day or day of the week is felt to be more common with the Indian alcohol abuser. There are many jokes about "white man's time" and "Indian time" referring one way or another to white society's eight-to-five, five-days-a-week work orientation. It's much easier to have such an orientation when your group's unemployment rate is 7 percent than when it's 70 percent as it is in some Indian communities. Thus the fact of high unemployment, while perhaps not obvious at first, contributes both to a pattern of drinking and the difficulties in building a workable treatment plan.

There are a number of other historical factors that contributed in some way to Indian drinking, such as the effects of Indian wars; relocation with confinement to reservations; acculturation, deculturation stresses; and the substitution of the farmer for the warrior role.

There are also some current aspects to Indian alcoholism which may or may not be unique to Indian communities, but are nevertheless a problem. One perplexing aspect is what appears to be a much more devastating impact on the physical health of the Indian as a consequence of abusive drinking. This does *not* refer to any increased susceptibility of the Indian to alcoholism in the sense of an addictive disease.

Rather, it refers to the high incidence of repeated, severe and multiple pathological damage to organs, such as the twenty-four year old with end-stage liver disease, severe hemorrhagic pancreatitis and severe alcoholic polyneuritis, or the thirty-four year old with cirrhosis, chronic gastritis and cerebellar degeneration. Of even greater concern is the increasing proportion of young Indian women among those suffering severe pathology of this type.

One could argue that this is simply the result of heavy, prolonged intake of alcohol during the few years of the person's drinking life. But my impression is that in many of these individuals, the drinking history did not seem to be all that remarkable. One could also argue individual susceptibility except that of the top ten killers of Indian people, *five* are alcohol-related. They are accidents, cirrhosis of the liver, alcoholism as a primary diagnosis, suicide and homicide.

What I believe (although I have no proof) is that Indians as a genetic group may yet be found to have a genetic predisposition to severe pathological damage to organs either from alcohol, its metabolites or something in alcoholic beverages as a contaminant. This is quite apart from the issue of whether or not Indians have a genetic predisposition to alcoholism.

## Indian Alcoholism Services

There are also problems in the area of service delivery. Many Indian alcoholism programs are funded at a minimal level, yet are expected to provide a full range of services to a large number of people over a wide geographical area. There are few programs that have a good range of treat-

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*BOB MOORE, PAST President of the National Indian Board of Alcoholism and Drug Abuse (NIBADA) (right), Elwood Saganey, chairman of the National Indian Health board (NIHB) (middle), and Caleb Shields, chairman of the National Council of American Indians (NCAI) Alcoholism Committee (right), partake in a workshop on Alcohol and Drug Abuse at the Fourth National Indian/Alaska Native Health Conference held last April in San Diego. The workshop explored the state of alcoholism and drug abuse intervention and strategies with Native American and Alaska Native communities.*

### **Innovative...**

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ment services such that they could be fairly evaluated for effectiveness; instead, there is a very limited range of treatment options (e.g., individual counseling, valium, Alcoholics Anonymous or antabuse). If the patient cannot fit into this suit of clothes, he's considered a "treatment failure" when in fact it is the program that is failing.

Some programs with too few staff rely heavily on Alcoholics Anonymous, more out of necessity than from proven effectiveness in Indian communities. While this program offers perhaps the most effective approach in the non-Indian world, the fact remains that in small Indian communities life is simply not anonymous. While it may be characteristic of Indian people in general, many have complained that the practice of self-revelation, confrontation and intervention is not "the Indian way" and makes them uncomfortable.

In service delivery the current emphasis is still on late identification of the patient after he is well into an advanced stage of alcohol abuse (i.e., we're picking up the casualties). What is really needed is a system of early identification of the alcohol abuser as he interfaces with various agencies so that intervention can occur when it's more likely to be effective. Unfortunately, the greatest pressure on the programs is still to "get the drunks off the streets."

Personnel problems — involving the hiring, firing and retention of staff — are another difficulty within the programs. Few, if any, personnel practices exist in some programs. There is often no requirement for proven, sustained sobriety and often no contract for the director to protect

against unfair practices. In addition, there are problems with program staff having inadequate training in the basics of counseling techniques and the development of an individualized treatment plan for their clients. Lacking this, many counselors try to recast their clients in their own image and try to apply what worked for them (i.e., "I recovered this way and so can you").

There are also problems with physicians taking an exclusively scientific approach to alcoholism, with patients many times winding up overdressed but undertreated (i.e., physicians are applying a chemical answer to problems of alcoholism). Physicians must come to understand that for the alcoholic to be truly detoxified, he must be free of all psychoactive drugs. The usual one or two-week supply of such drugs only worsens the sense of isolation and panic the alcoholic will feel when he runs out of chemical support. Forcing the individual to relate to people rather than chemicals is the treatment of choice.

In order to achieve some sort of impact on the problem of alcoholism in Indian communities, there are several things to consider. Additional resources are needed for improved services, since what is being done now is inadequate. There should be support for programs that attempt to take innovative approaches to the treatment of alcoholism. Support should also be encouraged for those programs that emphasize early identification of the alcohol abuser and for those programs that provide a wide range of treatment services, with the goal of evaluating which ones work and with which patients.

Programs that show precisely how their services are coordinated with other services in the community (i.e., how

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## Innovative...

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they function as part of a network of services) should be encouraged. Without this, adding more services only makes the obstacle course the alcoholic must run even more chaotic than it already is now.

There should also be an emphasis placed on developing the patients' coping skills, with follow-up by a treatment plan that checks to see if the skills are being used and if they are effective.

In terms of prevention efforts, the following groups and problem areas should be targeted:

—*Women*—Encourage and support the development of innovative programs for Indian women, ones that provide support for women by linking up with other services in the community so that they can stay in treatment (e.g., child care services, assertiveness training to resist male domination, and special counseling services from the Indian woman's viewpoint).

—*Youth*—Encourage and support programs that actively reach out to Indian youth wherever they are (schools, recreation, natural groups including peer drinking groups) and that address the questions of value clarification; a clear concept of "self"; decision-making techniques, coping and just the basics of drug education, utilizing young Indian people as instructors or facilitators.

—*Fetal Alcohol Syndrome*—Support special demonstration projects that seek to identify women in the childbearing age groups, women already pregnant and those offspring with FAS with the intention of providing preventive and treatment services in an aggressive outreach program.

—*Violence*—Support programs that tie together services of other community agencies. Shelters, friends of the court programs and other strategies can be implemented in the community.

—*Troubled employees*—Support the development of a model troubled employee's program for tribes that are running their own programs. Many Indian people are rising to higher and higher positions of responsibility and stress, and sometimes they have little preparation for this. The result is an increasing number of troubled employees who get little or no service because they will not utilize the local "alcoholism program."

—*Research*—Support research that aims to answer some very pressing questions, such as: What works in prevention? What works in what combinations, for what kind of patient in treatment and rehabilitation? What minimal array of services has the greatest payoff in general for any Indian community? What are the strengths of Indian people that sustain them through centuries of programs aimed at their destruction as a cultural group? What survival skills are possessed by the community and by individuals who do not drink excessively? Much of this research could be done from the perspective of determining what is *right* about Indian culture, rather than what is *wrong*.

—*Training*—There are many problems in this area, not the least of which is the immense need by many groups for training, not just in alcoholism but in related areas such as mental health, crisis intervention, management principles, community education techniques, treatment strategies, etc. Since so many groups need so much training, there needs to be some decisions as to priority target groups (e.g., police officers, tribal judges and alcoholism counselors) and some decisions as to curriculum. No mat-

ter how large and varied a training project is, it cannot provide everything to everybody. In addition, whatever training is developed should be accredited so that those receiving the training can make use of it in a personal way (e.g., accreditation, degree requirements, or for re-licensure).

### Alcoholism - Individual or Community Problem?

At present, many tribal leaders take the view that alcoholism is a problem for the individual or, at most, the individual and his family. From this position it is natural and logical to support policies and programs that focus on the individual with the problem and, perhaps, his family.

Education of tribal leaders should be aimed at helping them to stop taking alcohol abuse for granted. It is not inevitable that five of the top ten causes of death among Indian people are directly related to alcohol abuse. They must be helped to see that alcoholism is preventable and, where it could have been prevented (in most individuals) but wasn't, it is treatable. They must be helped to see alcohol abuse as destructive and painful for the whole tribe.

This is very important since it influences what policies and programs tribal leaders will support. If, for example, the view is that alcoholism is an individual problem then policies and programs that target individual drinkers (e.g., driving under the influence laws, detox centers) may be supported. Such policies will usually be supported by the majority of citizens who perceive themselves as free from the problem of alcoholism but who want to do something for those perceived to be afflicted with the problem. For this reason the individualistic approach is popular with most political leaders and is currently in vogue.

If, on the other hand, the view is that alcohol abuse or alcoholism is an environmental problem then a different approach is needed. Policies and programs must address the environment and its institutions and seek to alter the conditions under which anyone can drink or act as a consequence of drinking.

Policies and programs that target the environment include such steps as: prohibition; restricted sales (e.g., by age limits, hours of sale, place of sale); taxing to increase prices; sale of alcohol in connection with food or recreational activities versus the "drinking only" setting; tax hard liquors to encourage a switch to diluted forms of alcohol, such as beer; programs to stress moderate consumption; rationing, as is being tried in Greenland; and increased recreational opportunities.

These policies and programs, because they apply uniformly to all drinkers whether or not they have drinking problems, are often not readily supported by the majority of citizens. Very often they are seen as restricting one's freedom. The failure of prohibition in this country illustrates this lack of majority support. In addition, special interest groups (e.g., the licensed beverage industry, bar owners and others) can be expected to oppose such policies and programs.

For these reasons, political leaders need a great deal of support and a sense of personal commitment if they are to support an environmental approach to the problem of alcoholism rather than an exclusively individual one. Demonstration projects which help tribal leaders develop a comprehensive set of policies and programs, utilizing both individual and environmental approaches, should be supported. ■

# Indian Communities Face Difficult Health Challenges in Coming Years

*In our last issue we published the first of a two-part interview with Dr. Emery A. Johnson, who retired from his position as Director of the Indian Health Service on September 1. In the first part of the interview, Dr. Johnson discussed some of his early career experiences as a reservation doctor. Among other things, Dr. Johnson indicated that his work on Indian reservations showed him the importance of community and tribal government involvement in health programs. In this second segment, Dr. Johnson discusses the role of tribal government in today's Indian health programs, and reviews some of the major health issues that will affect American Indians and Alaska Natives in the coming years.*

**HEALTH REPORTER:** With respect to Indian self determination, how effective do you feel this policy has been in allowing tribes to assume control of health programs?

**JOHNSON:** See what's happened and then you tell me whether it has worked or not. Over a relatively short period of time, 10 percent of the tribes are managing their entire health programs. We've got another third that have major components that they're managing. We have 90 percent that are managing at least part of their program. That's in five years, and we have not yet had one dry up. We have not yet had an Indian leader indicted, let alone go to jail, for mismanaging Indian Health Service funds. How many community programs can say that?

**HEALTH REPORTER:** Nevertheless, tribes have been critical of IHS and its implementation of Indian self determination.

**JOHNSON:** I'm not suggesting any perfection. This program has many imperfections and many problems with management, but I'm talking about balance. We have been able to come through potentially turbulent times, and not only maintained but enhanced the quality of clinical practice — the public health practice, the dental practice — and brought the tribes to a level of participation to a degree that I don't think any of us would have dreamed of ten years ago. It has not become dysfunctional, and the tribes that have taken over programs have been successful.

Some of the *best* health programs in this country are managed by tribes. I recently sent a professor from the University of Pennsylvania Wharton Business School to look at the health program of the Seneca Nation. He came back and said he could hardly believe it, it's such an excellent program. We've got some programs run by the tribes that are *every* bit as good as the best programs that we can offer and some that are better than we might offer.

**HEALTH REPORTER:** How have health professionals within the agency viewed this federal/tribal partnership?

**JOHNSON:** I used to say that we'd probably have a few problems at first, that are going to create some extra work, but if we ever get the relationship established, we'd see

that the community's involvement doesn't create problems for us but eliminates them. Bringing the tribe in as a partner is a tough thing for doctors, particularly because we're trained to think we're second to God, and some days not even second. It's terribly hard to respect and understand the need for this participation. In this respect, I think the Indian Health Service is years ahead of the United States community and the general practice of medicine, because I believe in time the mainstream of medical practice in this country is going to have to involve itself more with the community.

**HEALTH REPORTER:** How do Indian health programs differ from other health care delivery systems in this country?

**JOHNSON:** In the private sector, there's a tendency to design health systems for the convenience of the provider rather than in relationship to the needs of the people. Each doctor responds to the needs of his patients, but who worries about all those people who don't have a private doctor?

It's the difference in thinking; we tend to think about all the people in the community, not just the particular patients that come to us. We have a different concept in that we don't think on the basis of our practice. We think on the basis of the community. Because of the nature of our program and the community's involvement in it, we practice on a community basis to a degree that is not considered in the mainstream of American practice.

I'm not suggesting that this is ideal, because we have to get products of American medical schools and they are not taught to think in terms of community perspective. So we do have the extra problem of trying to help them reframe their sense of practice and to recognize the other parts of the community. We don't get 100 percent of the doctors to believe in this concept, but we have enough so there is some community concept.

**HEALTH REPORTER:** Do you think it's more difficult for a physician practicing in the Indian Health Service than in the private sector?

**JOHNSON:** Sure, it's tougher for a couple of reasons. In private practice a doctor may serve whom he pleases to serve, and the patient also has the option of going where they want. So, that puts another stress on the relationship between the physician and patient when there is no choice involved. And there are patients who are difficult patients because they're difficult people, and when you're out on the reservation they're going to show up in your waiting room five afternoons a week.

Medicine is a very stressful occupation to a degree that very few things in this world are. Doctors can never really get away from their job. They close the door to the clinic, but the problems of the day are still in their heads. The miracle to me has been the relatively few experiences that we've had of real clashes between doctors and communities, considering the thousands of doctors and

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*ELWOOD SAGANEY (left), Navajo tribal councilman and chairman of the National Indian Health Board (NIHB), chats with Dr. Emery Johnson and Dr. Edward Brandt during retirement dinner for Johnson. On behalf of NIHB, Saganey presented Johnson with a special award for his 26 years of service in Indian health.*

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### Indian Communities...

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millions of patient visits. I think that says a lot about the quality of the professional staff and also about the quality of the Indian community.

**HEALTH REPORTER:** What do you see as the major health challenges for Indian people and IHS in the coming years?

**JOHNSON:** I've pointed out frequently to Congress and others that we're now facing some of the most difficult problems, because we've dealt with a lot of those health problems that are treatable. For diseases such as trachoma and tuberculosis, we knew what to do and we could treat them.

Now we're talking about problems that require behavioral change, things like diabetes, homicide, suicide, and alcoholism. And, of course, most of the homicide and suicide is alcohol related. Those are problems that are going to be solved by behavioral change in individuals, families and the communities. The Indian Health Service has a role to play, but we can't cure these kinds of problems. As I keep pointing out, do not expect the Indian Health Service as an agency to eliminate the problem of alcoholism in Indian people. People say it's a medical disease, but doctors can't fix that kind of disease. And it's hard to understand obesity; medicine cannot fix the problem of obesity. People have to change their behavior, and these are the health problems that are so difficult to deal with.

So the Indian Health Service has some of the toughest assignments ahead of it. We've done all the easy things that medical science knew how to deal with. Now we're trying to deal with community kinds of problems where *no one* has the answer. No one has the answer to the problem of alcoholism in this country. It's not an Indian problem; the problem is just as true in white communities, in rich communities, poor communities and everywhere else. So we have to have much more involvement in the community

itself to try to work out the solutions. That's the real challenge that I see in the future for Indian communities and the Indian Health Service.

**HEALTH REPORTER:** How will these kinds of problems be addressed?

**JOHNSON:** We certainly don't have all the knowledge and tools and abilities to deal with them, because I think those haven't even been invented. But I certainly think that there's a couple of things that we've got going for us.

First of all, I think the Indian community has the basic cultural strength and a tradition of working together to solve community problems that I don't think is found in most other American communities. Here again, I think the Indian community is years ahead of the general U.S. community in terms of understanding the relationship between health and their involvement in the health process as a community, in their understanding of health planning and working things out together.

There's a sophistication about health in the Indian community that is not an academic sophistication but an understanding of how things fit together. That's what is going to be the strength in dealing with these problems, and I think the community and the professional staff together can do it.

**HEALTH REPORTER:** For the first time in more than 12 years, IHS will be dealing with these problems with a director other than yourself. What attributes do you feel are important for the position of Director of the Indian Health Service?

**JOHNSON:** I think first of all it's important that anyone in this job have a basic commitment to the Indian community and the Indian special relationship to the government of the United States, understand the government-to-government relationship and that what we're doing is part of an agreement between the government of the United States and the Indian Nations that goes back more than 100 years. It's carrying out a business agreement. This care is not free, but paid for by all this good land. It's also important to believe in people, believe in the wisdom of the Indian community, and believe in the commitment of their leadership to work for its community.

Besides that, obviously, it's got to be someone who knows what a health program is and understands the complexity of managing it. It's got to be someone who has a real strong commitment to management and who will work hard enough to understand the process and make it work. And it will take someone who has enough understanding of the imperfections of the world to realize that things are always going to be changing. The Indian health program is changed by evolution, not by revolution.

The program now is getting to where one of the hardest things is to keep up with the community. Any new director is going to have to keep pumping to keep the program up to speed with the development of the communities, which is a complete reversal of the way it was ten years ago. And that's the delightful part of it, you see, because the things that have to happen now are to a large extent generated in the community. You don't have to create this; you simply have to respond to it.

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**HEALTH REPORTER:** How do you feel about the time you've spent in the Indian Health Service, particularly serving as director?

**JOHNSON:** It's been a lot of fun, and the fun of it has been to see what happens. I can look back and see White Earth over 25 years. I can see the time when this was a colonial program and we've come from that to a program that to a large extent is an Indian partnership with the federal government. That evolution has taken place and it's been done without major catastrophe.

That's why it's been a good job. And the good things are a hundred times, a thousand times more than the bad times and frustrations. I leave it with a great deal of regret. I'll never do anything in my life that I've enjoyed as much as this, and yet I've come to the conclusion that there is a time, and when that time comes you need to make a decision.

**HEALTH REPORTER:** And you feel this is the time to retire?

**JOHNSON:** To the best of my judgment, this is the time.

**HEALTH REPORTER:** Is there any highlight that particularly sticks out over the past 25 years?

**JOHNSON:** When you look at the changes in health standards, you can say Indian babies and mothers are no longer dying like they used to. Indian kids are living longer; Indian mothers and fathers are living longer, and they're healthier people than they were 25 years ago. When you talk about the ultimate highlight, it has to be that. And that's the final evaluation, what really happened with the health of the people. It is better; it's clearly, demonstrably, and impressively better than it was 25 years ago. ■

## Indian Handicapped Face Unique Problems on Reservations

by Carol Jones, Administrative Assistant  
Administration for Native Americans

*Cage the badger and he will try to break from his prison and try to regain his native hold. Chain the eagle to the ground — he will strive to gain his freedom, and though he fails, he will lift up his head and look to the sky which is home . . .*

Navajo Headman, 1868

In the spring of 1976, the first Inter-Tribal Symposium on the subject of handicapped Native Americans was held at Window Rock, Arizona on the Navajo Reservation. The symposium brought together handicapped Native Americans, their parents, friends and advocates from all over the United States. Although the symposium centered around the situation of the Navajos, it presented a new effort focusing on the unique problems of all handicapped Native Americans.

The following information was taken from a report on the Window Rock meeting. Titled "He will lift up his head," the report was developed through a contract awarded by what is now the HDS Administration on Developmental Disabilities. It was prepared by James S. Haskins and J.M. Stifle and documents the problems faced by handicapped Native Americans — problems still faced in 1981, The International Year of Disabled Persons.

The primary goal for the handicapped Native American — equal access to public services so that they may become productive members of society — is certainly the same for all handicapped people. But because Native Americans occupy a unique position in American society, especially Native Americans living on reservations, the problems of Native American handicapped people demand unique solutions. Inadequate education, few treatment and rehabilitation facilities, and lack of appropriate housing are among the problems which keep them outside the mainstream of society.

Here are some facts about the problems which plague the handicapped Native American: — In spite of the increases in personnel and the improvement and construction of health facilities that have taken place since 1955, health care services for Indian people still lag far behind the national standard.

— While exact figures for all tribes are not available, the Indian Health Service (IHS) and others indicate that 37 percent of young Indian children enter school with hearing defects; 25 percent enter school with speech, visual, emotional and other impairments.

— Utah State University conducted a study involving 2,000 Inter-mountain Indian School students which found that 53 percent had visual defects that could not be helped with corrective lenses. Of 308 students who had their hearing tested, 32 percent had significant hearing losses.

— The Indian Health Service reports a high incidence of Indian children between the ages of one and five who contract diseases, such as meningitis, which produce high fevers that often lead to brain damage. Approximately 200 infants are admitted to Public Health Service facilities with such diseases each year.

— Two other important elements in the lives of handicapped Native Americans are housing and employment. The situation of the handicapped with regard to adequate housing and employment is particularly acute. Their needs must compete with those of the general Native American population.

One of the first priorities of any grassroots movement to achieve parity for the handicapped must be public education. The public, particularly the families of the handicapped, must be made aware of the true nature of handicaps. In this way, cultural prejudice handicaps can be wiped out.

The plight of the handicapped Native American is serious, but there are signs of optimism. Today, many tribes are planning and providing services for their

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# Sioux Tribal Home Therapy Services Aid Troubled Families

SISSETON, S.D. — In an effort to strengthen the family structure on its reservation, the Sisseton-Wahpeton Sioux Tribe has initiated a unique program that provides comprehensive home-based services to troubled families.

According to tribal family therapist Vince Two Eagles, such families have often broken up and had their children placed in either a state foster home or an adoption agency. But through the tribe's Child Protection Program the families are now being provided culturally oriented home counseling services that help reduce the incidence of adoption and family separations.

The problems leading to child adoption and the evolving deterioration of the family structure spurred the tribe three years ago to provide its own foster care, adoption and counseling services to reservation families, says Two Eagles.

Originally, the focus of the program was to prevent placement of tribal children outside their natural home, he said. "When it first began the tribe found the state was overwhelming with caseloads and was never able to give intense, long-term service to the families. As a result of this the tribal staff felt that family therapy had to be developed and implemented," said Two Eagles.

Out of this initial effort came the "In-Home Services Project." The project, according to Two Eagles, was a pilot program funded by the state of South Dakota in an effort to identify the families who were in danger of losing their

children, and to provide a counseling approach based on the historical recognition of "parenting" as a learned process.

"In our case," says Two Eagles, "many of our dysfunctional families have parents who were raised in boarding schools and therefore never learned parenting, marriage, or home management skills because of a lack of adequate role models."

Statistics gathered from the Child Protection Program indicate that during 1979-80 over 160 families (dysfunctional due to lack of parenting skills or any learned behavior parenting models) had been counseled. The statistics also show a significant reduction in child adoption and family separation.

The success of the program is a result of the staff's constant interaction with troubled families, says Two Eagles. Weekly visits are made by a family therapist, and two parent aides meet with the families daily to work on home management and parenting skills.

Funding has run out for the In-Home Services Project, and according to Two Eagles, the timeframe designated for the project was not sufficient to accurately measure the effectiveness of a concept relatively new to the reservation area.

"Some families need more than one year to rectify many years of dysfunction," says Two Eagles. ■

## Indian Handicapped...

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members, including handicapped persons. As functioning units of government, tribes are coordinating resources — federal, state and tribal — toward their needs and priorities. This is a step toward self-determination and self-sufficiency.

Tribes which run their own programs must be aware of their responsibility for the civil rights of all individuals, including handicapped people. Section 504 of the Rehabilitation Act of 1973 provides, in part, that qualified handicapped persons cannot be denied the benefits of any program or activity receiving federal assistance.

In 1979, the Administration for Native Americans and the Office for Civil Rights within the Department of Health and Human Services began a joint project to provide training and technical assistance on Section 504. The contractor, Minority Enterprise Service Associates of Orem, Utah, has trained more than 2,100 people in 24 workshops, including representatives of tribal governments and councils, handicapped persons and advocates from tribes and off-reservation organizations. At times, severely disabled persons traveled hundreds of miles across almost impassable reservation roads to attend. One handicapped participant said, "I didn't know handicapped people had any rights until I attended this workshop."

The contractor also developed a Section 504 Training and Technical Assistance Manual, and limited quantities are still available. Call or write Carl Moore, project director, or Sandy Lucas, technical assistance specialist; Minority Enterprise Service Associates; 1156 South State, Suite 105; Orem, Utah 84057. The toll-free number is 1-800-453-1183. ■

## Inter-Tribal Group to Address Bemidji Health Concerns

MARQUETTE, MICH. — For the first time since the Bemidji Area Indian Health Board was dissolved seven years ago, the 29 tribes in the four state area of Michigan, Wisconsin, Minnesota and Iowa have an official forum to address Indian health concerns.

At a meeting of the Four-State Inter-Tribal Assembly here September 21-22, delegates from the 29 tribes voted to designate the assembly as the official Indian organization for speaking to tribal health concerns in the four-state region. In addition, the Four-State Inter-Tribal Assembly will, in the absence of a Bemidji Area Indian Health Board, serve as the official area organization to the National Indian Health Board (NIHB).

More than 400 representatives from the 29 tribes met for the two-day session here to examine tribal issues related to federal budget reductions, hunting and fishing rights, economic development, health, and other matters. The 29 area tribes plan to convene regularly at least every six months these issues on an ongoing basis.

Donald LaPointe, a Chippewa from Houghton, Mich., who was the last chairman of the Bemidji Area Indian Health Board, was appointed as the assembly's area representative to NIHB. He has a long history of involvement in the field of health, having worked with the state mental health department for 8 years, and has been active in tribal health and alcoholism programs for 11 years. LaPointe has also been involved with Indian education projects on a national, state, and local level. ■

# Training Seminars Focus on Nutrition, Food Science

SANTA FE, N.M. — Preparing hospital and institutional foods that retain flavor, nutrients and color is no easy chore; nor is teaching students that through nutrition and diet control, many illnesses and diseases can be prevented.

Skills such as these, as well as food management and supervision, are presently being offered to Native Americans through the Indian Health Service (IHS) Nutrition and Dietetics Training Program.

The program, located at a training center on the grounds of the IHS hospital here, serves as the principal IHS focus for career development and training in nutrition and dietetics, says program chief Dr. Yvonne Jackson.

In the past five years, says Jackson, the program has provided training in nutrition and hospital food service to 867 American Indians and Alaska Natives. Of these, 537 were employed by tribal programs having a food and nutrition component and 330 were IHS employees.

The program proves valuable in that it prepares its participants for careers in the field of nutrition and dietetics, says assistant chief Martha Cornelius. "Three students who completed the Hospital Food Service Supervisors Course decided to further their education and are now Registered Dietitians," says Cornelius. Others have gone on to study hospital administration and are now in administrative positions, she said.

One of the program's graduates was an Isleta Pueblo man who completed the training program and went to Bethel, Alaska as a hospital food service supervisor. Shortly after his arrival there was a power blackout and the hospital was the only place that had an emergency generator, said Cornelius. "They prepared meals for the whole village for five days until the power was restored.

Since that time he has become the hospital's administrator," she said.

Before this program, which began 13 years ago, there was no such training for Native Americans, continued Cornelius. More than 90 percent of those trained in the program are still employed by IHS hospitals, she says.

The program's courses, which run from two to six weeks, consist of developing skills in nutrition science, food management and supervision, food preparation and nutritional care for specific age groups.

For further information on the program contact: Martha Cornelius, Assistant Chief; Nutrition and Dietetics Training Program; Indian Health Service; P.O. Box 5558; Santa Fe, N.M. 87502; or phone (505) 988-6470. ■

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