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Indian Health Service Alcoholism/Substance Abuse Program

Background, Plenary Session, and Action Plan

IHS Alcoholism/ Substance Abuse Prevention Initiative

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Preface

The Indian Health Service (IHS) is an organization in transition. Many of the health challenges of the past are now under control: trachoma is effectively eradicated; neonatal mortality among American Indians and Alaska Natives is lower than for the rest of the U.S. population; and tuberculosis has declined dramatically. However, many "new" diseases affecting American Indians and Alaska Natives demand effective disease prevention and health promotion programs. In 1986, IHS began a dramatic shift of resources to address these issues.

Indeed, 1986 is a most auspicious year in the history of alcoholism/substance abuse programs serving American Indians and Alaska Natives. It is a year of renewed focus on a problem that has plagued these communities for many years. It is a moment in time that marks the beginning of an intensive community-based effort to prevent this major health program that, perhaps more than any other, influences the lives of American Indians and Alaska Natives. *IHS Alcoholism/Substance Abuse Prevention Initiative: Background, Plenary Session, and Action Plan* is the manifesto of the program expectations for the future.

This document has been developed as part of a management review of the alcoholism programs that was requested by the Director of IHS, Everett R. Rhoades, M.D., and initiated in the summer of 1984. A number of national and international authorities were invited to perform the review and to (1) define the information necessary for a review; (2) examine this information in concert with IHS managers and tribal managers and leadership; and (3) recommend future actions for improving the alcoholism programs.

The background section is designed to expose the trends and issues affecting the alcoholism programs prior to 1984. The three major trends identified in that section underscore the critical and primary commitment of Indian community leaders in the development of Federal support and involvement in addressing this health problem. The first trend was the initiative of tribal members themselves that led to Federal funding in the 1960s. From the beginning, community commitment to the resolution of this issue has been the driving force.

Historically, a second recognizable trend has been an intensive investment in treatment programs. This is reflected by the number of Indian communities with programs aimed at detoxification and rehabilitation efforts. This in part reflects the prevailing belief that was dominant in the 1960s when many programs started that the treatment model was the most useful and necessary approach to the problem. The results of attempts to treat alcoholism as a disease, exclusively using the medical model, are outlined.

A third trend is the isolation of many of the programs. This isolation is of a kind and degree not unlike that suffered by many programs dealing with health problems not traditionally included in medical environments. This theme has had many ramifications on the past performance of the alcoholism programs.

The second section, the plenary session, documents the proceedings of the second stage of the alcoholism programs management review. This session took place in Denver, Colorado, in May 1985. It brought together IHS managers, tribal managers and leadership, and the aforementioned authorities to review and discuss in some detail the successes and failures of the Indian alcoholism programs and to define future directions for these programs. Five intensive days were devoted to these discussions.

The full emotional impact of this 5-day meeting cannot be totally appreciated in the proceedings transcribed in the plenary session section. The intensity of concern expressed by the Indian community members was difficult to capture. However, the meeting closed with a great deal of optimism and unity in the face of these extremely difficult issues. There was also satisfaction that a substantive and tangible effort was well begun.

The last section, the action plan, is a presentation of the recommendations developed by the contributors in the plenary session. The tasks listed are a collation of the 173 recommendations generated in Denver. They were organized by the invited authorities and the steering committee to reflect the management approach utilized by IHS. Included are target dates for completion and the accountable parties for accomplishing these tasks. The completion of the tasks is currently "on target" with recommended dates.

The action plan has been designed to address all of the relevant management functions. These functions include: planning, standards setting, monitoring, evaluation, resource management, operations, coordination, research, and training. A definition of each function is included in the body of the document. Development of a major redirection of the programs logically requires that goals be defined and performance standards established before a monitoring tool can be finalized. Thus, the recommendations for planning and standards setting are addressed prior to detailed monitoring steps.

This document reviews the history of the American Indian and Alaska Native alcoholism programs and presents a road map for the future. It establishes a new priority. IHS will, in collaboration with other Federal entities, and especially tribal communities, establish an effective and permanent alcoholism/substance abuse prevention program. This will demand enhancement of treatment program effectiveness and realignment of resources. The effort will require commitment and creativity from all participating parties and many changes that are radical departures from things as they have been. This document provides the rationale, structure, and strategies—a new direction to combat alcoholism and substance abuse.

Acknowledgments

Through their active assistance and collaboration, numerous individuals and organizations made invaluable contributions toward the development of this foundation document. They provided helpful suggestions, observations, background, and data bearing on the complex scientific, clinical, and societal issues. All of these efforts, spanning more than 2 years, culminated in the publication of this timely and provocative document.

The editors especially wish to express their gratitude for the major and vital contributions made by the following people.

- Richard L. Zephier, Ph.D., Ina C. Palmer, R.N.M.S., and Patricia D. Mail, M.P.H., prepared the background section, with staff work by L. Della Valincia.
- The steering committee members, tribal leader representatives from each IHS area or program office, alcohol program representatives from each IHS area or program office, IHS area alcoholism coordinators, selected IHS line and staff officials, the National Indian Health Board and staff, and the invited presenters collectively made possible the successful implementation of the plenary session, which led to the final product, the action plan.
- Special recognition is offered to reviewers, who are known nationally and internationally for their contributions to the field of alcoholism and substance abuse management, prevention, and research. These individuals provided great insight and effort in accomplishing this review.

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- Management efforts by Patricia DeAsis and staff work by Laura West and Lisa Bowman assured the success of the project logistics.

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Background

Background: Native Americans and Alcohol

Native American Introduction to Alcohol

The Native American population was "discovered" in the late 15th century by European explorers seeking a new passage to India for trade. Sailing into what are now known as the Caribbean Islands, the inhabitants of the New World were incorrectly identified by the explorers as "Indians." This name has persisted, and it is the term by which both Native Americans and nonnatives alike refer to the New World peoples.

During the early European migrations to the New World, several diseases were transmitted to the Indian populations to which they had had little or no prior exposure. The most devastating of these were smallpox and tuberculosis. Syphilis was less immediately destructive. Another "disease" that the European immigrants carried with them is one that continues to this day to have serious consequences for Indian people. This is the disease commonly known as "alcoholism."

The majority of Indians in the New World had no prior experience with alcohol, and thus they had little understanding of its use or functions. There were only two groups north of Mexico who had discovered and manufactured beverage alcohol prior to European contact. These were both located in what is now the American Southwest: the "O:odham," or the Hohokam peoples of the Sonoran Desert in northern Mexico and southern Arizona (Underhill 1938; Driver 1955), and the Apaches, or the Athapascan descendants of the Alaskan emigrants (Driver 1969; Bruman 1941). Both the Hohokam (latter day Pima-Papago) and Apachean peoples fermented a beer-like beverage called "nawait" or "cactus wine" by the Papago (Saxton and Saxton 1969; Davis 1920) and "tulapai" or "tiswin" by the Apaches (Flannery 1932; Hrdlicka 1904). However, the vast majority of Native Americans had had no exposure to alcohol. Even those who did have experience with alcohol did not have problems with abuse until the introduction of Western European liquors (Boyer 1964) and the behavioral models presented by the trappers, sailors, and frontiersmen with whom they came in contact (Winkler 1969).

Initially, some tribes were much more receptive to alcohol use and its perceived and obvious effects because of elements and practices within their cultures that predisposed them to acceptance (Levy and Kunitz 1974), such as rituals that were facilitated and supplemented by its use (e.g., the Iroquoian dream quest) (Carpenter 1959). However, some Indian leaders were cautious and spoke out against the use

of alcohol. Indeed, the initial effects of alcohol in those Indians who were encouraged to drink were often so violent and "wild" that they alarmed the "settlers." Still, hunters and trappers traded alcohol for furs all along the frontier, despite laws to the contrary, and the liquor trade continued to flourish in one manner or another until the national prohibition era (Bearass 1968; Heaston 1971; Prucha 1970; Viola 1974). (See appendix A.)

Sanchez (1967) divided the history of Indians and alcohol into three major phases: the impact period, the prohibition period, and the recreation period. In the impact period (15th century to 1850), alcohol was introduced to the Indians. Initially, because it had been the European custom to drink together to signify friendship or to mark ceremonial occasions, the Indians were encouraged to join in this practice. Later, alcohol became a valued trade commodity, and its effects rapidly spread into the less settled parts of the New World. All of the Western European and Russian explorers, trappers, and traders carried and used alcohol. Rum, brandy, and vodka were in common use by the early 1800s. But while liquor was being used for trade with the Indians, its use by them was being legislated against, first by the individual colonies, and finally by the newly formed United States Congress. Efforts to control Indian drinking culminated with the passage of the 1832 Indian Intercourse Act.

The prohibition period (1850 to 1953) was characterized by legal sanctions against the purchase, possession, transportation, and use of alcohol; however, bootlegging and illicit trade in whisky and other spirits flourished in Indian territories and among Indian peoples everywhere. It was during this period that the majority of the Indian treaties were negotiated, and common to all treaties was a clause prohibiting alcohol on newly created Indian reservation lands. Concurrently, but for a shorter stretch of time, alcohol was banned for the entire Nation under the 18th amendment (1919 to 1933). Illegal production and sale of liquor was unmanageable, so the amendment was repealed. However, prohibition of liquor for Indians was continued until it was finally rescinded in 1953. By the time it became legal for Indians to buy, possess, transport, and use alcohol, the abuse of alcohol was a widely acknowledged problem among Indians.

The recreation period (1953 to present) encompasses the time from the legalization of Indian alcohol use onward. No longer prohibited, except on those reservations choosing to continue prohibition within their boundaries, alcohol became available for use in a social and recreational context, so-called "normal" drinking. But after a century and a half of prohibition, few Indians have used alcohol in any context except that of rapid consumption, or "drinking to get drunk." Social drinking practices may eventually become a possibility for many Indians, but few have used alcohol in this manner up to the present.

There is considerable literature investigating each of these periods. Historical recounts can be found in the writings of missionaries and early settlers as well as contemporary historians. Information about the prohibition period is available from government and judicial records and has been reviewed by historians, sociologists, and anthropologists. The most recent findings and speculation concerning the effects of alcohol on Indians are presented in a multitude of forums, from medical to journalistic.

Alcoholism as a Disease

Alcoholism is a disease that continues to incapacitate and kill Indians at rates far above those for the non-Indian population. As a disease, it is considered to be a treatable entity, but unlike organism-caused diseases, against which we can usually vaccinate or immunize, there is no simple cure. Treatment of alcoholism requires a change in manner of living, shifting from "user" to "abstainer" on a permanent basis.

Although alcohol arrived in the New World in the late 15th century, it was not considered to be at the root of any disease until nearly two and a half centuries later. The term "alcoholism" was coined in 1849 by Magnus Huss, a Swedish physician. The disease concept of alcoholism was first articulated by researchers such as E.M. Jellinek in work beginning in the 1940s. However, as Blume (1983*a*) observed, the initial conceptualization appeared in the late 18th and early 19th centuries and is attributed to Benjamin Rush of Philadelphia, the father of American psychiatry and Thomas Trotter of Edinburgh, Scotland. Rush was the first to express the idea of drug addiction, and alcohol was the first drug to which this addiction concept was applied (Levine 1978). As Blume (1983*b*, p. 11) outlined, "Rush described 'habitual drunkenness' as an involuntary condition, stated that it was a disease caused by

Table 1.—Leading causes of death among American Indians and Alaska Natives, 1981-1983, compared with the U.S. general population, 1983

Cause of death[a]	Indians and Alaska Natives, 1981-1983		All races, 1983	
	Number	Percent	Number	Percent
Diseases of the heart (1)	4,220	21.9	755,592	38.3
Accidents (4)	3,324	17.3	94,082	4.8
Malignant neoplasms (2)	1,966	10.2	433,795	22.0
Chronic liver disease and cirrhosis (8)	949	4.9	27,690	1.4
Cerebrovascular diseases (3)	915	4.8	157,710	8.0
Pneumonia and influenza (5)	638	3.3	48,886	2.5
Homicide (9)	612	3.2	22,358	1.1
Diabetes mellitus (6)	594	3.1	34,583	1.7
Suicide (10)	565	2.9	20,794	1.0
Certain conditions originating in the perinatal period (7)	383	2.0	28,242	1.4
Other	5,071	26.4	352,065	17.8
Total	19,237	100.0	1,974,797	100.0

[a]Numbers in parentheses=ranking for all races.

Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Department of Health and Human Services, 1986.

Table 2a.—Leading causes of death among American Indian and Alaska Native males, 1981-1983

Cause of death	Number	Percent
Accidents	2,472	21.4
Motor vehicle	1,321	11.4
Other	1,151	10.0
Diseases of the heart	2,463	21.3
Malignant neoplasms	1,229	10.6
Chronic liver disease and cirrhosis	534	4.6
Suicide	474	4.1
Cerebrovascular diseases	444	3.8
Homicide	444	3.8
Pneumonia and influenza	357	3.1
Diabetes mellitus	250	2.2
Certain conditions originating in the perinatal period	221	1.9
Other	2,649	23.0
Total	11,537	100.0

Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Department of Health and Human Services, 1986.

'spirituous liquors,' and further stated that total abstinence was necessary for its cure."

Considerable time elapsed before alcoholism was officially codified as a disease. Alcohol addiction and alcoholism were first listed in the *American Standard Classified Nomenclature of Disease* in 1933 (Blume 1983*b*, p. 10), but consensus diagnostic criteria were not published until 1972, when the National Council on Alcoholism promulgated its *Criteria for the Diagnosis of Alcoholism.* Blume (1983*b*, pp. 7-8) defined "disease" as "a condition in which bodily health is seriously attacked, deranged, or impaired; sickness, illness" in which the underlying pathogenesis is clearly understood. While the idea evolved slowly that alcoholism is a disease, it was the work of Jellinek and others, and the birth of Alcoholics Anonymous in 1935, that stimulated the acceptance of the disease concept. Jellinek's writings broadened the scope of consideration to include individual physical, psychological, and social factors in the disease and provided strong support for the treatability of alcoholism (Blume 1983*b*, pp. 11-12).

By the beginning of the 20th century, the adverse consequences of alcohol consumption by Indians had been clearly established. By the second half of the century, alcohol abuse had been declared one of the most serious health problems facing Indian peoples (Indian Health Service 1969, p. 17). The deadly effects of this alcohol abuse is most evident by examination of the causes of death for American Indians from 1981 to 1983. (See tables 1 and 2a,b.)

Table 2b.—Leading causes of death among American Indian and Alaska Native females, 1981-1983

Cause of death	Number	Percent
Diseases of the heart	1,757	22.8
Malignant neoplasma	1,111	14.4
Accidents	852	11.1
Motor vehicle	548	7.1
Other accidents	304	4.0
Cerebrovascular diseases	471	6.1
Chronic liver disease and cirrhosis	415	5.4
Diabetes mellitus	344	4.5
Pneumonia and influenza	281	3.6
Homicide	168	2.2
Certain conditions originating in the perinatal period	162	2.1
Nephritis, nephrotic syndrome, and nephrosis	154	2.0
Other	1,985	25.8
Total	7,700	100.0

Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Department of Health and Human Services, 1986.

Alcohol abuse is frequently cited as a direct contributing factor for at least 4 of the top 10 causes of death: accidents, liver disease (cirrhosis), homicide, and suicide. In addition, excessive alcohol is known to be deleterious to human physiology. Thus, alcohol abuse could hasten death from heart disease, cerebrovascular disease, diabetes, cancers, and could possibly contribute to debilitating and fatal conditions affecting newborns, such as fetal alcohol syndrome. Deaths from pneumonia or influenza could also be affected by alcohol abuse due to a lowering of disease resistance. In essence, alcohol abuse may significantly contribute in one way or another to each of these 10 killers of Indian peoples.

Age-specific alcoholism mortality rates for Indians and Alaska Natives are shown in table 3 and figures 1 through 5. In table 4 and figure 3, note a gradual rise in the death rates due to alcoholism from 1969 to 1973 and the beginning of a reduction in the death rates thereafter. This decline can be attributed to three major factors: 1) development of specific treatment standards in 1980 and implementation of a treatment guidance system; 2) increased primary prevention activities, targeted at school populations, individuals, and communities, utilizing workshops and mass media; 3) improved program effectiveness and efficiency motivated by the implementation of performance evaluations of contractors from 1982 to 1984 examining goals; objectives; policies; procedures; and outcomes to assure effectiveness, efficiency, appropriateness, and adequacy of programs.

Table 3.—U.S. alcoholism mortality rates per 100,000 by age and sex

Age (yr)	All	Males	Females
	Indians and Alaska Natives[a]		
Under 5	—	—	—
5-14	0.1	0.2	—
15-24	2.3	3.2	1.4
25-34	24.7	32.7	17.0
35-44	61.1	80.3	43.1
45-54	85.0	109.2	62.6
55-64	70.2	97.4	45.9
65-74	57.7	101.3	21.9
75-84	24.5	36.1	15.5
85 or more	18.4	30.8	10.2
	All races[b]		
Under 5	0	0	0
5-14	0	0	—
15-24	.2	.3	.1
25-34	2.2	3.0	1.4
35-44	7.9	11.8	4.1
45-54	17.6	26.4	9.4
55-64	21.4	33.3	11.0
65-74	17.7	30.3	8.1
75-84	7.9	15.4	3.5
85 or more	2.2	5.4	.9
	All races excluding whites[b]		
Under 5	0	0	0
5-14	0	0	—
15-24	.3	.5	.2
25-34	6.2	7.8	4.7
35-44	20.9	31.7	11.6
45-54	34.5	53.9	18.6
55-64	33.5	54.4	17.0
65-74	20.7	35.4	10.0
75-84	9.7	18.6	4.0
85 or more	3.4	4.4	2.9

[a]Data from States with reservations from 1981 to 1983.

[b]Data from 1982.

Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Department of Health and Human Services, 1986.

Table 4.—U.S. alcoholism deaths and mortality rates, 1969-1983

Year	Number of deaths		Age-adjusted rates[a]		Ratio
	Indians and Alaska Natives	All races	Indians and Alaska Natives	All races	
1983	293	15,424	28.9	6.1	4.7
1982	298	15,596	30.9	6.4	4.8
1981	338	16,745	36.1	7.0	5.2
1980	382	17,742	41.3	7.5	5.5
1979	398	17,064	45.1	7.4	6.1
1978	437	18,490	54.5	8.1	6.7
1977	429	18,437	55.5	8.3	6.7
1976	425	18,484	58.2	8.6	6.8
1975	403	18,190	62.2	8.6	7.2
1974	417	18,530	64.2	8.6	7.5
1973	399	17,791	66.1	8.6	7.7
1972	315	17,484	55.0	8.6	6.4
1971	334	16,891	62.9	8.4	7.5
1970	272	16,130	56.2	8.1	6.9
1969	267	15,138	56.6	7.7	7.4

[a]Rates per 100,000.

Note: For 1969-1978, includes deaths due to alcoholism, alcoholic psychoses, and cirrhosis of the liver with mention of alcoholism. For 1979 and after, includes deaths due to alcohol dependence syndrome, alcoholic psychoses, and chronic liver disease and cirrhosis specified as alcoholic. Population estimation methodology for the Indian and Alaska Native population revised in 1976. Maine, New York, and Pennsylvania included as reservation States beginning in 1979. Connecticut, Rhode Island, and Texas included as reservation States beginning in 1983. Decennial census population counts used for 1970 and 1980.

Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Department of Health and Human Services, 1986.

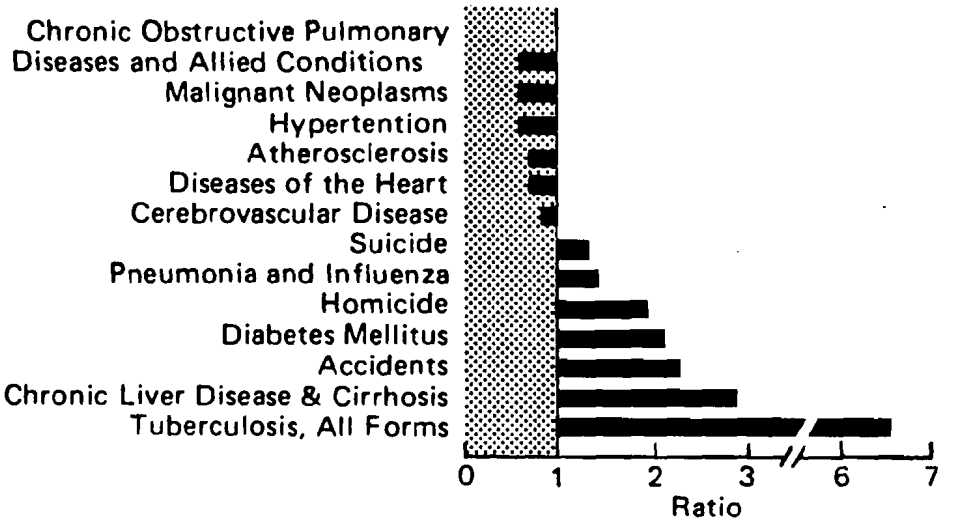

Figure 1. Selected U.S. age-adjusted death rates: ratio of Indians and Alaska Natives to general population. Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Indian Health Service, 1986.

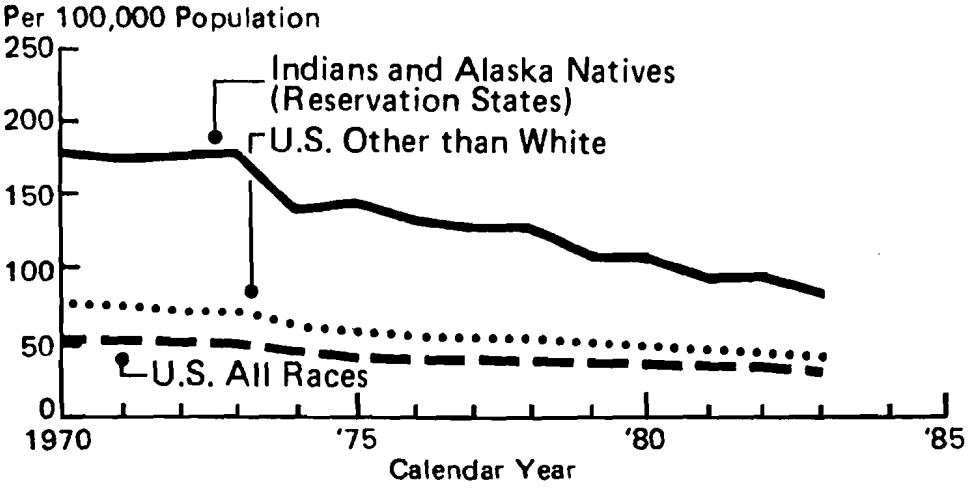

Figure 2. U.S. age-adjusted accident death rates for Indians and Alaska Natives from States with Indian reservations, nonwhites, and general population. Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Indian Health Service, 1986.

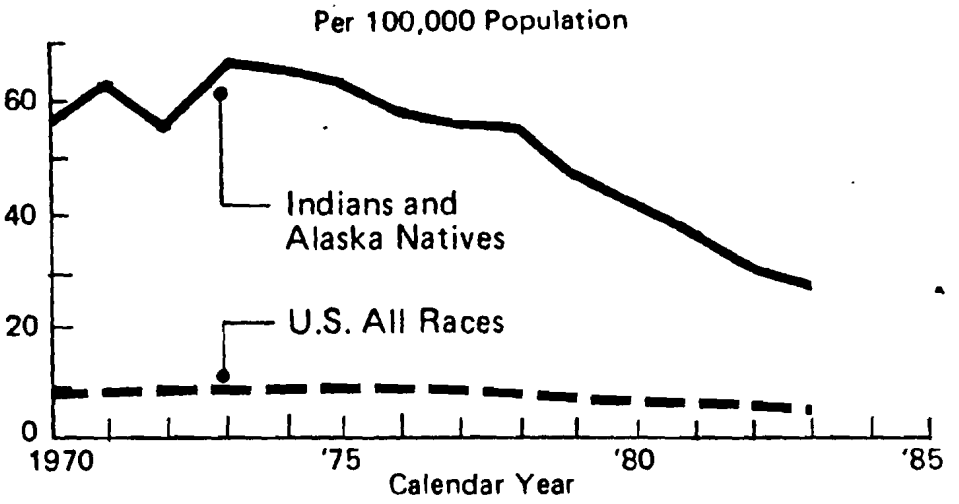

Figure 3. U.S. age-adjusted rates of deaths due to alcoholism for Indians and Alaska Natives and general population. Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Indian Health Service, 1986.

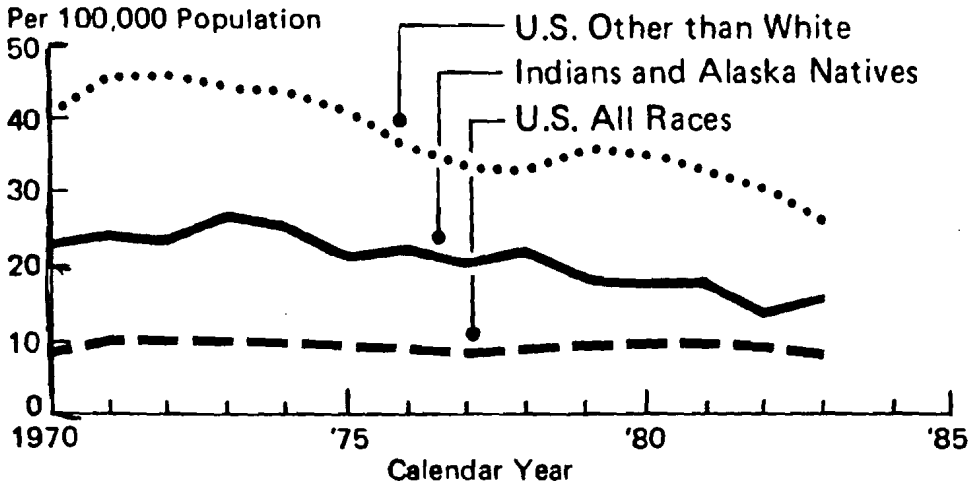

Figure 4. U.S. age-adjusted rates of death due to homicide for Indians and Alaska Natives, nonwhites, and general population. Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book.* Rockville, Md.: Indian Health Service, 1986.

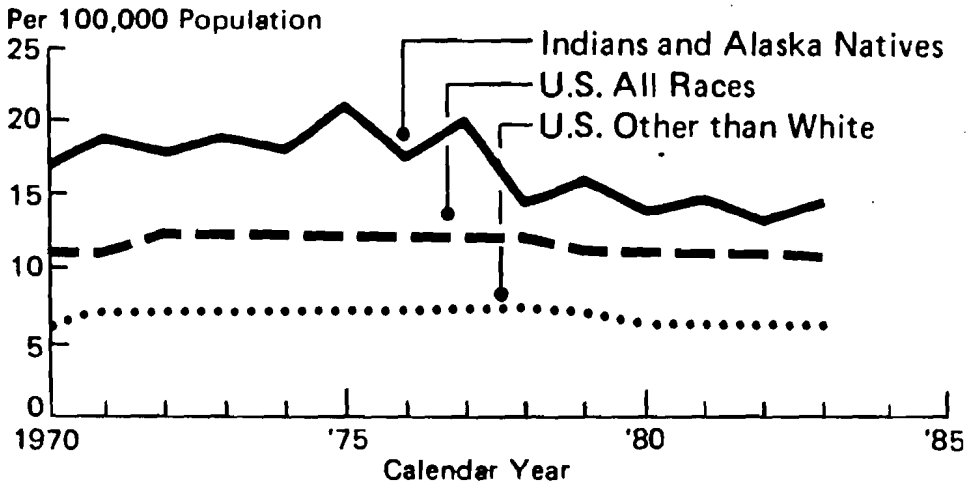

Figure 5. U.S. age-adjusted rates of death by suicide for Indians and Alaska Natives, nonwhites, and general population. Source: Indian Health Service, Program Statistics Branch. *Indian Health Service Chart Series Book*. Rockville, Md.: Indian Health Service, 1986.

Data recently compiled by the Indian Health Service (IHS) (1984*a*, p. 3) demonstrate a significant increase in Indian life expectancy. In 1939, Indian life expectancy at birth was 51 years. By 1981, it was 71 years, representing a gain of 20 years in life expectancy, accomplished primarily by reduction of mortality from acute and infectious diseases and major efforts to improve sanitation. Efforts to combat alcoholism will help to contribute to this trend.

Alcohol Morbidity

Although a number of Indian people die each year as a direct result of alcohol-related illnesses or injuries, many more experience the more pervasive and insidious consequences of alcohol abuse: chronic disability, loss of earning capacity, family disruption, incarceration, and considerable pain and illness.

Andre (1979) reported "approximately 70% of all treatment services provided by the IHS directly through its hospitals and clinics, or purchased by the IHS from contract providers are for alcohol-related conditions." He listed the causes of morbidity that he identified to be directly related to alcohol abuse but that do not immediately result in death: accidental injuries, cirrhosis of the liver, alcoholism, attempted suicides, attempted homicides, malnutrition, pancreatitis, gastrointestinal bleeding, fetal alcohol deformities, mental and emotional disorders, organic brain syndromes, alcoholic heart disease, primary cancer of liver and pancreas, and family violence (abuse/neglect) (Andre 1979, pp. 5-6).

He also suggested causes of morbidity that are aggravated by alcohol abuse and/or indirectly related to it: infections, diabetes mellitus, convulsive disorders, hypertension and heart disease, respiratory disorders, neuritis, and anemias.

In addition to data reported from outpatient and inpatient admissions and alcohol programs, a review of the mental health reporting system (Andre 1979, addendum 2) has yielded additional information on the pervasiveness of problems caused by alcohol abuse.

1. Between fiscal year (FY) 1974 and FY 1977, alcohol misuse ranked as the number one problem in terms of the number of patients seen by mental health staff within IHS.
2. Alcohol abuse was 1 of the 3 most frequently seen problems as reported by mental health staff in 8 of the 10 IHS areas.
3. For this same period, the number of patient visits for alcohol misuse increased by 57 percent, 20 percent in FY 1977 alone.
4. The second and third most common problems in terms of frequency of diagnosis between FY 1974 and FY 1977 were anxiety and depression. In this period, anxiety increased 137 percent and depression, 130 percent. Both were commonly secondary to alcoholism within the family.

Of particular concern to many Native American groups is self-destructive behavior. Many reports indicate that Indian suicides and suicide attempts are accompanied by intoxication. The literature contains many thorough reports on self-destructive behavior. These span many years and reflect observed experience among many tribes or cultural groups. All of the studies have indicated that Indian suicides occur at rates far above the rates for all other races in the United States (see tables 5 and 6). However, it is important to keep in mind three influences on suicide data.

1. There is enormous variation among groups. Not all groups have a major problem with suicides, but for those reported, almost all suicide rates are above the U.S. all-races rates.
2. Investigators tend to examine communities-in-crisis, which may artificially inflate rates during the study period.
3. Some cultures have traditions and values that do not condemn self-destruction, and cultural predisposition may influence rates.

Data on delinquency, homicide, assaults, and other criminal justice statistics also reflect the sociocultural impact of alcohol abuse. In a review of Indian alcohol literature from 1900 to 1975, some 1,009 articles and papers were reviewed (Mail 1982, p. 14). Of these, 37 percent (378) discussed physical and social pathologies directly related to alcohol abuse. There are less data available on the specific impacts of alcohol abuse and alcoholism among Indian women and children.

Alcohol Use Among Indian Women

One of the areas in which few investigations have been conducted is the use of alcohol by Indian women. While all of the reports suggest that far fewer women abuse alcohol than do men, those women who do abuse alcohol cause great concern. It has often been noted that Indian women have been a major stabilizing factor during

Table 5.—Studies reporting suicide rates for suicides associated with alcohol abuse

Cultural group or tribe	Suicides (per 100,000)	Study period	Reference
Shoshone-Paiute	150.0	1969-1978	Berman, unpublished
Shoshone-Bannock	127.0	1973-1978	Holman, unpublished
Shoshone-Paiute	117.0	1949-1978	Berman, unpublished
NANA Eskimo	106.0	1974-1980	Travis 1984
NANA Eskimo	90.0	1977-1980	Travis 1983
Pueblo	45.0	1967-1969	Biernoff, unpublished
Apache (New Mexico)	44.7	1959-1978	VanWinkle, unpublished
Zuni Pueblo	40.0	1965-1974	Andre and Ghachu, unpublished
Warm Springs Tribes	35.0	1973-1978	Stowell 1979
Papago	30.0	1969-1971	Conrad and Kahn 1974
Alaska Natives	29.6	1970	Kraus and Buffler, unpublished
Pueblo	28.2	1959-1979	VanWinkle, unpublished
Pacific Northwest	28.0	1969-1971	Shore 1975
NANA Eskimo	26.1	1967-1973	Travis 1984
North Slope Eskimo	23.7	1967-1973	Travis 1984
Inupiat Eskimo	23.2	1960-1966	Travis 1984
New Mexico Apache	20.8	1953-1962	Levy 1965
White Mountain Apache	20.0	1965-1967	Levy and Kunitz 1969
North Slope Eskimo	19.2	1974-1980	Travis 1984
New Mexico Pueblo	18.0	1960-1969	Biernoff, unpublished
New Mexico Navajo	15.1	1959-1979	VanWinkle, unpublished
Navajo	12.8	1968-1969	Miller and Schoenfeld 1971
New Mexico Pueblo	10.2	1953-1962	Levy 1965
Navajo	8.3	1954-1963	Levy 1965
NANA Eskimo	0	1960-1966	Travis 1984

the intense cultural changes that have occurred within Indian communities. In various roles as wives, mothers, and elders, women have quietly maintained their cultures and have endured. However, as a mother, the alcohol-abusing woman incurs the irrevocable risk of giving birth to an alcohol-damaged child, and at the very least, she can no longer adequately care for the children she may already have. Occurrences such as these threaten the very posterity of a tribe because children are the future; numbers of damaged and retarded children are not the future that tribes would desire. May and Hymbaugh (1982/83) observed that the number of women at risk in a community is relatively small, but there have been multiple documented occurrences of babies born with fetal alcohol syndrome (FAS) to alcoholic Indian

Table 6.—Age-adjusted mortality rates per 100,000 for New Mexico Apache, Navajo, and Pueblo Indians and New Mexico general population, 1976-1980

Cause of death	1976	1977	1978	1979	1980	1976-1978	1971-1980
			Apache, Navajo, and Pueblo Indians				
Accidents	205.02	157.42	143.32	153.90	135.92	167.62	144.68
Cirrhosis	68.88	66.79	18.95	30.56	27.15	50.30	28.81
Homicide	37.35	34.73	38.12	38.43	23.48	36.68	25.56
Suicide	40.28	37.53	20.89	30.53	20.87	32.53	25.59
			General population				
Accidents	49.99	50.03	47.61	47.66	41.79	49.06	87.12
Cirrhosis	18.22	12.96	13.52	13.39	12.85	14.82	13.12
Homicide	12.89	13.99	14.91	14.54	16.32	13.95	15.46
Suicide	20.43	19.62	17.58	19.82	17.84	19.16	18.80

Source: Reidy, R.J. "A Comparative Study of Mortality Among New Mexico Apache, Navajo and Pueblo, 1969-1980." Unpublished master's thesis, University of New Mexico, Albuquerque, 1982.

women. Williams (1977, p. 17) noted that 40 percent of children born to chronic alcoholics are mentally retarded. The burden that many damaged children place on families, communities, and helping resources is enormous. Thus, prevention of FAS became a major IHS priority beginning in FY 1982.

Johnson (1980) compared cirrhosis mortality among Indian women for 1975 and 1976 and noted several striking differences that have raised questions and are cause for concern. Fifty-eight percent of deaths due to cirrhosis occurred in the least populated areas, presumably reservations. Yet reservation-dwelling women reportedly use alcohol far less than urban Indian women. Further study of rural/urban differences is needed to clarify the different patterns of liver cirrhosis mortality (Johnson 1980, p. 462). Johnson (1980, p. 456) also noted that Indian women constitute about 20 percent of the clients in Indian alcoholism treatment programs sponsored by the U.S. Government. She also pointed out that Indian women account for almost half of the total deaths from cirrhosis, compared to about one-third of the deaths for the same cause among other racial groups (e.g., whites and blacks).

Reviews of hospital records have indicated that the typical profile of an alcoholic client admitted to IHS hospitals would be a male, in his 30s, 40s, or 50s, who has been observed to be a poor user of outpatient services (Mulligan 1982, p. 4). Data from the IHS alcoholism reporting system indicate that nearly 30 percent of alcoholism program clients are women. It is clear that some women are finding their way into IHS treatment programs. It is possible that some are also seeking assistance in other programs, thus not appearing in the IHS data base. Yet little is known about the drinking patterns of women or how to structure treatment for them.

Another study of Indian drinking practices in 20 Indian communities looked at a sample of 1,811 drinkers, 43.2 percent of whom were women (Moss 1979, p. 11). Review of data in the Alcohol Epidemiologic Data System (AEDS) of the National Institute for Alcohol Abuse and Alcoholism for 1975 showed that the cirrhosis rate for Indian women was almost as high as that of Indian men. One of every four deaths for women aged 35 to 44 was attributed to cirrhosis, which is a rate 37 times that of white females in the same age group (National Institute on Alcohol Abuse and Alcoholism 1978, p. 2). Clearly, Indian women are using and abusing alcohol.

Leland (1978) has reported on Indian women's drinking practices based on work conducted in Nevada. She examined two aspects of Indian women's relationship to alcohol: their drinking behavior and their techniques for coping with men's drinking behavior. The population surveyed consisted of 277 adults, 134 of whom were women. Indian women, when interviewed, sorted drinking behavior into two major categories: those who can and those who cannot handle alcohol. Nearly 75 percent of the adult women seldom, if ever, drank or got drunk (compared to 40 percent of the men). Only 7 percent of the women fell into the category of abuser. The remaining women utilized alcohol in a style that was not considered troublesome by community standards.

Leland (178, p. 111) noted that there needs to be further study on the range of variation in women's coping behavior to seek clues in helping men better control their abusive drinking behavior. Also, treatment for some women may necessitate strengthening their coping skills. Weibel-Orlando (1986) cautioned that the intertribal variation in drinking behavior among women is an important factor to be considered.

The majority of Indian treatment programs funded by IHS have been established for, or tend to attract, men. This may be due to several factors, including: 1) statistically, Indian alcohol abuse is a male problem; 2) cultural expectations may prevent equal access to treatment (e.g., the view that a woman should be home caring for her children); 3) societies generally tend to be more protective of women; and 4) the majority of treatment counselors are male, which may discourage some women. In the United States, only four programs funded by IHS are specifically for women: 1) the Ponca City Inpatient Treatment Program in Oklahoma; 2) a residential program for women of the Native American Rehabilitation Association in Portland, Oregon; 3) the outpatient support program of the Yakima Nation of Washington; and 4) the Wren House, a halfway house for women in Duluth, Minnesota. Most of the rural, reservation-based, and urban programs seek to serve women clients, but only the few cited above are specifically designed for the treatment of women. One major differing factor is the provision of child care by some of these programs. Another factor for women in a woman-oriented treatment setting is the elimination of male-female role expectations to facilitate easier concentration on recovery.

Fetal Alcohol Syndrome

A recently identified, extremely serious problem that occurs only in the offspring of the female alcohol abuser is FAS. Originally defined as a syndrome by doctors at the University of Washington (Jones and Smith 1973; Jones et al. 1973), this pattern of infant malformation has now been diagnosed worldwide.

Once FAS was identified, it was natural for clinicians and alcohol program workers to wonder what the incidence and prevalence was among Indians, since Indians have had a long history of alcohol abuse and a high birth rate. While fewer women were reported to abuse alcohol than men, the reports of children failing to complete school were alarmingly high, as were statistics on infant mortality.

To acquire data on the incidence and prevalence of FAS among Indians, a major study was undertaken in the Southwest (May et al. 1983). This region of the country was chosen primarily because the principal provision of direct medical care is through the IHS clinic and hospital system. Therefore, access to staff and medical records was facilitated. Also, a number of different cultural groups were situated within a 500-mile radius of Albuquerque, New Mexico, making access to clinical sites easier.

It needs to be reiterated that FAS is not exclusively an Indian problem. It has been shown to be an international problem, with children of all races exhibiting this birth defect. It is a problem unique to the children of alcohol-abusing women, and it results in a birth defect solely due to introduction of alcohol into the uterine environment.

Careful research conducted among southwestern tribes established the baseline data for future Indian comparisons. The data revealed the following (May et al. 1983):

1. The incidence of FAS was highly variable from one cultural group to another (1.3 per 1,000 live births to 10.3 per 1,000).
2. The pattern of age-specific prevalence indicates an increase over the past 15 years.
3. The overall rate of mothers who produced FAS children was 6.1 per 1,000 women of childbearing age (range, 4 to 33 per 1,000).
4. Twenty-five percent of all mothers who produced one affected child had also produced others.
5. The overall rate of Indian FAS births was comparable to data from Seattle, Roubaix (France), and Goteberg (Sweden).
6. A great majority of FAS children were placed in foster homes, due to either the death of the mother or her inability to take care of the child.

Fetal Alcohol Effects

Because alcohol, like other substances that may adversely affect the developing embryo (teratogens), gives rise to a spectrum of defects, children damaged by maternal drinking exhibit a range in the extent and severity of damage. Not all will exhibit the full range of FAS symptoms of growth and mental deficiency and specific facial disfigurement (dysmorphism). Thus, as Little and Ervin (1984) pointed out, the original term "fetal alcohol syndrome" may be misleading now, because FAS refers only to the severest end of the spectrum. Recommended for use is the term "fetal alcohol effects" (FAE), which they defined as "those signs in the offspring that have been linked to alcohol use during pregnancy by the mother" (p. 158). The

major FAE are growth retardation, morphological abnormalities, central nervous system damage, and mortality.

In a recently completed 10-year followup on the first FAS children diagnosed at the University of Washington, Seattle, Streissguth and associates (unpublished) reported that, among the eight subjects followed, all continued to exhibit dysmorphism and growth deficiency. None of the eight have normal intelligence, although four are borderline and with remedial help can make academic progress. The other four are severely handicapped intellectually and require complete supervision. They found that degree of growth deficiency and intellectual handicap were directly related to the extent of craniofacial abnormalities (Streissguth et al., unpublished, p. 2).

The most promising effort mounted to deal with FAS is the National FAS Prevention Project funded by IHS. During FY 1983, screening tools and educational materials were developed addressing FAS and FAE. A training endeavor was initiated in FY 1984 with the objective of preparing local trainers in every service unit in IHS. The local trainers, in turn, would work toward developing a community understanding of FAS and FAE and promote prevention of FAS within their communities.

By the end of FY 1984, preparation of trainers had been completed in 59 sites, accounting for over 60 service units. A total of 1,279 local people had received training. Evaluations from the field have been positive. Over 90 percent of trainers felt training was worthwhile. The training sessions were well supported by good audiovisual material, and their real strength was in their emphasis on local responsibility and continuation. Through this training, the community awareness of FAS has increased enormously (Little, unpublished).

It is clear that FAS is a serious and handicapping condition. However, it is a *totally preventable* birth defect, and IHS has launched a strong initiative to address this issue at the local level. This approach is consistent with the Surgeon General's *Objectives for the Nation* (Public Health Service 1983), which call for a 25 percent reduction in the incidence of infants born with FAS by 1990. An additional objective is that the proportion of women of childbearing age who are aware of the risks associated with pregnancy and drinking be raised to 90 percent (p. 122).

Substance Abuse and Indian Youths

A second understudied and underreported population that warrants much more attention is Indian children and adolescents. A growing body of research documents disproportionately high rates of alcohol use, as well as inhalant and drug use, among Indian youths. Weibel-Orlando (1984, p. 313), in a review of substance abuse among Indian youths, noted that several factors implicated in this abuse include peer group encouragement, laissez-faire childrearing practices, conflicts between cultural ideals and behavioral realities, parental and community attitudes about drug and alcohol use, and concomitant adult drug- and alcohol-use models.

In earlier adolescent studies, the majority of research reported came from paper-and-pencil self-report surveys gathered from school-aged populations. While useful, these data do not reflect the number of Indian youths who have dropped out of

schools (and who may be at much greater risk for substance abuse). Also, there are virtually no ethnographic data available reporting adolescent perceptions, attitudes, and drinking practices. Data recently collected by Moss and Janzen (1980, p. 30) in 20 Indian communities revealed that 32.4 percent of adults surveyed reported beginning to use alcohol between the ages of 11 and 15 and that 46.2 percent began between ages 16 and 20. This is corroborated by earlier community surveys by Whittaker (1962, p. 472) and Mail (unpublished). Olsen and Baffi (1982) reported that 68.8 percent of Indian adults began drinking between ages 13 and 16.

Obviously, if Indians are exposed to and begin to use alcohol as early as ages 10 through 13, educational and preventive interventions need to be applied starting in the elementary grades. Yet it is only now that legislators and professionals are calling for the inclusion of alcohol and drug education in Indian schools (National Indian Health Board 1984, p. 7-10). For those Indian students enrolled in State-operated schools, the chance for exposure to alcohol education or good coping-skills courses is hit or miss, since each State has differing requirements for curriculum content and mandatory health education.

What is clear is that Indian youths seem to start experimenting with alcohol earlier and use it more often than their non-Indian counterparts. Research suggests that peer influence is a major factor in alcohol and other chemical abuse, yet peer counseling, peer training, and intervention projects are few and poorly funded. The evaluation report for FY 1984 identified only 32 community-based prevention programs. However, several urban and reservation-based programs have also received competitive grants from their States to develop programs focusing on intervention and prevention for youths. A few schools have reported outreach programs as well. The Intermountain School in Brigham City, Utah, initiated a peer influence program coupled with alcohol education, but the school was closed just as the project began (Lyons et al. 1982).

A survey by the Bureau of Indian Affairs of its schools (tribal, Federal, day, and boarding) revealed that some 90 percent of student incident reports were related to alcohol abuse. Yet these same schools reported widely disparate policies for dealing with the problems, lack of trained personnel, little alcohol education, and a lack of any uniform definition of what constituted alcohol and substance abuse (U.S. Bureau of Indian Affairs 1982).

A frequently mentioned need is for the development of chemical-free, planned and structured alternative activities in which youths might participate (e.g., recreation, community service). The enormous investment of time, energy, and money by the non-Indian society in youth activities, sports, and organizations (e.g., scouting, YMCA, Little Leagues, Jobs Daughters, 4-H, etc.) clearly demonstrates the assumption that there is worth and value in having these outlets available to young people. In Indian communities, traditional (historical) youth activities have slowly disappeared, and very few modern activities have replaced them. Particularly disrupted has been the relationship between the elders and youths, as well as restructuring of the traditional kinship tutoring roles. The impact of diminished guidance from the elders has been particularly noted in many communities. Recent research has given clues to some protective approaches that might be applied for Indian youths. However, these results are mixed in their conclusions and indicate a need for more work in prevention strategies. For example, Oetting and Beauvais (1982) found, in

studying a large sample of Indian children from several tribes, that younger children who are bicultural, identifying with both Indian and non-Indian ways, exhibited the lowest drug and alcohol use. Longclaws et al. (1980) found that cultural factors were not predictors of drug use, but the quality of the family relationship and the participation in and pursuit of hobbies was important. May (1982) found evidence that the peer influence was strong but that teenagers strongly rooted in a well-integrated tribe in which cultural identification was strong were less apt to abuse substances. When youths lose their cultural anchors and family support, the loser is not just the youth but the community as a whole.

Abuse of other substances, often in conjunction with alcohol, has been reported. Inhalant abuse, marijuana use, and increasing involvement with other drugs are being reported (Oetting et al. 1980; Olsen and Baffi 1982; Schottstaedt and Bjork 1977). However, more recent research findings have indicated that stability of the home and family may have a much greater influence on determining chemical use behavior in young Indians than previously suspected or acknowledged (Garcia-Mason, unpublished). This work reinforces findings by Swanson et al. (1971) in which youths who abuse substances heavily were observed to come from families characterized by disruption.

Efforts at prevention should target Indian youths, as well as families, and an interagency collaboration would allow for the widest commitment of resources.

If the stability of the home and family is crucial to the prevention of substance abuse, the implications for activities supporting and strengthening families become of paramount importance. Red Horse (1980), in providing an overview for a conference on Indian families, observed that:

> culturally distinct American Indian family patterns lack scientific representation in mental health research. As a consequence, mental health programs designed to serve American Indian populations... are informed through research findings that are alien to an American Indian philosophy of life. The professions, therefore, seldom exercise informed judgment in organizing service models for either prevention or intervention.

Red Horse (1980, pp. 5-7) recommended actions that would contribute to the strengthening of the family, including highlighting family strengths, including family stress as a factor for exploration, assessment of normal family adjustments and adaptations to social environments, and investigation of family survival within an arena of institutional neglect.

Thomas (1980) specifically highlighted the need to involve family in alcoholism treatment. He noted that alcoholism and family breakdown rates are correlated. There needs to be identification of the positive elements in families and a way to reinforce positive kinds of adjustments. A series of questions that would improve family services once the answers began to accumulate were presented by Hoffman (1980, pp. 125-126) and include:

1. What coping mechanisms are unique to Indian families?
2. What cultural norms are related to Indian childrearing processes?
3. What is the effect of consensus decisionmaking processes on Indian family life?

4. What are the commonalities between Indian family values and professional methodological values?
5. How can the extended Indian family be revitalized in developing treatment modalities?
6. What methodologies are relevant to Indian needs?

Indian Treatment and Prevention Program Development

We turn now to examine the steps being taken to deal with the problem of alcohol abuse. This section discusses the history and current status of Indian alcoholism program efforts.

The initial efforts to deal with abuse of alcohol in Indian communities came about largely through the activities of recovering Indian alcoholics who were members of Alcoholics Anonymous (AA). These individuals, for the most part, had become affiliated with AA in urban settings or introduced to AA during hospitalization for alcoholism treatment. Some of them returned to their reservations to encourage tribal leaders to address rampant alcohol abuse. At the same time, in a few reservations there were isolated AA groups also developing. These individuals were living proof that the achievement and maintenance of sobriety was possible for Indians. This "AA phase" began to develop in the middle to late 1950s.

A parallel movement toward sobriety was lodged in the Indian religious sphere. Several religions with traditional roots such as the Iroquoian long house, Indian Shaker, and the Native American Church all strongly advocate sobriety and the value of the family. Several more Protestant and Fundamentalist religions that are active on many reservations also hold abstinence as a major tenet of their beliefs.

These seeds of Indian alcoholism program efforts were given a major boost when the Economic Opportunity Act and its programmatic arm, the Office of Economic Opportunity (OEO), provided funding for outreach and treatment in Indian communities in the late 1960s.

In addition to efforts in Indian communities, there was increasing national attention given to alcohol abuse, culminating in 1970 with the passage of Public Law 91-616, The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act (42 USC 4582). This act created the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

On July 1, 1972, the 50 OEO-funded projects and 1 Indian counselor training program (at the University of Utah) were transferred to NIAAA. For support and liaison, an Indian desk was also established. In 1976, Public Law 94-371 reauthorized the alcoholism act, which continued NIAAA and for the first time, specifically included mention of programs "to provide treatment and prevention service with special emphasis on currently underserved populations, such as racial and ethnic minorities, Native Americans, youths, females, and individuals in geographic areas where such services are not adequately available" (Burns, unpublished, p. 11).

This legislation also gave NIAAA the total Federal responsibility for alcoholism programs and alcoholism issues. IHS, while providing medical care for on-reservation Indians, did not have the legislated authority for alcoholism programs. So NIAAA continued funding for the original 50 programs, and over some years provided startup funding for an additional 108 reservation-, rural-, and urban-based demonstration Indian programs. This effort continued through FY 1979.

Along with this Federal support for prevention, treatment, and rehabilitation, there were also State-funded treatment programs (e.g., State hospitals) and State funding available to some tribes for treatment of Indian patients. The Veterans Administration hospitals continued to be a resource for the treatment of alcoholic Indian veterans, and the Bureau of Indian Affairs created a position in March of 1971 for an alcoholism program specialist. This position was to provide an appropriate focal point for Bureau of Indian Affairs activities relating to alcoholism, as well as a liaison to other Federal alcohol programs.

Table 7.—Indian alcoholism programs: Authorized appropriations from FY 1978

Fiscal year	Number of programs	Authorized funding ($ thousands)
1978	36	3,862
1979	88	8,692
1980	120	13,541
1981	136	15,047
1982	139	12,290
1983	158[a]	20,207
1984		23,469
1985		24,607
1986		26,131[b]
1987		24,776[b]

[a]Transfer of programs from NIAAA to IHS complete.

[b]Office of Management and Budget allowance.

Note: A total of 158 programs were transferred from NIAAA. The total number of programs to date have increased to approximately 200. Two activities accounted for this increase. 1) Umbrella programs were broken up, and contracts for services were awarded to individual tribes. 2) The creation of the Equity Fund allowed tribes to develop and start new programs. In addition, beginning in FY 1984, $1,151,000 was appropriated by Congress under the Equity Fund specifically for alcoholism program efforts. The intent of this authorization was to reduce the level of resource deficiency for those tribes that had identified alcoholism treatment and prevention as an unmet need. This funding allowed for the development of new community-based programs.

In 1976, Public Law 94-437, the Indian Health Care Improvement Act, was passed by Congress. Contained within the provisions of this act were the first official authorizations for IHS to involve itself in alcoholism program activities. Much of the impetus for the transfer of programs came from tribal leadership, as articulated by the National Congress of American Indians and the National Tribal Chairmen's Association. Title II set aside funds for research (25 USC 1621), and Title V encouraged the establishment and support of programs in urban areas (25 USC 1651).

Partly as a result of Public Law 94-437, which identified Indian alcohol abuse as an Indian health problem, and because the initial NIAAA funding was for demonstration purposes only and not intended for long-term support, Congress directed that the 158 Indian programs be transferred to the jurisdiction of IHS. This transfer process was to be a phased transfer, moving "mature programs" (i.e., those that had received NIAAA support for 6 years) to IHS. In FY 1978, 36 programs were transferred through a memorandum of agreement between IHS and NIAAA. This memorandum of agreement (dated May 5, 1978) included the directive that IHS would provide program direction, coordination, technical assistance, and general administrative support services. IHS also agreed to develop a data system to monitor and evaluate transferred programs and to establish staffing support for programmatic activities. The number of programs transferred between FY 1978 and FY 1980, plus programs funded and supported since then, are summarized in table 7.

Appendix

Summary of Significant Legislation

The following briefly summarizes the significant legislative focus on Indians and alcohol use. Indians were the only group in the United States singled out for attention specifically in relation to liquor. The passage of the 18th amendment to the U.S. Constitution in January 1919 mandated national prohibition, but this was repealed in December 1933 for everyone except Indians.

1787	Ratification of the U.S. Constitution, which contained provisions for negotiations with American Indians.
1776-1858	Active U.S.-Indian treatymaking period in which prohibition of alcohol was widely included in treaty provisions. Earlier colonial treaties with Indians had also incorporated prohibition articles.
	The Indian Intercourse and Trade Acts, 1790-1834
1799	Selling of liquor prohibited in Indian towns in which the Society of United Brethern conducted missionary activities (Prucha 1970, p. 104).
1802	President authorized "to take such measures ... as ... may appear expedient to prevent or restrain the vending or distributing of spirituous liquors" to Indians (Prucha, ibid.).
1805	Sale or distribution of "ardent spirits" to any Indian prohibited within 30 miles of a place where a council or conference was being held with Indians (Prucha 1970, p. 106).
1806	Distribution of liquor to Indians prohibited within 40 miles of Vincennes, Indiana. Also, similar legislation for the Louisiana Territory (Prucha 1970, p. 106-107).
1807	Provisions of the Act of 1805 continued (Prucha, ibid.).
1809	Fines levied on those individuals selling intoxicating liquor to Indians (Prucha, ibid.).
1812	Specific legislation passed by the State of Louisiana banning provision of liquor to Indians (Prucha 1970, p. 108).
1813	Selling or giving of liquor to Indians prohibited in Illinois Territory and fines levied upon conviction (Prucha 1970, p. 107).

1814	More specific prohibitions imposed than the 1813 Illinois legislation (Prucha, ibid.).
1815	Liquor sales to Indians banned in Michigan and offenders made liable for injuries and damages done by Indians while intoxicated (Prucha 1970, p. 108).
1816	Laws passed by Mississippi Territory strengthening the 1799 provisions and forbading sale of liquor in taverns to Indians (Prucha, ibid.).
1822	Intercourse Act of 1802 amended, which authorized Indian agents, superintendents of Indian affairs, and military officers to search the goods of all traders if there was a suspicion of liquor being carried into Indian country (Prucha 1970, p. 110).
1832	Law passed declaring introduction of liquor into Indian country absolutely prohibited, rescinding any previous exemptions, and clarifying unclear language in the acts of 1802 and 1822 (Prucha 1970, p. 133).
1849	Department of the Interior and Bureau of Indian Affairs (BIA) established, with jurisdiction for enforcement of the Intercourse Acts' liquor provisions.
1919	18th amendment to the Constitution passed, which made the manufacture, sale, or transportation of alcoholic beverages illegal.
1921	Snyder Act of 1921, in which the first specific funding for "relief of distress and conservation of health" for Indians, authorized.
1924	Division of Indian Health in BIA created.
1926	Meriam Report completed, which detailed the poor status of Indians and provided the cornerstone for major reform in Indian affairs. Alcohol abuse was cited as one of the many problems.
1933	18th amendment repealed for the Nation. However, most Indian reservations elected to remain "dry," or the States in which they were located continued local prohibition for Indians.
1934	Act of May 21, 1934, enacted, which removed certain discriminating Federal laws of early origin that allowed military and civil control within reservation boundaries and that hampered freedom of speech. The Indian liquor law and the law prohibiting the sale of firearms to Indians remained in force (U.S. Bureau of Indian Affairs 1973, p. 129)
	Indian Reorganization Act of June 18, 1934 (Public Law 73-383), enacted, which was designed to restore tribal sovereignty and Indian self-determination.
	Johnson O'Malley Act of April 16, 1934, passed, which gave BIA authority to contract for medical services from the States, local governments, and private organizations.
1953	Intercourse Act of July 9, 1832, which illegalized selling liquor to Indians, repealed.

1954	Transfer Act of 1955, under which responsibility for the health of Indians was transferred to the newly created Division of Indian Health, Public Health Service, passed. Division of Indian Health later became IHS.
1960s	Funding of programs for Indian alcohol abusers, largely through the Community Action Programs, provided by Office of Economic Opportunity (OEO).
1970	National Institute of Alcohol Abuse and Alcoholism (NIAAA) established by Public Law 91-616, The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.
1972	OEO-supported Indian programs transferred to the jurisdiction and support of NIAAA on July 1, 1972.
1973	Comprehensive Employment and Training Act (CETA) passed, allowing the Department of Labor to fund direct grants with Indian communities to provide training and employment of local people in service programs, including referral to alcoholism and drug abuse programs if such addictions affected the employment potential of the individual. National Institute of Drug Abuse (NIDA) established in September 1973. This agency has increasingly supported work and research on drug abuse among American Indians, as well as major efforts in prevention.
1975	Public Law 93-638, The Indian Self-Determination and Educational Assistance Act passed, which enabled BIA and IHS to contract with Indian tribes for planning, development, and/or operation of their own service programs, including medical care and alcoholism treatment.
1976	Public Law 94-371, The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1976 passed, which reaffirmed the intention of Congress to provide legislative support for alcoholism treatment among Native Americans. Section 311(A) 2 read "to provide treatment and prevention service with special emphasis on currently underserved populations, such as racial and ethnic minorities, Native Americans, youth, female alcoholics, and individuals in geographic areas where such services are not adequately available." Public Law 94-437, The Indian Health Care Improvement Act passed, which provided continued funding of Indian alcohol programs by IHS, as well as funding for research to improve alcohol service delivery.

Current Program Status

To put the activities and organization of the Alcoholism/Substance Abuse Program Branch into perspective, a review of IHS goals and objectives for alcoholism is provided. This is followed by a brief overview of the program's administrative structure.

IHS Alcoholism Goals and Objectives

Alcohol abuse and alcoholism have been recognized as a major Indian health problem. The first clear policy statements on this problem were set down in the summary report of the IHS Task Force on Alcoholism (1969).

The task force promulgated several excellent recommendations, but there was no structure existent within IHS to assure the implementation of these recommendations. The creation of an infrastructure to address alcoholism problems had to wait for passage of the Indian Health Care Improvement Act of 1976 (Public Law 94-437). For the first time in Indian health legislation, there existed specific authorization for an alcoholism program effort. This act resulted in the establishment of the Office of Alcoholism Programs (now the Alcoholism/Substance Abuse Program Branch). Once staffed, this office immediately articulated a set of goals and objectives for the IHS alcoholism programs. These goals and objectives are providing the major programmatic guidance today.

GOALS

1. The branch will attempt to lower the incidence and prevalence of alcohol abuse and alcoholism among American Indians and Alaska Natives to a level at or below that of the general population in the United States within a 15-year period.

2. The branch will assist American Indian and Alaska Native groups through community-based planning in establishing effective programs of prevention, treatment, and rehabilitation for persons suffering from or afflicted with problems arising from alcoholism and alcohol abuse.

OBJECTIVES

1. Guide the development of a comprehensive, effective, and culturally relevant program of prevention, with emphasis on Indian youths and family.

2. Guide the development of a comprehensive, effective, and culturally relevant network of Indian community-based treatment services for alcoholics and their families. Such a network will include emergency, inpatient, and outpatient services.

3. Guide the development of a comprehensive, effective, and culturally relevant network of Indian community-based rehabilitative services for alcoholics and their families. Such a network will include quarterway, halfway, and domiciliary facilities, as well as outreach and aftercare services.

4. Develop a series of well-designed, relevant, and practical research projects on alcohol abuse and alcoholism among American Indians and Alaska Natives.
5. Develop a system that meets the needs of IHS and American Indians and Alaska Natives for relevant alcoholism data.
6. Assure the establishment of accessible medical and social detoxification services within each area served by IHS.
7. Establish standards of care, staffing, and resource allocation criteria.
8. Develop an evaluation and quality assurance methodology.
9. Provide technical assistance to staffs of alcoholism programs and training in alcoholism to IHS professional staff in the 123 service units (79 IHS and 44 tribal administered).

Administrative Structure

At the time of the transfer, and under the authority of the Indian Health Care Improvement Act (Public Law 94-437), IHS undertook the administration of a major alcoholism effort. The Director, IHS, created the Office of Alcoholism Programs (OAP), despite lack of authorized administrative funds for positions to staff this office. The Indian alcoholism program directors and tribal leaders had strongly advocated for a visible leadership, and IHS was sensitive to this request.

The purpose of the office was to administer the transfer from NIAAA to IHS and the eventual management of the Indian alcoholism programs. In addition, the non-IHS Indian program leadership had requested regional liaison people who would be available for technical assistance, planning, and coordination. The newly established Office of Alcoholism Programs worked with the 12 IHS area and program offices to identify funding and with individuals to find area alcoholism coordinators for the IHS area offices. This preliminary administrative infrastructure was in place by the end of FY 1979-1980.

Since its creation, the IHS headquarters operation has undergone a congressionally authorized reorganization (completed in FY 1984). This resulted in moving OAP from the Office of the Director, IHS, to the Office of Program Operations within the Division of Clinical and Environmental Services (now the Division of Clinical and Preventive Services). In addition, the alcoholism unit was retitled the IHS Alcoholism Program Branch and has since been retitled the IHS Alcoholism/Substance Abuse Program Branch (A/SAPB). A/SAPB has seven positions on the headquarters staff, three in Rockville, Maryland, and four in Albuquerque, New Mexico.

Organizationally, A/SAPB consists of the branch chief, with subordinate positions including deputy director, physician advisor, director of research and evaluation, and director of training and quality assurance.

This administration maintains close linkage with all IHS area/program offices through their respective area alcoholism coordinators.

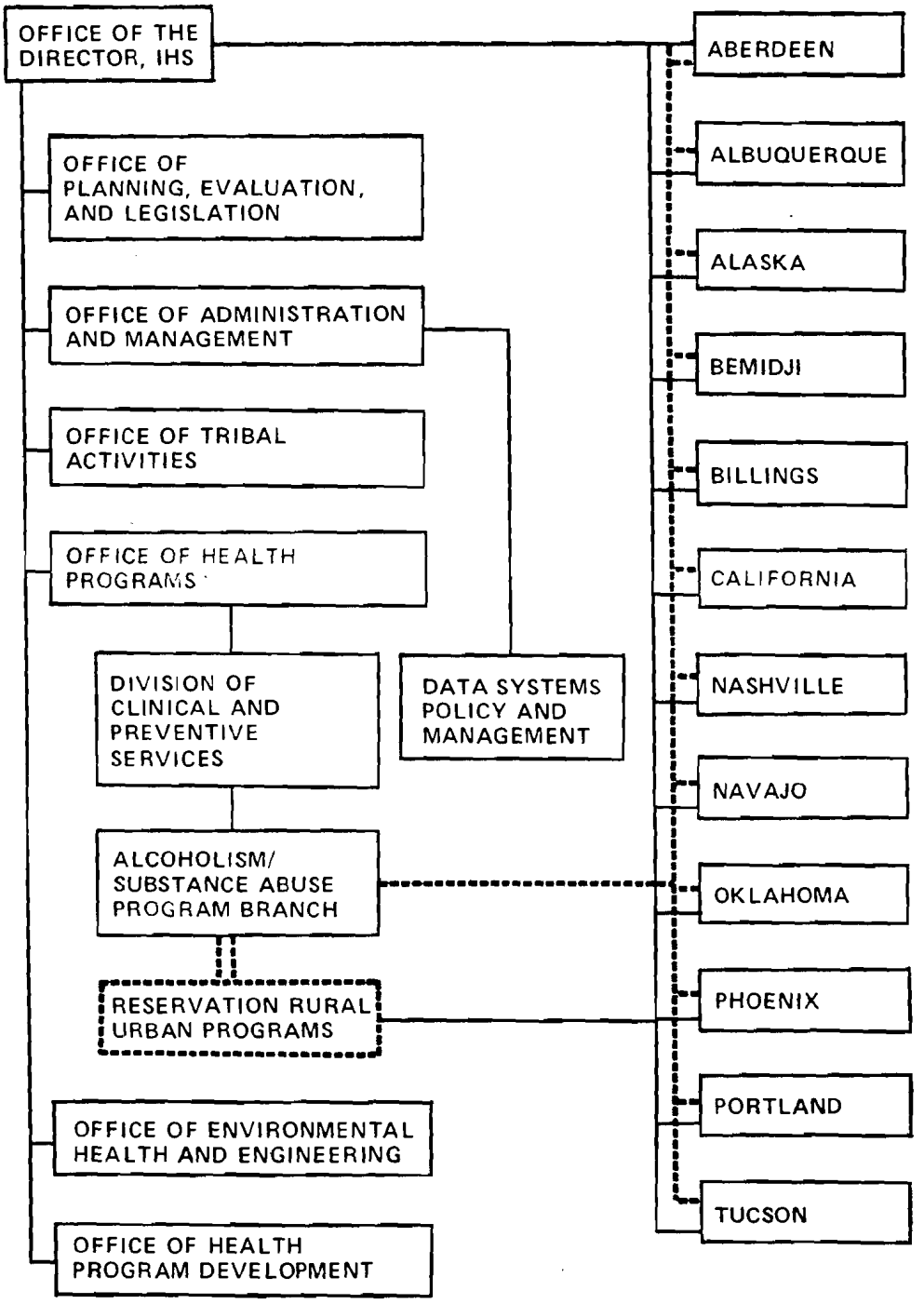

Figure 6. Relationship of Alcoholism/Substance Abuse Program Branch to IHS and local alcoholism programs. Solid line=line authority; dotted line=technical assistance and consultation.

Figure 6 depicts the basic relationships among A/SAPB, the areas, and the Indian programs. The primary responsibility of the headquarters staff is to support requests for continued funding and to recommend and explore with area IHS staff ways to improve both program services and quality of care. Thus, the headquarters staff includes a medical advisor who can address treatment issues, and staff members are available to concentrate on research, evaluation, training, and quality assurance.

Implementation of recommendations from IHS is facilitated by the 12 area coordinators. They arrange for training and evaluation and provide technical assistance and consultation to the programs. The purpose of all of these activities is to assist the programs in meeting standards and in maximizing their treatment, intervention, and prevention efforts.

The IHS representative to local alcoholism programs is the project officer, who monitors contract/grant performance and can indicate to the area coordinator a need for assistance and training. The project officers may be area or service unit personnel.

Thus, it is the responsibility of the branch to provide overall guidance and direction for the IHS alcoholism program effort. This is communicated through the area coordinators and/or the project officers. The direct responsibility for the contracting process comes from the Director, IHS, to each of the area directors, and then to the tribal or urban program directors. There are essentially two lines of communication and consultation: 1) a line authority for funding and programmatic responsibilities, and 2) a technical-assistance and consultative capacity from the branch to help programs staff and manage their particular responsibilities.

Additionally, the branch has the responsibility to identify, utilize, and coordinate with other Federal alcoholism activities to develop, improve, and deliver services to those who need them.

References

Andre, J.M. *The Epidemiology of Alcoholism Among American Indians and Alaska Natives.* Albuquerque: Indian Health Service, Office of Alcoholism Program, 1979.

Andre, J.M., and Ghachu, S. "Characteristics of Completed Suicides in an American Indian Community of the Southwest." Unpublished paper prepared for the Indian Health Service, Albuquerque, 1974.

Bearass, E.C. The Arkansas whiskey war: A Fort Smith case study. *Journal of the West* 7:143-172, 1968.

Berman, A.L. "An Analysis of Suicidal and Non-Natural Deaths Among the Duck Valley Reservation Indians." Unpublished report, Department of Psychology, The American University, Washington, D.C., 1974.

Biernoff, M. "A Report on Pueblo Suicide." Unpublished fellowship field report for the Ambulatory and Community Medicine Department, University of California School of Medicine, Los Angeles, 1969.

Blume, S.B. The disease concept of alcoholism, 1983. *Journal of Psychiatric Treatment and Evaluation* 5:471-478, 1983a.

Blume, S.B. *The Disease Concept of Alcoholism Today.* Minneapolis: The Johnson Institute, 1983*b*.

Boyer, L.B. Folk psychiatry of the Apaches of the Mescalero Indian Reservation. In: Kiev, A., ed. *Magic, Faith and Healing.* New York: The Free Press, 1964. pp. 384-419.

Bruman, H.J. "Aboriginal Drink Areas of New Spain." Unpublished dissertation, University of California, Berkeley, 1941.

Burns, T.R. "A Review and Application of Indian Health Service Alcoholism Program Standards TN 80-4 to Phoenix Area Alcoholism Programs." Unpublished report for the Indian Health Service, Office of Alcohol Programs, Phoenix, 1982.

Carpenter, H.J. Alcohol and the Iroquois dream quest. *American Journal of Psychiatry* 116(8):148-151, 1959.

Conrad, R.D., and Kahn, M.W. An epidemiological study of suicide and attempted suicide among the Papago Indians. *American Journal of Psychiatry* 131:69-72, 1974.

Davis, E.H. The Papago ceremony of Vikita. *Indian Notes and Monographs* 3(4):158-178, 1920.

Driver, H.E. Alcoholic beverages in Native North America. *Proceedings of the Indiana Academy of Science* 64:50-51, 1955.

Driver, H.E. *Indians of North America.* Chicago: University of Chicago Press, 1969.

Flannery, R. The position of women among the Mescalero Apache. *Primitive Man* 5(1):26-32, 1932.

Garcia-Mason, V. "Relationship of Drug Use and Self-Concept Among American Indian Youth." Unpublished Ph.D. dissertation, University of New Mexico, Albuquerque, 1985.

Heaston, M.D. Whiskey regulations and Indian land titles in New Mexico Territory 1851-1861. *Journal of the West* 10(3):474-483, 1971.

Hoffman, F., ed. *The American Indian Family: Strengths and Stresses.* Proceedings of the Conference on Research Issues. Isleta, N. Mex.: American Indian Social Research and Development Associates, 1980.

Holman, S.W. "Suicide Patterns and Fort Hall, Idaho: 1973-1978." Unpublished report of the crisis intervention program, Shoshone-Bannock Tribal Health Department, Fort Hall, Idaho, 1978.

Hrdlicka, A. Method of preparing Tesvino among the White River Apache. *American Anthropologist* 6:190-191, 1904.

Indian Health Service, Task Force on Alcoholism. *Alcoholism: A High Priority Health Problem.* DHEW Pub. No. (HSM) 73-12002. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1969.

Indian Health Service, Office of Alcoholism Programs. *Alcoholism Treatment Guidance System: Counselor's Resource Manual.* 3d ed. Rockville, Md.: Indian Health Service, 1983.

Indian Health Service, Program Statistics Branch. *American Indian and Alaska Native Life Expectancy, 1979-1981.* Rockville, Md.: Indian Health Service, 1984.

Johnson, S. Cirrhosis mortality among American Indian women: Rates and raiots, 1975 and 1976. In: Galanter, M., ed. *Currents in Alcoholism.* Vol. VII. New York: Grune and Stratton, 1980. pp. 455-463.

Jones, K.L., and Smith, D.W. Recognition of the fetal alcohol syndrome in early infancy. *The Lancet* 2(836):999-1001, 1973.

Jones, K.L.; Smith, D.W.; Ulleland, C.N.; and Streissguth, A.P. Pattern of malformation in offspring of chronic alcoholic mothers. *The Lancet* 2(815):1267-1271, 1973.

Kraus, R.F.. and Buffler, P.A. "Sociocultural Stress and the American Native in Alaska: An Analysis of Changing Patterns of Psychiatric Illness and Alcohol Abuse Among Alaska Natives." Unpublished working paper prepared for the Alaska Federation of Natives, Anchorage, n.d.

Leland, J.H. Women and alcohol in an Indian settlement. *Medical Anthropology* 2(4):85-119, 1978

Levine, H.G. *The Good Creature of God and Demon Rum.* Berkeley: University of California, 1977.

Levine, H.G. The discovery of addiction. *Journal of Studies on Alcohol* 39:143-174, 1978.

Levy, J.E. Navajo suicide. *Human Organization* 24:308-318, 1965.

Levy, J.E., and Kunitz, S.J. Notes on some White Mountain Apache social pathologies. *Plateau* 42;11-19, 1969.

Levy, J.E., and Kunitz, S.J. *Indian Drinking: Navajo Practices and Anglo-American Theories.* New York: Wiley-Interscience, 1974.

Little, E.M. "Analysis of Effectiveness of FAS Education, Task V." Unpublished report prepared for the All Indian Pueblo Council, November 1984.

Little, R.E., and Ervin, C.H. Alcohol use and reproduction. In: Wilsnack, S.C., and Beckman, L.J., eds. *Alcohol Problems in Women.* New York: The Guilford Press, 1984. pp. 155-188.

Longclaws, L.; Barnes, G.E.; Grieve, L.; and Dumoff, R. Alcohol and drug use among the Brokenhead Ojibwa. *Journal of Studies on Alcohol* 41(1):21-36, 1980.

Lyons, C.A.; Carpenter, R.A.; and Strelich, T.J. *The Intermountain Model: An American Indian Peer Assisted Alcohol Abuse Prevention Program.* Brigham City, Utah: Bureau of Indian Affairs, Office of Technical Assistance and Training, 1982.

Mail, P.D. "The Prevalence of Problem Drinking in the San Carlos Apache." Unpublished master's thesis, Yale University, Department of Epidemiology and Public Health, 1967.

May, P.A. Substance abuse and American Indians: Prevalence and susceptibility. *International Journal of the Addictions* 17(7):1185-1209, 1982.

May, P.A., and Hymbaugh, K.J. A pilot project on fetal alcohol syndrome among American Indians. *Alcohol Health and Research World* 7(2):3-9, 1982/83.

May, P.A.; Hymbaugh, K.J.; Aase, J.M.; and Samet, J.M. Epidemiology of fetal alcohol syndrome among American Indians of the Southwest. *Social Biology* 30(4):374-387, 1983.

Miller, S.I., and Schoenfeld, L.S. Suicide attempt patterns among the Navajo Indians. *International Journal of Social Psychiatry* 17:189-193, 1971.

Moss, F.E. *Drinking Attitudes and Practices in Twenty Indian Communities.* Salt Lake City: University of Utah, Western Region Alcoholism Training Center, 1979.

Moss, F.E., and Janzen, F.V. *Types of Drinkers in Indian Communities.* Salt Lake City: University of Utah, Western Region Alcoholism Training Center, 1980.

Mulligan, W.J. *The Santa Fe Service Unit Alcoholism Study, 1982.* Public Health Service Indian Hospital Special Study. Santa Fe: Public Health Service, 1982.

National Indian Health Board. Alcoholism/drug abuse bill stresses prevention among Indian youth. *NIHB Health Reports* 3(13-14):7-8,10, 1984.

National Institute on Alcohol Abuse and Alcoholism. Data disclose Indian women's drinking. *NIAAA Information and Feature Service,* Sept. 20, 1978. p. 2.

Oetting, E.R., and Beauvais, F. *Drug Use Among Native American Youth: Summary of Findings (1975-1981).* Fort Collins: Colorado State University, Department of Western Behavioral Studies, 1982.

Oetting, E.R.; Edwards, G.S.; Goldstein, G.S.; and Garcia-Mason, V. Drug use among adolescents of five southwestern Native American Tribes. *International Journal of the Addictions* 15(3):439-445, 1980.

Olsen, L.K., and Baffi, C.R. A descriptive analysis of drug and alcohol use among selected Native American high school students. *Journal of Drug Education* 12(2):97-101, 1982.

Prucha, F.P. *American Indian Policy in the Formative Years. The Indian Trade and Intercourse Acts of 1770-1834.* Lincoln: University of Nebraska Press, 1970.

Public Health Service. Public Health Service implementation plans for attaining the objectives for the Nation. *Public Health Reports* September-October (suppl.): 1983.

Red Horse, T. American Indian family: Research perspectives. In: Hoffman, F., ed. *The American Indian Family: Strengths and Stresses.* Proceedings of the Conference on Research Issues. Isleta, N. Mex.: American Indian Social Research and Development Associates, 1980. pp. 1-11.

Sanchez, P.R. Nature of the alcoholism problem. In: *Lectures and Notes, 1967 Manual Supplement.* Salt Lake City: University of Utah, School of Alcohol Studies, 1967.

Saxton, D., and Saxton, L. *Pima and Papago to English Dictionary.* Tucson: University of Arizona Press, 1969.

Schottstaedt, M.F., and Bjork, J.W. Inhalant abuse in an Indian boarding school. *American Journal of Psychiatry* 134(11):1290-1293, 1977.

Shore, J.H. American Indian suicide—Fact and fantasy. *Psychiatry* 38:86-91, 1975.

Stowell, C. Suicide: A community problem that's getting harder to hide. *Spilyay Tymoo* (Warm Springs Tribes, Oregon), Mar. 16, 1979. pp. 6,15.

Streissguth, A.P.; Clarren, S.K.; and Jones, K.L. "Natural History of the Fetal Alcohol Syndrome: A 10-Year Follow-Up of the Initial Eleven Patients." Unpublished report for the University of Washington, Seattle, 1984.

Swanson, D.M.; Bratrude, A.D.; and Brown, E.M. Alcohol abuse in a population of Indian children. *Diseases of the Nervous System* 31:835-842, 1971.

Thomas, R. Overview. In: Hoffman, F., ed. *The American Indian Family: Strengths and Stresses.* Proceedings of the Conference on Research Issues. Isleta, N. Mex.: American Indian Social Research and Development Associates, 1980. pp. 116-119.

Travis, R. Suicide in northwest Alaska. *White Cloud Journal* 3:23-30, 1983.

Travis, R. Suicide and economic development among the Inupiat Eskimo. *White Cloud Journal* 3:14-21, 1984.

Underhill, R.M. *Singing for Power.* Berkeley: University of California Press, 1938.

U.S. Bureau of Indian Affairs. *A History of Indian Policy,* by Tyler, L.S. Washington, D.C.: U.S. Bureau of Indian Affairs, 1973.

U.S. Bureau of Indian Affairs. *Alcohol and Drug Abuse in BIA Schools.* Washington, D.C.: U.S. Bureau of Indian Affairs, Office of Indian Education Programs, 1982.

VanWinkle, N.S. "Native American Suicide in New Mexico: A Comparative Study (1957-1979)." Unpublished master's thesis, University of New Mexico, Department of Sociology, Albuquerque, 1981.

Viola, H.J. *Thomas L. McKenney: Architect of America's Early Indian Policy: 1816-1830.* Chicago: Sage Books, 1974.

Weibel-Orlando, J.C. Substance abuse among American Indian youth: A continuing crisis. *Journal of Drug Issues* 14(2):313-335, 1984.

Weibel-Orlando, J.C. Women and alcohol: Special populations and cross-cultural variations. In: National Institute on Alcohol Abuse and Alcoholism. *Women and Alcohol: Health-Related Issues.* Research Monograph 16, DHHS Pub. No. (ADM) 86-1139. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1986.

Whittaker, J.O. Alcohol and the Standing Rock Sioux Tribe. I: The pattern of drinking. *Quarterly Journal of Studies on Alcohol* 23:468-479, 1962.

Williams, A.F. *Transition from the Reservation to an Urban Setting and the Changing Role of American Indian Women.* Oakland, Calif.: American Indian Bay Area Interagency Association, 1977.

Winkler, F.D. Current status of research demonstration programs in the primary prevention of alcohol problems. In: National Institute on Alcohol Abuse and Alcoholism. *Prevention, Intervention and Treatment: Concerns and Models.* Alcohol and Health Monographs. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1982. pp. 3-57.

Plenary Session

Introduction

At the direction of the Director, Indian Health Service (IHS), a comprehensive program review of the IHS efforts to address the problem of alcohol abuse and alcoholism in American Indians and Alaska Natives (collectively referred to herein as "Indians") was undertaken in fiscal year (FY) 1985. A series of meetings were held from April 28 to May 3, 1985, in Denver, Colorado.

The overall purposes of the comprehensive review were to

- define the scope of alcoholism treatment and prevention efforts at the tribal level as well as at the IHS Service Unit, Area, and Headquarters administrative levels;
- identify existing program strengths;
- identify those unique programmatic approaches in various locations that warrant broader application;
- identify deficiencies that may exist in the overall alcoholism program;
- set forth actual steps to address deficiencies; and
- make recommendations regarding the mission and future directions of the IHS alcoholism program effort.

To initiate the review, a steering committee was appointed by the Director, IHS, in July 1984. The objectives of the steering committee were to

- plan the review;
- determine the contents of the appraisal;
- identify project participants;
- solicit input from tribal and IHS staff; and
- schedule other activities necessary to accomplish the overall goal.

The steering committee was composed of individuals representing tribal programs, IHS program components, and representatives from other Federal agencies with interest and involvement in alcoholism-related program areas. Members of the steering committee and staff included—

Steering Committee

Everett R. Rhoades, M.D. (Chairperson), Director, IHS
Craig Vanderwagen, M.D. (Co-Chairperson), Acting Director, Division of Clinical and Preventive Services, IHS

Russell Mason, Chief, Alcoholism/Substance Abuse Program Branch, IHS
Luana Reyes, Associate Director, Office of Planning, Evaluation and Legislation, IHS
Yvette Joseph, Program Director, Colville Indian Alcoholism Program
Phyllis Eddy, Area Alcoholism Coordinator, Nashville Program Office, IHS
Fleetwood Roberts, Division of Extramural Research, National Institute on Alcohol Abuse and Alcoholism, Department of Health and Human Services (DHHS)
Victor R. Heyman, Ph.D., Health Resources and Services Administration, DHHS
Patricia DeAsis, Public Health Adviser, Division of Health Systems Development (Tucson), IHS

Staff

Alan Allery (Review Chairperson), Bemidji Program Director, IHS
Lisa Bowman, Office of Program Operations, IHS
George Buzzard, Office of Planning, Evaluation and Legislation, IHS
Anabel Crane, Health Resources and Services Administration
Marion Goodluck, Alcoholism Program, IHS
Chuck Hedin, Alcoholism Program, IHS
Patricia Mail, Puget Sound Service Unit, IHS
Laura West, Alcoholism Program, IHS
Richard Zephier, Ph.D., Alcoholism Program, IHS

The Program Review Process

The program review process, as a management tool, has been adopted by the Health Resources and Services Administration (HRSA) as a means to improve decision-making focusing on selected programs. It is intended to provide an overview of (1) the design of the program; (2) the appropriateness of level and allocation of resources; (3) the extent to which the program has achieved the objectives for which it was established; and (4) the potential need for changes in design and administration.

Program reviews should include three major phases: (1) planning and documentation; (2) discussion and recommendation; and (3) implementation planning. Within each of these major phases, there are critical steps that an agency or program can take to develop a review.

Planning Phase

- Select the program(s) to be reviewed.
- Establish a steering committee to guide the entire process and to develop an overall schedule.
- Identify the issues to be reviewed.
- Develop an agenda and set location and dates for the plenary session.
- Develop a list of people to attend the plenary session, designate a chairperson, and identify specific roles for attendees.

- Plan and prepare a briefing book.
- Complete travel and other logistical arrangements and distribute the final agenda and briefing book to plenary session participants.

Discussion Phase

- Conduct a plenary session.
- Condense notes and gather materials for a draft of the plenary session summary report.

Implementation Phase

- Draft, refine, and distribute a summary report.
- Formulate plenary session recommendations and develop an action plan.
- Establish agency response to recommendations and inform participants.
- Make plans for program implementation and assign responsibility to specific organizational units for implementation and monitoring progress.

To provide some background information and references, a briefing book was compiled for all presenters and participants of the plenary session. The object of this document was to become part of a process that

- pulls together and summarizes current knowledge about the problem and the status of programs;
- indicates areas of concern that have not been adequately explored;
- stimulates discussion that will generate the recommendations and results; and
- complete the action plan.

The briefing book was mailed out prior to the plenary session to all invited participants.

It is within this framework that the present review was undertaken.

The Plenary Session

The plenary session was designed to address the specific issues identified by the steering committee and to generate recommendations. Participants invited for this session included (1) tribal leader representatives from each IHS Area/Program Office; (2) alcohol program representatives from each IHS Area/Program Office; (3) the IHS Area Alcoholism Coordinators; (4) selected IHS line and staff officials; and (5) individuals knowledgeable in the field of alcoholism but not directly connected with IHS or tribal programs (such as alcoholism professionals or university-based researchers). The participants were selected to reflect a wide range of interests and concerns. In addition to those specifically invited, about 30 individuals paid their own expenses to attend.

The participants brought together to discuss and critique the IHS Alcoholism Program approach included "outside reviewers" and presenters. Outside reviewers presented a view of alcoholism issues that is outside the IHS system. Each morning the presenters provided an overview of the major topics of discussion planned for the afternoon. The presenters were from the academic, medical, and program management areas of the alcoholism field.

Daily the presenters provided information to those attending the plenary session. (See appendix A.) In the afternoon, all participants joined small groups to identify and discuss various issues related to the IHS Alcoholism Program and to develop recommendations based on those discussions. Six groups were formed of participants who were specifically invited, and a seventh group was created of those who informally attended the meeting.

The review process permitted a broad, diversified, and critical evaluation of the IHS Alcoholism Program and a clear articulation of the directions to be taken for the next several years.

This report summarizes the key points raised by presenters and other participants during the 5-day plenary session. It is based on materials from presenters, other participants, and groups sessions. The content is organized according to the plenary session agenda. (See appendix A.) This report provides a synopsis of each presentation.

Synopses of Presentations

The general sessions included keynote presentations in the morning of the first 3 days. The presentations were arranged to provide a continuum of perspectives on the past, present, and future of Indian alcoholism programs. The goals of the presentations were (1) to augment the information presented in the briefing book; (2) to highlight the character of the problem of alcohol abuse among Indians; and (3) to provide personal and professional perspectives on available programmatic approaches. Detailed synopses of each presentation are included in this section.

The presentations delivered by Turner, Ducheneaux, and Anderson provided a historical, legislative, and treatment background of the Indian alcoholism program and treatment approaches to alcohol abuse. Turner's role in the community-based movement to address the problem provided unique insight into the origins of the contemporary program. Ducheneaux's vantage point as a congressional staff member provided a legislative context for the programmatic activity. Finally, Anderson's long involvement with an internationally recognized treatment center provided a base for his discussion of the development of treatment options.

The second day's presentations focused on contemporary program features. Light, an IHS clinician and administrator, provided his view of the program in the context of the overall clinical programs. Charleston's presentation highlighted contemporary evaluation processes in the alcohol programs. Benton described the program he manages at Mash-Ka-Wisen and the issues affecting managers.

The presentations on the third morning offered perspectives on future options and approaches. The future for treatment options and standards were described by Walker. Weibel-Orlando's academic experience in researching alcohol abuse enhanced her presentation on research opportunities pertaining to Indian alcohol programs. Prevention options for the future were highlighted by May, whose major research has been in the prevention of Fetal Alcohol Syndrome. Schneider, a nationally recognized physician in the field of alcoholism, summarized many of the opportunities for program enhancements. Clarke, an Indian physician, provided perspectives on the unique cultural opportunities for future intervention in Indian alcohol programs. Finally, Carlson of HRSA, delivered a message on current legislative and administrative concerns.

During the first 3 days of the plenary session, Dr. Rhoades, Director of IHS, moved from group to group, participating in discussions of issues and conversing informally with individuals. He was the keynote speaker on Monday, April 29, 1985, and addressed the steering committee session on April 29, 1985, and the general session on April 30, 1985.

Everett R. Rhoades, M.D., Director, IHS
Opening Address

Dr. Rhoades began his presentation by sharing his determination to set aside rhetoric and to actively take steps in the promotion of health and the prevention of disease. He stated that it makes little sense to attempt to treat clients unless we are willing to make our work environment as safe as possible. He announced establishment of a new IHS policy of a smoke-free environment in the IHS hospitals and clinics.

Dr. Rhoades said that Dr. Robert Graham, HRSA Administrator, had indicated a desire to conduct an intensive review of one IHS program each year. In 1984, the IHS examined the Mental Health Program; in 1985 IHS continued the series by reviewing the Alcoholism Program.

Dr. Rhoades stated that IHS has a single goal—to raise the health status of Indian people to the highest possible level. A part of this effort is to review its health care delivery system. Dr. Rhoades asked for a comprehensive review of the alcoholism programs. A review is not an evaluation, he added, although evaluative concepts will be utilized in the review process. He presented major objectives for the review participants.

- Define the scope of alcoholism treatment and prevention efforts at all levels and describe what the current levels and current activities are.
- Identify existing program strengths.
- Identify those programmatic approaches in various locations that may be unique and may need to be looked at for replication in other communities.
- Identify deficiencies.
- Make recommendations regarding the mission and future direction of the Indian Health Service program effort.

Alcohol abuse among Indian people has reached epidemic proportions, and Dr. Rhoades stressed his commitment to the implementation of an action plan.

Dr. Rhoades suggested combining an experienced health care system and recent research with community approaches to accomplish disease reduction (e.g., hepatitis B).

He said that the program analysis would focus on all the functional attributes necessary for the management of a medical and social health care system. There are nine functional activities necessary for the management of any program or activity: planning, standards setting, resource management, operations, monitoring, evaluation, coordination, training, and research. This approach would provide a management framework for the clinical triad: patient care, training, and research. Dr. Rhoades added that there is an expectation that the IHS Alcoholism Program and the Indian alcoholism programs will exhibit all of these elements at levels appropriate to their operations. The Alcoholism Program levels are the same as IHS program levels: (1) Tribal; (2) Service Unit Area; (3) IHS Area/Program Office; and (4) IHS Headquarters.

Dr. Rhoades outlined some primary tasks for participants.

- Review existing programs at all four levels.
- Provide unfettered discussion and points of view to the reviewers.
- Develop recommendations.

Dr. Rhoades then shared his concern and interest in young Indian people among whom needless alcohol-related deaths occur in epidemic proportions. He warned that there are markers of future pathology that are laid down in early life. The conclusion that services must be directed toward Indian youths is inescapable.

Dr. Rhoades also expressed a desire to see a redirection of IHS efforts toward alcoholism pathology and its sequelae. He wants to see a reduction in incidence and prevalence and an increase in innovation of treatment, prevention, and early intervention.

He cautioned that the status of the American medical and health care budget is now at a zero-base sum and that there is a need to manage existing resources better. No resources will be added unless they come from some other line item. Dr. Rhoades explained that this does not mean that there will not be additional resources for alcoholism, but if programs are managed well, and after taking other factors into consideration (e.g., zero-base sum), Dr. Rhoades would be willing to realign resources to increase activities.

Everett R. Rhoades, M.D., Director, IHS
General Session

Dr. Rhoades sees zero-base sum as a way of looking at our health care system; all points of view are valid. He wants a review of the Alcoholism Program and what is needed. Some problems as seen by Dr. Rhoades included:

- Many IHS physical plants are abominable, especially in some of the alcohol program facilities. This is not an appropriate atmosphere in which to provide services. These problems are solvable.
- A mechanism for better horizontal and vertical communication between and within the IHS health care system and the alcohol programs is needed. This will require a commitment by IHS.

Dr. Rhoades again expressed his interest in young Indian people. To help him address Indian alcoholism issues, problems, and needs, he welcomes recommendations, specifics, justifications, and examples. Dr. Rhoades stated that he would do all he could within the limitations of his authority.

In closing, Dr. Rhoades expressed the desire that concerns, fears, and recommendations should be shared. He pointed out that this group could help formulate policy for the IHS and frame an accurate statement about problems related to Indian alcoholism.

Ernie Turner, Alcoholism Counselor
Milam Recovery Center, Bothell, Washington

Mr. Turner, a veteran of the Indian "alcoholism wars," has worked in this field for 15 years and was one of the founders of the Seattle Indian Alcoholism Program.

In his presentation, he gave an overview and history of Indian alcoholism programs, with personal reflections.

In 1968, Mr. Turner was hospitalized for late-stage alcoholism with acute withdrawal problems; the University of Washington used him as a research subject to do research on vitamin deficiency in alcoholics. When he left the research center, he went back to drinking and ended up in jail. The jail physician advised him to ask for help, which he did, and the judge sentenced him to 120 days in treatment.

When Mr. Turner was released, he teamed up with a couple of Canadian Indians and started a community effort to combat alcoholism problems. They were committed to working very hard, but they quickly recognized the need for an association of people with which to work, i.e., a network. They started a volunteer committee and some outreach and outpatient treatment. Mr. Turner got a job in a vocational resource center to contact alcoholics coming out of treatment.

Mr. Turner and his associates secured a National Institute of Alcohol Abuse and Alcoholism (NIAAA) grant in 1972 and their 3-person committee grew to 30. He saw the NIAAA grant as "seed money," and the Seattle Indian Alcoholism Program developed a 10-year plan, which included funding from local sources. They developed a philosophy that alcoholism is a physiological disease, not a mental or social disease, and that it should be treated as a physiological condition. Mr. Turner said that the Seattle Indian Alcoholism Program focused on the recovering alcoholic and sought to deal with "contamination" of clients due to alcohol ingestion. Such a program would be logically affiliated with a medical program. Turner's program, the Seattle Indian Alcoholism Program, approached the Seattle Indian Health Board for affiliation.

In 1975, Mr. Turner got involved in King County preventive and intervention efforts and summer youth projects. They looked for preventive/intervention strategies. Children of alcoholics were selected as a high-risk target group for emphasis on nutrition, values clarification activities, etc.

Mr. Turner was on a committee that founded the National Indian Board on Alcoholism and Drug Abuse, which held its first meeting on the Mescalero Indian Reservation in New Mexico. Mr. Turner said that the total alcoholism movement started as a grassroots effort, not from the top down—individuals talking to one another, forming small groups, which grew into bigger groups, which became statewide, regional, and finally, nationwide in scope.

Another important effort was the development of the Northwest Indian Training Institute, for training, and the development of the Northwest Indian certification committee, for standards. Mr. Turner said that their Indian certification effort was recognized by Washington State; the certification committee is still active.

Mr. Turner also worked with the Washington State Council on Alcoholism to separate alcoholism efforts from those of mental health and to decriminalize alcoholism. Through their efforts, the State established a separate Bureau of Alcoholism.

Mr. Turner shared his recollections about the transfer of programs from NIAAA to IHS. Many grassroots programs were fearful of the transfer. They perceived IHS as trying to get control over day-to-day operations.

He also expressed the idea that program administrators and clinicians felt that a universal data reporting system and evaluation tool should have been developed between IHS and all other funding sources, i.e., State and Federal.

Lastly, Mr. Turner cautioned about enabling behavior on the part of the system and the counselors. "It is hard to take a 'tough love' stand, but it is necessary. We must avoid enabling behavior; we need confrontive services, not the promotion of three meals a day and a place to sleep," he said.

Franklin Ducheneaux, Counsel on Indian Affairs
U.S. House of Representatives
Interior and Insular Affairs Committee

Mr. Ducheneaux began his presentation by noting that the earliest of treaties recognized the problem of Indian people and alcohol, and now as drug abuse becomes more of a problem, there seems to be a willingness to publicly acknowledge the problem. He continued by stating that peer pressure is a major factor in community drinking behavior. Community attitudes need to be changed—the idea that "it is okay not to drink" needs to be emphasized.

Mr. Ducheneaux further stated that legislation does not address the issues of alcoholism as a disease. The fact is that alcohol and drug abuse is the most serious health problem on Indian reservations. To develop more effective prevention, treatment, and rehabilitation programs, there needs to be more data, insight, and understanding. He also said that the solution lies in the community and the "grassroots." There needs to be a reaching out to resources; one of those resources is IHS.

He noted that prevention is a major new emphasis, that there is truth in the adage, "An ounce of prevention is worth a pound of cure." An IHS commitment to environment, education, and alcoholism is important. Mr. Ducheneaux also noted that the IHS administration is ignoring prevention. For example, funding for sanitation facilities is reduced, yet we know that this is vitally important to acute disease reduction among Indians.

Mr. Ducheneaux reiterated that the responsibility lies in the community, that efforts to reduce alcohol and drug abuse must involve the community and not place all of the responsibility on IHS. There needs to be a coordinated approach with the Bureau of Indian Affairs (BIA), States, and local and Indian governments. He emphasized that there will be no more new money, so Indian programs must look at reprioritization and reaching out, including new linkages and collaborations.

In terms of reprioritizations, Mr. Ducheneaux pointed out that most programs now focus on the adult male, and there is an increased need to focus on juvenile abusers and women. In terms of coordination, he proposed a national memoranda of understanding between BIA, the Department of Education, the Department of Justice, and IHS.

Mr. Ducheneaux closed by stating that if alcoholism programs are ever going to be effective, there needs to be recognition that IHS and the alcoholism programs cannot do it alone; there is a need to cooperate with other governments and agencies.

Daniel Anderson, Ph.D., President
Hazelden Foundation, Center City, Minnesota

Dr. Anderson's topic was the evolution of treatment methodologies. He started by saying that alcoholism is a controversial and contradictory subject—there is still room to learn. He noted that of all of the mood-altering substances in the world, alcohol has become socially acceptable, as contrasted with drug use, which has legal sanctions. However, historically there has been a distinction between drinking too much and sick drinking. He pointed out that one of the earliest treatments, promoted by Aristotle, was aversion therapy. He also stated that there are a variety of approaches to alcoholism treatment, all of which have worked some of the time.

After reviewing the history of alcohol use and abuse and alcoholism treatment, Dr. Anderson emphasized that the treatment must be proven to be effective, but effective in terms of cost effectiveness. He stated that 80 percent of the people who are ill from any disease suffer from a chronic disease. However, most services provided are good for acute flareups, but they do not provide the good support for the day-to-day help that is necessary for the chronically ill. He also pointed out that noncompliance with any kind of treatment plan is a very American trait and that denial of illness is present among hypertensives and diabetics, as well as among alcoholics.

Dr. Anderson noted that no one knows the real cause of alcoholism. There may be predisposing or precipitating factors. He also noted that culture is an extremely significant influence in the sobering up process.

When asked about the role of outpatient programs, Dr. Anderson stated that we have arbitrarily decided that there will be inpatient and outpatient programs. We know that outpatient programs are less expensive, but we do not know which people respond best to which mode of treatment. The goal of a residential treatment program is to have a controlled environment to establish new attitudes, learning, and behavior. Outpatient programs are fine, if effective. Outpatient treatment seems to be better if the client has a drinking problem of short duration, a job, and a good home environment. However, this is not the classic Indian client. He noted that both kinds of treatment are essential. Alternatives need to be explored. In situations in which treatment is located close to home, short inpatient treatment with a closely monitored outpatient program could be an option.

Richard Light, M.D., Chief Medical Officer
IHS Nashville Program Office, Nashville, Tennessee

Dr. Light began his presentation with an outline of IHS organization and activities in alcoholism.

- Congress is the source of money and authorization.
- The IHS programs are a part of the Department of Health and Human Services, Public Health Service, and under the Health Resources and Services Administration.
- Within IHS, there is an Alcoholism/Substance Abuse Program Branch both at Headquarters (Rockville, Md.) and at Headquarters West (Albuquerque, N. Mex.).
- Each IHS area/program office has a program coordinator for alcoholism.

Dr. Light shared some of his perceptions of how clinical staff once viewed alcoholism programs.

- Generally, tribal leaders did not recognize or accept that alcoholism was a problem.
- Programs were funded by separate agencies, resulting in no overall control or direction.
- Programs were perceived as make-work for recovering alcoholics and substance abusers.
- Alcoholics were viewed as a nuisance, combative and difficult; clinicians did not like working with them.
- Clinicians saw initial programs as detoxification exclusively; this led to failure because patients were drunk again shortly after treatment.
- There was no effort to change home and community environment through alcohol programs.
- No integration of IHS and non-IHS programs was effective; there was a separate budget and office, but no authority.
- There was a requirement to maintain nonfunctional programs for 1 year after transfer.
- There was poor communication between alcoholism staff and IHS professionals.
- There was no professional training of staff, no change-agent skills.
- IHS clinicians were not trained that alcoholism is a treatable disease; thus they had no perception of successful treatment.
- People coveted the alcoholism budget.

Dr. Light pointed out that these perceptions do not necessarily apply today; there are successes. Programs now require trained employees; there are greater efforts toward certification. Tribal leaders are coming to see alcohol abuse as a problem. Prevention is seen as a valued program, not just alcohol-free recreation. He closed his presentation by stating that alcohol programs should emphasize:

- development and implementation of good professional education for IHS physicians and nurses, with a focus on anatomy, physiology, the role of the physician in community programs, and active participation in schools and prenatal programs, screening and referral skills, and improved treatment;
- development of health department roles in alcohol programs, especially prevention;
- development and implementation of community education programs;
- leaders and IHS staff as positive role models; and
- personal support of alcohol-free activities.

Mike Charleston, Ph.D., President
DATASTAT Computer Center, Oklahoma City, Oklahoma

Dr. Charleston's presentation was based on the use of evaluations in the planning process. He began by describing the purposes of evaluation: to fire, to defund, to get funded, and others. Evaluation is the ongoing process of planning, collecting, analyzing, and reporting information for the purpose of decisionmaking. To ensure an effective evaluation process, the following critical items must be included:

- the evaluation process itself must be useful;
- the process must be feasible;
- the process must recognize the ethical considerations in human services; and
- the evaluation process must be accurate and valid.

Dr. Charleston pointed out the distinction between research and evaluation. Although both research and evaluation provide information for decisionmaking, there are distinct differences. For example, (1) evaluation is a process, while research is a project; (2) evaluation looks for a change, but research looks for stability of results; (3) the methodology utilized for both is different; (4) research comes out of the hard sciences, whereas evaluation is rooted in people-oriented service projects; and (5) evaluation is conducted in real-life settings, whereas research can be manipulated or contrived in a laboratory with controlled variables and random sampling.

Dr. Charleston stated that program goals and objectives need to be strengthened to ensure a better evaluation. For example, are programs going to consider alcoholism as a treatable disease or a social services program? A clear decision is necessary. It now appears that alcoholism is considered a social services operation, but for successful treatment, we need to approach alcoholism as a disease and set our program goals and objectives accordingly. The treatment of disease means commitment to work toward specific goals and objectives that are clearly defined. This requires trained, qualified staff. However, current alcoholism program staff are low paid, few in number, and not well trained. In addition, there must be some uniformity and standardization of recordkeeping, and there needs to be strong scopes of work with treatment objectives.

The scope of work needs to guide and direct the activities of the staff. Thus, the scope of work should be designed around outcomes in treatment behavior. Dr. Charleston identified the following four elements necessary in the development of treatment objectives.

- *Actor.* This refers to the patient or client. Be specific. Specify which clients. Specify the population to be treated. Determining the severity of the illness enables referral of inappropriate clients.
- *Behavior.* This refers to the expected behavior of the client or patient, not to that of the staff. This is the action one expects the client should take in treatment.
- *Condition.* This is a simple statement of what will be provided in the treatment plan. This is the expected modification or change in clients' behavior during treatment.

- *Degree.* This refers to the extent that a client or patient will perform the expected behavior; to what degree will the client or patient act?

Dr. Charleston went on to note that social service programs are easy to manage, but taking responsibility for change is difficult. There needs to be a set outcome, e.g., a given percentage of the clients move from stage 2 to stage 4 illness. Time limits need to be set; specifications need to be tightened. We must determine the worth and value of programs—not based on the number of clients seen, but on the behavior changes of clients and patients.

He also pointed out that these kinds of changes will not be easy. Scopes of work need to include program goals and treatment objectives. These must be negotiated between the IHS and the contractor and placed in contracts, not just imposed. Since the key is to work toward a change in clients, Dr. Charleston encouraged reviewing data and using that information to plan for next year's program.

When asked about accounting for alcoholism as a chronic disease with relapses, Dr. Charleston stated that accountability must be standardized but the recognition of variables that will influence the client's behavior should be included. There needs to be a realistic frame of reference in relation to program and treatment goals.

In response to a question about the evaluation of prevention programs, Dr. Charleston pointed out that prevention objectives are hard to outline because one must specify target groups and describe the desired behavior outcome. He suggested avoiding "pre/post" and "increase/decrease" measures because they create more administrative and recordkeeping tasks. He would prefer to establish a threshold or level of outcome to be achieved, and then "post" testing only.

Lastly, Dr. Charleston noted that often tribes do not expect the same professional standards from alcoholism staff as they expect from other service staff. This is an unfair expectation.

Elwin Benton, Administrator
Mash-Ka-Wisen Treatment Center, Sawyer, Minnesota

Mr. Benton is the administrator of Mash-Ka-Wisen, a primary residential treatment facility in Minnesota, which provides a continuum of care; a 28-bed primary residential treatment, with two 10-bed halfway houses. Mash-Ka-Wisen was founded as a result of a bill proposed by the Governor of Minnesota in 1975. Mr. Benton described the organization as nonprofit, with six tribal chairmen as board of directors—a consortium.

Mr. Benton pointed out that IHS has no job descriptions for "medicine man" or "native practitioners," so the State of Minnesota developed its own. He believes that this traditional healer is important to the health of clients. The Indian alcoholism movement has legitimatized the utilization of Indian spiritual counselors and has made effective use of them.

Networking throughout the State is very important; alumni are good public relations subjects and provide support, says Mr. Benton, for the programs. There is a need for family treatment. Motivation of clinical staff as to the necessity of documentation is critical, and good treatment includes planning with goals and objectives. Mr. Benton made several recommendations for IHS.

- Develop and establish a national training center for counselors and managers of programs.
- Standardize terminology. What Minnesota calls a residential treatment center is not the same as primary residential treatment in the rest of the country—many primary residential treatment facilities are really halfway houses. Facility standards are needed.
- Provide incentives for those programs that excel. In 1981, IHS spoke of a Congressional mandate to evaluate alcoholism programs. However, there were no incentives resulting from positive results. There were no rewards for successful programs, no followthrough, and no defunding for noncompliance. The poor programs got extra money; the good programs got a pat on the back.
- Convene a national forum on Indian alcoholism that would involve national philanthropic organizations. These programs could be motivated to meet with the administrators of individual alcoholism programs—they are resource alternatives.
- Establish regional treatment centers that are strategically located. It is not practical to provide every tribe with a primary residential treatment facility. Existing IHS facilities or Indian-owned and Indian-staffed facilities should be converted.
- Develop an equalization formula. The State of Minnesota provides more money for Indian alcoholism than the IHS area office provides for programs in four States.

Dale Walker, M.D., Chief
Alcohol Dependency Treatment Branch
Veterans Administration Hospital, Seattle, Washington

Dr. Walker noted that alcohol misuse is the single most important issue in Indian communities today. Desperately needed is a national demonstration project looking at various aspects of treatment with the overall outcome of the treatments directly applicable to Indian communities.

Dr. Walker emphasized the need for collaboration between IHS and NIAAA to provide training for those working directly in the field.

In a study with the Seattle Indian Health Board, Dr. Walker found cultural and psychosocial differences between two groups: those who grew up on reservations and those who attended boarding schools.

He also found that having attended boarding school correlates with alcohol dependency (50 percent of males) and that for women, growing up on a reservation was correlated with the problem of alcoholism.

Dr. Walker emphasized that family history is critically important to predict alcohol problems. Responding to a question, he identified two useful assessment instruments.

- Alcohol Use Inventory. Drinking patterns between men and women are significantly different, and this has implications for treatment.

- Michigan Alcoholism Screening Test (MAST). The first two questions are not applicable to Indians and should be omitted when using MAST. The remaining eight are good screening tools. We need a definition of "normal" drinking in Indian communities. This is the most useful instrument available; it should be incorporated into the assessment process in medical and psychiatric facilities.

Dr. Walker believes that the Veterans Administration's so-called "safety net" is not working. The lack of access to psychosocial services is causing a great increase in stress and psychopathology, a problem of epidemic proportions.

Dr. Walker has had 50 patients in detoxification over the past 3 years. They averaged 44 admissions to detoxification, plus 64 days of other kinds of inpatient care and 6 weeks of detoxification. What is the cost effectiveness of this, he asked? Further, it must be acknowledged that current treatment methods are not only *not* working, but they are actually prolonging treatment, resulting in negative outcomes. Dr. Walker shared some detoxification data—after 2 years, 82 percent are back in detoxification and 93 percent are back to drinking.

Dr. Walker pointed out that psychosocial factors do predict psychopathology and that a review of natural history issues associated with alcoholism could be instructive. Specifically, longitudinal studies (on the order of 20 years) of Indian alcoholics and assessments as to why some seek help could be revealing. In addition, the terminology used in such studies requires standardization; what is meant by "Indian," "alcoholism," and "alcoholic"?

Dr. Walker continued by emphasizing the need to investigate coexisting medical problems; most are treatable, but each condition may have to be treated differently. He underscored the need to involve Indian people in the process of medical planning. Indian people and clinicians need to communicate.

Dr. Walker stressed that treatment should not be viewed in terms of failures but more positively, emphasizing the need to motivate patients into treatment. Currently, most alcohol programs do not include outreach or followup services to continue therapy after the primary treatment phase.

A constant number of new Indian patients become alcoholics annually, he said, while the recidivism rate grows.

In speaking about program relationships, Dr. Walker saw the liaison between alcohol programs and other programs as crucial. Alcohol programs need to allow others to be involved, and clinicians can establish this liaison. Alcohol program people can reach out, ask for help and referrals, and report back.

On selection of patients, Dr. Walker believed the minimum treatment should be available to anyone who has problems, but that it was important to be selective about matching treatment to patients. Identifying differences in lifestyles, drinking patterns, and other factors contributing to the problem is essential.

Joan Weibel-Orlando, Ph.D.
Research Anthropologist
University of California at Los Angeles

Dr. Weibel-Orlando began her presentation by applauding the willingness of IHS to come to terms with its responsibility for addressing alcohol abuse as a medical

problem among its client population. A program review at this time seems particularly appropriate and constructive as IHS inherited the grassroots programs only in 1978 and is, therefore, a relative newcomer to the field of alcoholism treatment and prevention.

Dr. Weibel-Orlando described the kinds of alcohol research foci that she and her colleagues at the University of California at Los Angeles Neuropsychiatric Institute have done since she began her work in 1978. Through interviews and observations they have documented the range of drinking behavior in both urban and rural Indian populations and indigenously developed constraints to drinking. They have also looked at the role of indigenous healers in dealing with alcohol-related problems and the grassroots development of alternative treatment modalities.

Dr. Weibel-Orlando noted that vast amounts of demographic and ethnographic materials as well as theoretical studies about Indian drinking are already in place. She emphasized the relative lack of utility in continued research efforts about topics for which extensive data already exist. While descriptive, ethnographic information on drinking patterns of Indian women and youths is still lacking, she warns that these kinds of longitudinal survey studies are costly and, perhaps, better done elsewhere. Recognizing that IHS has limited research funds, Dr. Weibel-Orlando made several suggestions as to the direction and focus of future IHS-sponsored research.

IHS needs to consider ways in which research can maximize its program effectiveness, i.e., lengthen the time of sobriety after intervention. Dr. Weibel-Orlando suggested that IHS develop and support research that can be facilitated within its existing clinical data-gathering structure.

Dr. Weibel-Orlando noted that we still operate from the perspective that alcohol abuse is a sign of moral or spiritual weakness. She suggested that IHS adopt the disease concept of alcoholism and act on the problem from that perspective. She suggested that IHS use the metaphor of alcoholism as illness and approach alcohol abuse among its client population as a medical problem of epidemic proportions.

Continuing differences in tribal (cultural) perspectives further complicate the development of effective treatment for Indian alcohol abusers. Patient-specific treatment programs that take into account individual world views and specific areas of cultural and/or psychological conflict need to be developed. Understanding, appreciation, and incorporation of indigenous healing systems are also mandated. She stressed that bicultural competence is a positive, not a negative, attribute.

Dr. Weibel-Orlando then described her most recent work with 47 Indian alcoholism treatment programs in South Dakota, New Mexico, Arizona, California, and Oklahoma. Six treatment modalities ranging from conventional Western medical model to traditional healing ceremonies were described. One of the main issues confronting Indian alcoholism treatment programs is how to design a treatment program that deals effectively with cultural heterogeneity. Dr. Weibel-Orlando proposed that IHS develop a demonstration project to

- identify the range of treatment modalities within a catchment area;
- develop an intake protocol that assesses client world view and self-actualization conflicts;
- attempt to fit clients to optimal treatment modalities; and

- establish a regional approach to alcohol abuse intervention.

Dr. Weibel-Orlando recommended a systematic epidemiological data collection process for alcohol-related morbidity rates.

As a final recommendation, Dr. Weibel-Orlando suggested that the IHS has the structure to set in motion servicewide procedures for collection of data on alcohol-related illnesses or impairment. She proposed that IHS develop a diagnostic panel of laboratory tests and clinical observations to identify physiological parameters altered by alcohol ingestion. This objective panel and clinical survey would be administered to everyone on admittance to any service unit under the IHS umbrella at least once a year. These data would be systematically entered into a servicewide data bank, and the findings would be reported to both the presenting patient and attending medical staff for followup and treatment.

These data could be used to identify at-risk populations and to reallocate appropriate intervention responses into those areas. These morbidity data could also be used to secure additional service funds in amounts appropriate to mount effective counterepidemic intervention campaigns.

Dr. Weibel-Orlando suggested a long-term goal for the IHS Alcoholism Program. "By the year 2000, we should be able to say, 'alcoholism used to be an Indian disease,'" she concluded.

Philip May, Ph.D., Associate Professor of Sociology
University of New Mexico, Albuquerque

Dr. May's presentation was on prevention, and he began by stating that prevention has not been a top priority of IHS or in the general field of alcoholism. When IHS was transferred to the Public Health Service in 1955, there were manifest acute illness problems to be addressed. In addition, it was thought that the cultural diversity of Indian communities precluded prevention programs. However, Dr. May noted that one can find universal attributes that can be applied at the local level and adapted to local culture.

Dr. May continued by pointing out three specific issues in developing prevention programs: (1) identifying modifiable behaviors; (2) developing a program that has the "spark" to motivate people; and (3) enhancing optimism and positivism.

He described the demographics of Indian communities as a pyramid that has a very young population—the average age of Indians is 22—which lends itself to prevention activities. He also emphasized that many times alcoholism is the focus of treatment, while some of the evidence of alcohol abuse among those who are not necessarily alcoholics is ignored. He then identified indicators that give clues to alcohol abuse: motor vehicle accidents, suicides, and homicides. The sum of these indicators yields a death rate of twice that caused directly by alcoholism, and all are amenable to intervention.

Dr. May stated that prevention should focus on alcohol abusive behaviors rather than alcoholism. And since a majority of alcohol abuse deaths occur in those who are young, prevention programs should focus on younger populations to minimize alcohol abuse.

He also stated that public education campaigns are a part of prevention programs; kids may have the proper values early in life, but community norms do not reinforce or reward these proper values. He added that many tribes are isolated and are uninformed about a variety of alcohol and drug abuse aspects.

Dr. May has been affiliated with a particular aspect of prevention—the Fetal Alcohol Syndrome (FAS) Project. This project was a "spark" in the community. People related well to it, and FAS has been reduced. The project is based on a major Indian value—the importance of the child and the family.

Dr. May then pointed out that FAS is totally preventable. While 60 percent of birth defects have no known cause, FAS has a known etiology. FAS is highly concentrated in a very few Indian mothers. The average mother who has a child with FAS will have 1.3 children with FAS, but only 6.1 per 1,000 women of childbearing age will have FAS children. Using the community health representative and other health care providers, the abusing mothers can be identified and intervention can be supplied. Because it is estimated that the care of one child with FAS costs $250,000 to $300,000 over its lifetime, preventing one FAS birth could pay for the cost of the FAS prevention program.

He observed that there are several ancillary models for prevention that target manageable elements in the community. Basically, however, for a prevention program to be successful, it must identify something in the life of the community that is antithetical to alcohol abuse and reinforce that antithetical component.

Max Schneider, M.D., C.A.C., President
The American Medical Society on Alcoholism
and Other Drug Dependencies
University of California at Irvine
College of Medicine, Santa Ana

In a brief overview of the medical status of alcoholism, Dr. Schneider emphasized that it was the leading cause of death in the Indian population. Only 1 of 15 people in the United States who are alcoholics receive treatment. Even today, with thousands of treatment programs, 35 of 36 alcoholics die due to the effects of alcoholism. However, physicians rarely list alcoholism as a cause of death for fear of repercussions, upsetting the families, or negating insurance payments. He added that few physicians are adequately taught about alcoholism.

Dr. Schneider outlined the need for increased honesty in dealing with alcoholism. Programs that take patients for 3 or 4 weeks should provide long-term aftercare. He emphasized that alcoholism is a chronic disease with many stages, long-term medical and brain changes, and that patients cannot be expected to respond to treatment in a singular way. Inpatient programs lasting 21 or 28 days are not always necessary—and they are never enough for a successful outcome unless followed by continuing professional care. Outpatient programs must be structured, intense, and prolonged.

Third-party payers are usually willing to pay for the treatment of organ tissue damage from alcohol but often not for the treatment of its cause—alcoholism. Many insurers deem inpatient care as usually unnecessary but refuse to pay for outpatient care adequately.

Dr. Schneider reminded the audience that alcoholism is a common enemy and urged that all tribes and IHS together rise above turf and ideology battles and fight the disease together.

Frank Clarke, M.D., Family Physician Medical Educator
Clinical Support Center, IHS, Phoenix, Arizona

Dr. Clarke gave a presentation on holistic treatment and the components of such treatment. He started out with the statement that alcoholism is a disease—a classic disease like puerperal condition, typhoid fever, or polio. But alcoholism is also a psychosocial medical disease.

He related that in traditional concepts, the human being is a whole, with emphasis on the spirit, and thus, health is the ability to exist in balance and to function harmoniously. He pointed out that many Indians complain that they are entered in a program that is a box or place. The Western medical model separates the mind from the body and from the spirit; this is an artificial separation for Indians.

Dr. Clarke pointed out that self-esteem is based on the quality of interpersonal relationships, and for a strong sense of self-esteem, those relationships need to be positive. He stated that self-esteem is earned—earned by doing. Dr. Clarke also shared a technique of healing/counseling.

Listen
Overlook—both good and bad
Voice—communicate
Effect—do something for another

He continued by stating that medicine or treatment is more than a technical virtuosity. Real treatment or medicine necessitates enticing individuals to extract the best of themselves. He also stated that no alcoholic is going to get well if he or she does not accept individual responsibility to deal with the problem. Dr. Clarke identified several dimensions for healing.

- The therapist is not God; a team approach is necessary for healing.
- The patient must accept responsibility for his or her own healing.
- The family, community, and environment must be involved in the healing process.
- Alcoholism is a psychosocial medical disease; treatment requires time and a holistic approach.
- The patient must be integrated into the family, community, and environment (not accepted unless they are contributing).
- There needs to be a team or systems approach to health care.
- Involvement with the patient is required.

Dr. Clarke concluded by saying that the goal should be to improve the strength of the individual to resist a pathological environment. Again, health is the ability to exist in balance and function harmoniously.

Ron Carlson, Associate Administrator
Planning, Evaluation, and Legislation, HRSA
Rockville, Maryland

Mr. Carlson brought news from the HRSA concerning the status of current legislative and administrative concerns. In relation to HRSA, Mr. Carlson stated that Dr. Graham was leaving and that there were several vacancies in the Department of Health and Human Services to be filled on an interim basis. The Assistant Secretary for Health is vacant, and this makes continuity of planning and policymaking somewhat difficult.

Mr. Carlson then addressed the current status of the reauthorization of Public Law 94-437, the Indian Health Care Improvement Act. He stated that the Melcher amendment had been excluded from the bill by the Senate committee. He also stated that elevation of the status of IHS would not necessarily improve services. President Reagan had vetoed the reauthorization last year partly because of the elevation clause. Mr. Carlson also presented the administration's policy for the rest of the term, which he called the "three Ds": deregulation, deficit reduction, and downsizing government.

Mr. Carlson noted that anecdotal evidence will no longer be sufficient to identify problems or justify programs. Problems must be identified and described with facts, statistics, and other measurable and replicable data.

He indicated that there was a perceived expectation that State and local governments are in a better position than the Federal Government to promote funds and services to the poor and underserved. The solution must be found through the community's resources, and the key is to tap the human potential.

When asked what other influences may affect the IHS, Mr. Carlson identified the debate over financing and reimbursement, the current efforts to "rethink" health care in terms of "tiers" of acceptable levels of health care, and the "rethinking" of accessibility criteria, particularly the amount of resources that are used for health care.

Group Recommendations

The discussions of the issues relating to the alcoholism programs were facilitated by the breaking of the main group into seven smaller groups. Each group had a reviewer assigned to it as well as a facilitator. Initially, there were six small groups planned; however, the arrival of several participants who were not originally expected created the need for a seventh group. Group seven had a facilitator but not a reviewer. Each of the groups discussed issues related to the IHS Alcoholism Program, and from those issue discussions, recommendations were generated. Each of the groups approached the process differently; one discussed several issues in detail and then developed recommendations that addressed the issues. Another group developed a list of recommendations from rewording a list of issues that were raised on the first day the group met.

The different approaches taken by the groups have clouded the determination of what should be in the report from the groups. Because of the desire of the participants to maintain their groups' integrity, the recommendations of the groups remain intact. The report on the group sessions will consist of the recommendations and a summary of the group process.

Group 1

Reviewer	Susan Zepeda, Ph.D.
Facilitator	Jeff Butler
Members	Ralph Antone, Tucson (Program Director) Lionel John, Nashville (Tribal Leader) Yvette Joseph (Steering Committee) Joe Moquino, Albuquerque (Service Unit Director Representative) Bill Richards, M.D., Alaska (Area Alcoholism Coordinator) Ruby Schleuter, Billings (Program Director) Darrel White Bear, California (Area Alcoholism Coordinator)

Issue 1

IHS needs to "put its money where its mouth is" and declare alcoholism our number one health priority among Native Americans and Alaska Natives.

TYPE OF ISSUE

Affects all levels and aspects of program management.

RECOMMENDATIONS

1. Declare alcoholism the number one IHS health priority and stand behind it.
2. Reexamine all aspects of IHS funding, staffing, and activity to assure that they are consistent with this priority ranking.
3. Instigate and speed the passage of statutory legislation for alcoholism programs.
4. Refill vacant positions at the IHS program office.
5. Determine the adequate staff required for all program levels.

Issue 2

Eliminate segregation of alcoholism and alcohol treatment from mainstream of IHS health care delivery.

TYPE OF ISSUE

Affects all levels and aspects of IHS program management.

RECOMMENDATIONS

1. IHS should adhere to the disease model of alcoholism.
2. Plans for all IHS components must include the response to identified alcoholism and the strategies to identify alcoholism in patients.
3. Operational protocols must address the appropriate response to chronically inebriated and alcoholic patients.
4. Training of staff on alcohol and alcoholism at all levels is needed to close gaps.

Issue 3

Alcoholism requires a holistic approach.

TYPE OF ISSUE

Affects all program levels, especially planning, operations, training, and evaluation.

RECOMMENDATIONS

1. Support or encourage the use of traditional healers, peer counselors, family involvement, and primary prevention programs.
2. Provide training to support this type of involvement.

3. Begin an information-sharing clearinghouse at IHS on successful implementation of a holistic approach.

Issue 4

Resource allocation process is not clear or fair, and it does not foster program or staff stability.

TYPE OF ISSUE

Affects headquarters, tribal levels, special needs of areas, and resource management.

RECOMMENDATIONS

1. The planning process should provide the basis for equitable resource allocation.
2. Evaluation information should be used in resource allocation.
3. Use of IHS funding for alcohol-related problems should be acknowledged, documented, and supported (e.g., on a percentage basis).
4. Create 2- or 3-year funding cycles.
5. Create sole-source funding for alcoholism programs.

Issue 5

Alcoholism is a community problem, not just an individual problem.

TYPE OF ISSUE

Affects all management aspects, but especially at the tribal level.

RECOMMENDATIONS

1. Community leaders must acknowledge the problem and understand their role in the solution.
   - Legal or policy aspects: availability (type and number of alcohol outlets), drinking age, and taxes and fines.
   - Role modeling of acceptable drinking behavior.
   - Teaching or sharing with other leaders and other communities.
2. Provide training and technical assistance to community leaders.
3. Tie funding to community support through tribal resolution.

OBSERVATIONS

Many exciting responses to combat alcoholism and to bring communities together have been developed at the local level.

1. The All-Indian Pueblo Council "Two Worlds Project" has programs in nature and survival and in self-reliance skills.
2. The Alaska Natives 4-step model includes:
   - law changes
   - education—village workshops, town meetings, a school program, public service announcements, attitude surveys
   - culture/community support spirit program (elder as consultants), summer camp, a tribal doctor/apprentice program
   - augmented direct services, village counselors, State certification, quality assurance activity, annual alcohol school for counselors
3. Primary prevention projects of the Seneca Nation identify youth leaders and train them as peer counselors.

Issue 6

Current planning is inadequate to address all aspects of the needed response to alcohol abuse and alcoholism.

TYPE OF ISSUE

Affects all levels of planning.

RECOMMENDATIONS

1. Develop and implement a model for needs assessment, with participation at all levels.
2. Update morbidity/mortality data at the service unit level.
3. Adopt "healthy people" objectives as a nucleus for an IHS comprehensive plan.
4. Provide a total picture on IHS funding of alcoholism responses (administration, medical, community-based intervention, training, etc.).
5. Aim prevention efforts at youths.
6. Identify indicators for health status outcomes.
7. Provide a planning base for resource allocation decisions.

Issue 7

Need to foster innovation and flexibility in responding to problems of alcoholism.

TYPE OF ISSUE

Affects all levels of program management and includes aspects of planning, operation, evaluation, and training.

RECOMMENDATIONS

Secure funding to develop alcoholism model programs that is similar to Diabetes Model Project funding.

Issue 8

Communication at and between all levels needs improvement.

TYPE OF ISSUE

Affects all levels of management.

RECOMMENDATIONS

1. Develop information clearinghouse for resources and training.
2. Create a national newsletter.
3. Hold area program meetings on a regular basis.
4. Create a review and comment process for policies, evaluations, etc.

Issue 9

The role, purpose, and function of evaluation and research efforts are not clearly communicated.

TYPE OF ISSUE

Affects headquarters level in terms of program evaluation and research and includes involvement at all levels.

RECOMMENDATIONS

1. Develop and implement a model for evaluation procedures, with area, program, community, and service unit participation.
2. Disseminate evaluation/research plans and products to get broad feedback on assumptions, methodology, findings, and linkage to technical assistance and funding.
3. Make the intended use of evaluation/research findings explicit to all levels.
4. Evaluate general health services in terms of addressing alcoholism.

Issue 10

Efforts to enhance recognition of professionalism of alcoholism workers.

TYPE OF ISSUE

Involves all management functions and affects all levels.

RECOMMENDATIONS

1. Start a recognition/reward system for outstanding performance.
2. Create and support certification standards.
3. Create a registry of certified alcoholism counselors.
4. Reduce turnover by covarying pay with certification.
5. Support continuing education and recertification requirements.

Issue 11

Excessive paperwork and reporting (e.g., Alcoholism Treatment Guidance System) take valuable time from counseling activity.

TYPE OF ISSUE

Program staff (tribal) monitoring.

RECOMMENDATIONS

1. Data reporting should be limited to information needed for management monitoring (one-page form).
2. Analyze expense of data collection and dissemination; assess whether program benefit justifies cost.

Group 2

Reviewer	Max Schneider, M.D.
Facilitator	Charles Erickson
Members	James Brown, Bemidji (Area Alcoholism Coordinator) Charles Heller, Ph.D., Oklahoma City (Program Director) Bud Mason, IHS Headquarters (Steering Committee) David Means, Billings (Tribal Leader) Ina Palmer, Albuquerque (Area Alcoholism Coordinator) Frank Wright, Portland (Tribal Leader)

Recommendations

Note—The italicized words refer to the IHS management function that is responsible for the recommended action.

1. Program scope should include family therapy including codependents and significant others as appropriate (*standards*).
2. Employ available treatment techniques to treat the family without the patient and to treat the patient alone (*standards*). Make use of the community, support groups, and networking.
3. Shift emphasis to younger patients (*planning*). The emphasis now seems to be on older repeater patients.
4. Move treatment of alcoholism into the mainstream of IHS care program (*planning* and *standards*). Alcoholism is both a social problem and a disease, requiring an attack on all fronts by multidisciplinary, multicommunity groups. Alcoholism must be accorded the same status as heart disease or any other life-threatening condition. The patient and kin must be viewed as a whole. The problem has spiritual, cultural, emotional, and physical components, as in the medicine wheel.
5. Patients and caretakers need negotiated, realistic treatment plans, recognizing that alcoholism is as chronic a disease as diabetes or hypertension (*standards*).
6. Systematically assist personnel to improve their level of skills and raise the quality of services (*training*).
7. Make staff aware that dealing with alcoholism implies a process of care in which staff functions at multiple levels and in many roles (*standards, planning,* and *training*).
8. The program scope should include other substance abuse, especially with respect to youths (*planning*).
9. Sufficient resources are needed to support these programs at all levels. Consider the therapeutic and budgetary benefits of generating and employing third parties and other resources (*resource management*).
10. Conduct a study to determine the characteristics of nonabusing subsets of the population (*research*).
11. Selection and application of treatment methods must be sensitive to cultural differences (*standards operations*).
12. Provide competitive salaries for qualified personnel (*resource management*).
13. Prevention should be addressed as a major emphasis; all available techniques should be tried (e.g., "Babes"). Consider appointing a prevention coordinator at IHS headquarters (*planning, evaluation,* and *research*).
14. The extent of training required for each staff member (i.e., administrator versus physician training) should be systematically defined, alternatives should be developed, and programs should be designed and implemented (*training*).
15. Every Indian requiring aid should have access to detoxification, primary residential treatment centers, and halfway houses. Regional bases need to study the tradeoff between center size and economic feasibility and reevaluate underutilized IHS facilities (*planning* and *standards*).

16. Updated protocols and standards of care and diagnosis must be established for IHS facilities (*standards*).

17. The Resource Patient Management System projects incorporate the local, tribal, area, and headquarters alcoholism information needs for patient care management, local research, and other program aspects. Special emphasis needs to be placed on identifying alcohol- and substance-related problems and costs, by all data system users and inputers.

18. Alcoholism must be viewed as a progressive and potentially fatal disease. It involves loss of control of alcohol use in which a person persists in drinking, resulting in life-threatening consequences.

Closing-Day Recommendation

A meeting with all participants attending this review should be established and funded by IHS in 1 year to assess the action plan and implementation of recommendations. (Submitted by Charles Heller, Ph.D.)

Group 3

Reviewer	Joan Weibel-Orlando, Ph.D.
Facilitator	Shirley Dreadfulwater
Members	Ron Carlson, Health Resources and Services Administration Frank Clarke, Phoenix Clinical Support Center (invited participant) Phyllis Eddy, Nashville (Steering Committee) Donald Graham, Portland (Program Director) Giles Hart, Bemidji (Program Director) Dan Little Axe, Oklahoma City (Tribal Leader) Mannie Rubera, California (Program Director)

Recommendations

STANDARDS

1. Certify alcoholism counselors, either by the State and/or the tribal governments. Standards should be developed for staff positions at various levels, from entry level through program director. Certification would standardize a minimum level of knowledge, develop professionalism of alcoholism counselors, develop credibility of alcoholism staff to the referring physicians, and improve the quality of care.

2. Develop a minimum standard of continuum of care to be implemented in all 12 IHS areas.

3. Apply the performance monitoring system that is used for the area, service units, and program operations to the headquarters level as well.

4. Develop regulations at the area level.

RESOURCE MANAGEMENT

Provide adequate staffing and resources to support the area offices of alcoholism.

OPERATIONS

1. Devise a structured extension of continuum of care that promotes regular followup of a patient after inpatient care for at least 1 year (but preferably for at least 3 years).
2. Develop a funding mechanism for new programs and demonstration projects.
3. Develop a means to fund community-based substance abuse treatment programs for youths.
4. Delegate proper authority to the IHS area directors in the areas of training, employment, and reallocation of funds that affect service delivery and prevention.
5. Delegate the authority for all IHS decisions affecting IHS to the Director with the option of redelegation.
6. Give the 638 tribal contractors the option of using block grants.
7. Give the tribal programs the option of using the contracts or grants process as provided in Public Law 93-638.

PREVENTION OPERATIONS

1. Base prevention programs locally and plan them to maximize the involvement of the entire community.
2. Develop an academic course around the issue of prevention for schoolchildren from kindergarten to grade 12.
3. Develop joint funding with the Education Branch of the Bureau of Indian Affairs (BIA) to accomplish prevention activities.
4. Support community-generated efforts that promote human growth and development. These efforts should be characterized by broad-based community-development, participant productivity, a fostering of nonconventional prevention strategies, and most importantly, recognized community-identified problems and approaches.
5. Share information about successful prevention programs.
6. Identify one or more members of the IHS Director's staff to promote and assist in the development of community-based programs to prevent the onset of alcoholism.

MONITORING

Include a provision for documenting patient progress in future reporting systems.

EVALUATION

1. Formulate evaluations that point out strengths as well as weaknesses.
2. Focus evaluations on quality assurance.
3. Provide feedback in the form of constructive criticism to the participants within a reasonable period of time.
4. Standardize measurements.
5. Train evaluators adequately, especially in the cultural factors of each area.
6. Make evaluation a team effort, and include Federal, State, and project people in a recommended ratio of 1:2:1, depending on the funding source.
7. Use evaluators who have both front-line and administrative experience.
8. Spend more time evaluating each program and include observations of patient treatment in the evaluation.
9. Include the views of patients in the evaluation process.

COORDINATION

1. Establish a liaison between IHS and the Education Branch of BIA to include developmental health programs in the training curriculum.
2. Maintain an administrative separation between mental health and alcoholism programs, but continue to encourage a functional cooperation.

TRAINING

1. Provide funds for training activities within the alcoholism programs.
2. Direct those funds to the area coordinators.
3. Authorize the area coordinators to make decisions concerning the expenditure of these funds at the program level.
4. Establish a central location for the collection and dissemination of audiovisual materials and literature on Native Americans to be used in alcoholism education efforts.

Group 4

Reviewer Clay Roberts

Facilitator Bob Ashmore

Members
Tom Burns, Phoenix (Area Alcoholism Coordinator)
George Buzzard, IHS Headquarters (Steering Committee)
Joan Hamilton Cannelos, Alaska (Program Director)
Russell Hawkins, Aberdeen (Tribal Leader)
Neddeen Naylor, California (Tribal Leader)
John Richardson, Ph.D., Navajo (Area Alcoholism Coordinator)
Tony Secatero, Albuquerque (National Indian Health Board Representative)
Terrence Sloan, M.D., Aberdeen (Area Director Representative)
Eva Smith, M.D., Phoenix (invited participant)

Recommendations

1. The IHS Director should elevate the issue of alcoholism and direct the IHS staff to implement the comprehensive and integrated alcoholism programs in each area in accordance with the IHS Performance Appraisal System and manual issuance.
2. Revise the evaluation process to ensure that quality of services is measured by an out-of-area multidisciplinary team, using objective criteria that are known to the alcohol treatment programs. The focus should be on treatment services in relation to cost and outcome.
3. Review existing health care facilities with low bed utilization to determine if those beds can be used for alcoholism treatment programs to be operated by IHS or the tribe.
4. Determine the feasibility of regional inpatient treatment centers operated either by IHS or the tribe.
5. Implement chemical dependency treatment units at the Alaska Native Medical Center, the Gallup Indian Medical Center, and the Phoenix Indian Medical Center, which should also serve as training centers for substance abuse intervention for both tribal and IHS staff.
6. Implement inpatient alcoholism treatment programs. The Whiteriver Alcoholism Treatment Program should be explored as a model.
7. Establish a specific focus on substance abuse prevention for youths and early intervention activities with funding support.
8. Finance visits for tribal staff members to learn about successful programs, such as the Mash-Ka-Wisen Treatment Center and the Hazelden Foundation.
9. Implement the Primary Care Provider Training Packet.
10. Increase the funding available for alcoholism services at the local level by:

- seeking funds at the Federal and State levels from agencies that deal with alcohol and drug problems (e.g., National Institute on Alcohol Abuse and Alcoholism [NIAAA], National Institute on Drug Abuse [NIDA], Centers for Disease Control, Department of Transportation);
- utilizing existing IHS dollars more effectively (resurrection of underutilized facilities for alcoholism treatment, etc.);
- reallocating funds within the IHS system; and
- petitioning Congress for additional financing.

11. Distribute written progress reports about the implementation of the recommendations from this review to the IHS staff and tribal leaders on a semi-annual basis.

Closing-Day Recommendations

1. In accordance with Public Law 93-638, (1) the IHS Director, before implementing recommendations regarding the alcoholism review, should make available the results of this alcoholism review to all tribal governments, and (2) this review or any results of this review should not be construed as part of the consultation process with tribal governments, and the IHS Director should seek further advice from the tribal governments for implementing the recommendations.
2. If more monies are to be made available for alcohol treatment, the extra monies should *not* be taken from existing health programs to accomplish this goal. (Submitted by Neddeen Naylor.)
3. The unique status of the Alaska Native villages must be considered. To combat very high unemployment rates, many villages keep salaries low to discourage outsiders from joining the village and taking the few jobs available. Villagers can then take the positions and supplement them with food from hunting and fishing. (Submitted by Joan Hamilton Cannelos.)