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T ON ALCOHOL AND DRUG ABUSE

Task Force Eleven: Alcohol and Drug Abuse

FINAL REPORT

TO THE

AMERICAN INDIAN POLICY REVIEW COMMISSION

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REPORT ON ALCOHOL AND DRUG ABUSE

TASK FORCE ELEVEN: ALCOHOL AND DRUG ABUSE

FINAL REPORT

TO THE

AMERICAN INDIAN POLICY REVIEW COMMISSION

REUBEN SNAKE, Winnebago-Sioux, *Chairman*
GEORGE HAWKINS, Southern Cheyenne, *Member*
STEVE LA BOUEFF, *Specialist*

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LETTER OF TRANSMITTAL

AMERICAN INDIAN POLICY REVIEW COMMISSION,
CONGRESS OF THE UNITED STATES,
Washington, D.C., August, 1976.

AMERICAN INDIAN POLICY REVIEW COMMISSION,
Congress of the United States, Washington, D.C.

GENTLEMEN and MADAM: The Task Force on Alcoholism and Drug Abuse presents to you its Final Report pursuant to Public Law 93–580.

This report contains the results of one year of fact gathering, hearings, and on-site visits. Our recommendations are based upon the analysis of our investigations.

As a medical, mental and social disease, alcoholism and the misuse of alcohol and drugs leaves its destructive mark in some way upon every Indian individual and family.

Without a continuing commitment by the Congress of the United States, the devastating effect of alcoholism and alcohol and drug misuse among the American Indian and Alaska Native cannot be alleviated.

Respectfully submitted.

STEPHEN LABOUEFF, JR.
REUBEN SNAKE, *Chairman.*
GEORGE HAWKINS, *Member.*

CONTENTS

	Page
Letter of transmittal	III
Task force summary statement	VII
SECTION I:	
Introduction	3
SECTION II:	
Issues, problems, and recommendations in the Indian alcoholism and drug abuse field	11
A. Federal/State relationship and policies	11
B. The Indian people, alcohol and drugs	12
C. Scope of problem	15
D. Alcohol and drug abuse programs	18
E. Recommended legislative actions	20
F. Other issues:	
1. Community and social impact	22
2. Economic impact	23
3. Prevention and preventive education	23
4. Indian representation	26
5. The law, alcohol, drugs and the Indian	27
SECTION III:	
Appendices:	
A. The Snyder Act of 1921	31
B. Historical information	31
C. Excerpt from the Report of the Indian Health Service Task Force on Alcoholism	33
D. Drug usage summary	35
E. Summary of letters received by individuals, programs and tribal representatives in response to questionnaires	36
F. Statistical information	39
G. Program description of Federal, State and local agencies	45
H. An alcoholism program built around a comprehensive health model	58
I. Veterans' Administration Study on the Feasibility of Combined Alcohol and Drug Treatment Program	62
J. Excerpts from "The Alcoholism Report"	62
K. Excerpt from report of the Committee on Interior and Insular Affairs, U.S. Senate	62
L. Summary of task force hearings	64
SECTION IV:	
Bibliography	77
SECTION V:	
Addendum	
A. Decriminalization of alcoholic related offenses	89
B. Special report: Removal of Indian Children from Natural Homes and their Subsequent Placement in Non-Indian Foster or Adopted Homes	91
C. Specific correspondence	93

TASK FORCE SUMMARY STATEMENT

Because the alcoholism movement is of so recent evolution, the American Indian Policy Review Commission is of the greatest importance, not only in readjusting the Indian and Native Alaskans into the total society but also in getting the alcoholism movement pointed in the right direction.

Two key terms are useful in discussing alcoholism and other drug abuse. One is institution and one is movement.

In the broadest sense, institution means doing things in the accepted way in a society. For example, hospitals are the institution of health and all of their elaborate efforts are designed to restore patients to health.

Social movements arise when institutions are not working to the satisfaction of some groups. These groups then organize and make a common effort to modify, maintain, replace or destroy the institution in question.

The usefulness of the two key terms may be seen in the following ways. In the recent past, health institutions did not work to the satisfaction of groups interested in alcoholism. An alcoholism movement formed to restore health to the alcoholics, primarily because of the failure of the institutions to do so.

The alcoholism movement arose because of a stigma and its consequences. Whether it retains its form as a social movement or becomes a part of the institution of health or disappears altogether depends on a number of factors.

This report will concern itself within the context of the unique Federal-Indian relationship which recognizes certain Federal responsibility to the Tribes, including special services to Indians because of their status as Indians. Such services are predicted on treaties, laws and court decisions, rather than on race.

Task Force No. 3 has addressed itself to the question of "Federal Administration and Structure of Indian Affairs," and has pointed out the Indians' inherent right for self-government.

A primary problem as perceived by Task Force No. 11 is to bring Alcoholism, Alcohol and Drug Abuse to the attention of this Indian Self-Governmental structure and to the individual Indians. These problems have been readily identified as being the Number One prlblem afflicting the Indians and the Alaskan Natives, but the conservative element within this community still views these problems in the light of a *Moral Issue* and not as a respectable and treatable disease, and therefore this problem generally falls into the lowest priority.

The public awareness (or recognition) of the problem of Alcoholism was initiated in the founding of Alcoholics Anonymous in 1935, and instigated by the passage of the "Hughes Act," Public Law 91–616, December 31, 1970.

"Hard drugs" do not seem, except in some isolated areas, to have reached the problem intensity of alcoholism, but the emergence of drugs other than alcohol, especially among youth, is creating a great amount of concern.

Out of this hightened awareness of the problem, Drug Abuse is now beginning to receive the attention, resources, and recognition as a disease which it has previously lacked.

Factors—Problems and Issues

The problem of "anonymity" of the alcoholic has finally been resolved at the national level by the establishment of three (3) institutes under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Although tremendous strides have been made, the disparity of the alcoholism movement may be viewed, at the national level, by this tabulation of ADAMHA:

Institute	Personnel	Financial resources (fiscal year 1976)
NIAAA	195	$151,305,000
NIDA	397	232,170,000
NIMH	895	418,589,000

Although drugs other than alcohol seem to garner much of the Administration's and Congress' attention, (their being an esoteric and vote getting subject), alcohol is still the No. 1 problem.

At the inception of the alcoholism movement (Federal level) it was originally placed under the Institute of Mental Health. One of the basic reasons that a long hard look at alcoholism is so necessary is that it is a matter of record that the vast majority of alcoholics who have recovered have done so outside of, and in spite of, the mental health movement rather than within its therapeutic boundaries.

In a Congressional hearing during the period before the reorganization which moved the NIAAA out of the Institute of Mental Health, Mr. Ken Eaton, former Deputy Director of NIAAA, stated that alcoholism is "not a mental health problem," and that, "the psychiatric approach to alcoholism is not only the most expensive, but probably the least effective."

The diffused appropriation and/or allocation of funds for the alcohol and other drug abuse problems (which Indians could utilize, presumably they are used in the over-all head count) is phenomenal, e.g., DHEW (NIAAA, NIDA), Department of Justice (Juvenile Delinquency, LEAA) and Department of Transportation.

The devious or alternate routes of getting needed Indian programs funded, is exemplified by Mr. Burns' testimony. (Phoenix Hearing, p. 116).

An identifiable and permanent Indian alcohol and drug abuse entity is needed as a strong advocate for policy determination at the national level. Valuable time which could be devoted to the problem, is exercised by the Directors and Boards of programs, to funding problems. They are so deeply enmeshed in funding politics that it has become a serious problem. But they have had to do this to survive.

Urban and rural (reservation) problems in funding would be lessened and co-operative efforts would be enhanced if funding politics were eliminated. The problem here, it appears, is that there is considerable concern about urban programs taking from reservation programs, when the competition should be based on needs. (J. Hayes, Phoenix Hearing, p. 59).

Also, within the Tribal Area, there must be more cooperation by Tribal entities. When an individual moves from reservation or home base, service does not go along. (McCabe's testimony, Phoenix p. 42; Pennecoose, Salt Lake site visit, p. 10).

B.I.A.-Office of Education.—The Administration, at the local level, has shown a great deal of resistance toward any alcohol or other drug abuse effort, whether having special programs or inclusion within the curriculum. NIAAA awarded Chilocco Indian School a grant for "Chilocco Alcohol Education Program," but differences of judgment between the school administration, Grantee (Chilocco Advisory School Board) and the Program Administration caused this program to lose its funding. (See Att. file; Ms. Nez's testimony, Salt Lake City, p. 1; BIA Residential School Analysis, fiscal year 1976—1975–76 School Year).

I.H.S.—There is reluctance of local staff to administer or cooperate with the alcohol and other drug programs for treatment. One of the primary reasons is lack of empathy, possibly resulting from not fully accepting alcoholism as a disease by the individual and/or lack of training. Only five (5) University Medical Schools offer any training in alcoholism.

Inter-disciplinary training must be instituted.

Reluctance of medical personnel to diagnose alcoholism is a primary factor. (Sioux City, Phoenix and Anchorage Hearings).

Veterans' Administration.—Efforts are mostly rhetoric, and from a practical standpoint of the Indian Veteran nothing has been done. (see file on V.A. submitted to Commission; testimony by Ms. M. D. Trimiar, Window Rock Hearing).

In-House Civil Service.—Same category. (see G. Retholtz, Ph.D). Although efforts were mandated by Congress in Public Law 91–616, very little progress has been made.

Children.—We may be raising another generation of Indian alcoholics, and one of the primary factors could be the local statutes and regulations (State) in which Indian children are placed in non-Indian foster homes. (B. Albaugh's paper submitted to Commission; hearings at Salt Lake, Oklahoma City and Sioux City).

Forgotten Children.—Concern is being voiced for a group who have been termed the "Forgotten Children," aged 10–16. Some of the many unanswered questions:

Are the children more severely damaged than those in the troubled homes?

Is harm to children related more closely to drinking or the quality of the relationship between the alcoholic and his spouse?

Should the family be treated as a whole?

Would this produce a more complete recovery for the alcoholic?

Would it produce a lower rate of alcoholism, later on, in the children?

When the alcoholic and the spouse refuse outside help, is there any way in which assistance can be given separately to the children?

Alaska.—A very serious problem is developing here. The pipe line would leave the natives in a cultural vacuum—with nothing left of their natural resources but a polluted environment and broken health.

Communication and accessibility of any assistance is critical. In our site visits, one of the pointed problems was the language barrier; even though the Task Force was Indian, we still had to have an interpreter to communicate with the Native Chiefs and elders. One of the basic solutions offered by the local people was the effort by NIAAA in their Mini-Grant program. Our conclusion was that this would be the most feasible; it would seem to give the local people the opportunity to resolve local problems.

States.—The States do not seem to know what to do with their alcoholism effort. Kansas has it under "Social Services," Oklahoma has it under "Mental Health" and New Mexico under "Department of Health Institutions." (*See* position paper submitted by State of Washington, Submitted to Commission).

Indian input on States' alcoholism policy.—Tokenism seems apparent. (Sioux City Hearing). In this Task Force Member's experience, seated on the Oklahoma Alcoholism Advisory Board, no input into the "State Plan" was presented. Advisory Board has "review and comment on grant applications," but this concerns only "Formula Grant" monies received through NIAAA, no state monies appropriated by state specifically for alcoholism programs, although State Plan indicates "The Department of Mental Health expended approximately one-third ($6.5 million) of its entire budget for last fiscal year for alcohol-related treatment and rehabilitation in its three mental hospitals."

With the built-in "denial syndrome" of the alcoholic, it certainly deters the individual from seeking help in a state *mental* institution because he immediately associates it with a "crazy" or "Nut" house.

Municipal Constituencies.—For example, see the attached letter from Coal County Economic Foundation, Inc. After being funded by NIAAA, an attempt was made to locate their treatment center in Atoka which supposedly was meeting local ordinances and zoning requirements. During our interview with the former Director, he indicated (but it is not revealed in the letter) that a group of citizens (neighbors) petitioned the City Officials to restrict this type of facility from their area; they didn't want a bunch of drunks around. After the facility was placed at a site other than Atoka, the City fathers reversed themselves and re-zoned it to its former category.

Insurance.—This Task Force member, while Director of the Cheyenne-Arapaho Alcoholic Rehabilitation Center, in Bessie, Oklahoma, had an insurance policy (1st year) with the designation as a Rehabilitation center, with the premium set at $338.00 per year. The following year we received a notice that the insurance company had reviewed our policy and we would have to be designated as a "Mental Psychopath Institution-Governmental" at a premium rate of $109.00 per bed, (20 beds), a total of $2,018.00.

One of the basic questions that confronts the Indian Alcoholism effort is the policy and procedure of other disciplines, i.e., Social

Services, hospitals and clinics, which involves the Tribal entities, Advisory Boards, etc. They feel that the financial resources will be diverted from their objectives.

If all financial resources (NIAAA, IHS, BIA, LEAA, Justice Department, etc.) and policies and procedures were concentrated within one entity, it would certainly be more effective. Heretofore, programs had to staff (or assign) a position to keep up with available funding sources, proposal writing and advocacy. Boards of Directors and Program Directors are continually having to find and promote "affiliation agreements" with other sources of resources, whether financial or technical. This promotes competition within areas and/or programs and the amount of assistance given (although it may originate from a central source) depends on the local interpretation of policies and procedures. Examples of this are: I.H.S.-Billings area allocated funds for the establishment of detox units (the only area in which this was down) not because it was a priority but because the funds were in excess over the immediate needs of the area. This created quite a controversy among other areas.

The B.I.A.-Social Services contracted, from General Assistance Funds, with American Indian Special Services Project to assist their clients financially by paying $5.00 per day per man; Cheyenne Arapaho Alcoholic Rehabilitation Center, contracted $3.00 per day per man; Coal County Economic Foundation, Inc. was refused this type of assistance.

Jurisprudence

In interviewing Mr. William Stoneroad, who in turn had interviewed 25 inmates of the El Reno Federal Reformatory, El Reno, Oklahoma, these observations were made: (Mr. Stoneroad is Indian and counsels inmates on a voluntary basis).

Since this is a Federal Reformatory, they received their charges from all over the nation. Most of the inmates come from a reservation environment, originally, but we could not pin-point whether the incident which caused them to be incarcerated occurred on or off the reservation; a reasonable assumption would be that it occurred off the reservation.

25 inmates interviewed.

Median age—25 years.

99 percent did not seem to have criminal personality profile.

(Interviewers do not have academic background to scientifically evaluate)

At the instant of the incident for which they were incarcerated they stated they were in acute alcoholic condition. All 25 gave a positive answer to this question.

When questioned as to why they drank these were the responses:

1. There was nothing else to do on the reservation.
2. Lack of employment.
3. Peer pressure.
4. Inferiority complex, caused by:
   Attitude of teachers, while in school.
   Lack of skills to cope in the outside society.
5. Insecurity.
6. Males drink, only social activity.

They felt as if welfare aided and abetted their chronic alcoholism by supporting them and their families.

The training (job skills) they received while institutionalized was not relevant to what they might use when returning home.

Most seemed passive and felt they would have to do all of their time and would take whatever assignment given them, with the attitude of "why fight the system, I'll take what they give me and do my time."

They were not able to file appeals while in the institution, as some of the other non-Indian inmates were doing, because they did understand the appeal procedures and their rights (while in prison) were never fully explained to them.

Recommendation: Indian counselors and Ombudsman—More access to records of individuals.

Mr. Charles Kaubin, Counselor, Haskell Indian Alcohol, Education, Prevention and Treatment Program, Haskell Jr. College. (Sioux City hearing, Pp. 157–158). Counsels with inmates, Leavenworth Federal Prison. (Voluntary)

Most of inmates appearing before Parole Board are refused parole because of lack of preparation.

Need for an Indian parole counselor. It is hard for an Indian counselor to develop a relationship with the inmate, almost impossible for a non-Indian to establish rapport.

Most Indians turned down for parole; lack of personal resources, i.e., education and training. Perceives need for T.V. instruction (available in prison) to include basic skills, i.e. letter writing.

Parole Board's primary criteria is based on inmates' job potential. Most Indians do not have this.

55 inmates identified; 51 were incarcerated for alcohol related reasons and crimes that were committed during the time they were intoxicated or under the influence of drugs or alcohol.

Recommendation: See Appendix "G", Leavenworth Education Program.

Mr. John Poupart, Director Anishinabe Longhouse, Minneapolis, Minn., extension of Minnesota Department of Corrections.

Anishinabe Longhouse is After care from a penal institution. In a two year period, out of a total 100 individuals, 6 percent became victims of recidivity. However, before Anishinabe, 57 percent were convicted of new crimes and sent back to penal institutions. Although this is not a fair comparison it would indicate a very good response at Anishinabe for recidivism.

Poupart expresses fear that Attorney-at-Law will promulgate legislation that will not be in best interest of Indians.

Does not receive support of Indians.

Rejects assumption Indians received trial by jury of their peers:

(*a*) Indian people do not vote.

(*b*) Juries are drawn from registration lists.

(*c*) Although a greater percentage of crimes are committed by Indians, there are no Indian police—Non-Indian judges and probation officers—non-Indian wardens and deputy wardens. Police brutality, with no recourse.

Pre-sentence investigation looks at the following:

You didn't finish school—bad mark.

You don't have a skill—bad mark.

You don't have a permanent residence—bad mark. (Keep going back and forth to the reservation, you can't find a home and settle down).

You don't have a job—bad mark. (65 percent of people on reservation don't have jobs).

You don't have a credit rating—bad mark.

The system never looks to the reason as to why they dropped out of school. Dropout rate 6 times greater than other ethnic groups.

Recommendation: Re-evaluation of pre-sentencing procedures and parole system. More training for individuals who have a decision on these matters, if other than Indian.

Orville E. James, Associate Warden (Retired), El Reno Federal Reformatory. Address: 1602 Ridgecrest, El Reno, Oklahoma 73036. Tel. [redacted]. (Could be further utilized as Consultant.)

Work release programs in states should be further developed.

Reticence of Indian inmates to staff. No rapport.

Attitudes of staff are very negative.

Recommendation: Pay advisors small fee to work with parolees; senior citizens could be utilized (Indian). Training (Orientation) for these Advisors. Entire prison system should be over-hauled.

Lawrence Hart, Director, Committee of Concern, Inc. P.O. Box 173, Clinton, Oklahoma 73601, Tel. (405)–323–4111.

Has two (2) Programs:

1. Indian Offender Rehabilitation Program. Funded BIA.
2. Adult Misdemeanant Program. Funded LEAA.

98 percent of the clients were convicted for alcohol related crimes or perpetrated while intoxicated.

Drugs, other than alcohol, are not too prevalent.

Indians are not fully apprised of their basic rights or do not fully understand these, e.g., a ninety (90) day period in which they can file at appeal—the majority do not avail themselves of this procedure. Although the Committee of Concern is an advocate, they do not learn of the inmates' predicament until the ninety (90) day period has elapsed.

Mr. Hart recommends an Indian Counselor be provided to make these available to the inmate. He is very distrubed about the inadequacy of court appointed attorneys; sometimes when the charged is able to post a bond, using friends or relatives, the judge will not appoint an attorney to represent the client, taking the position that if they can post bond they can certainly get a lawyer.

He recommends a legal aid society for Indians. When an entity such as this has tried to organize, they encounter formidable resistance from the County Bar Associations.

Congress, the courts, and the medical profession now recognize that alcoholism is a major disabling illness. Therefore, the Task Force believes that revision of the Federal Criminal Code should explicitly provide that alcoholism is a defense to prosecution under Federal law to the same extent, and under the same conditions, as mental illness. Such legislation would substitute appropriate treatment and rehabilitation under civil law for punishment under the criminal law.

[From the "Alcoholism Report," 6/14/74]:

In a case dramatizing lack of treatment in penal facilities, the city of Cheyenne, Wyo., has been successfully sued and ordered to pay $70,816.43 in connection with the death of an alcoholic who spent nine days in the city jail without medical treatment.

The suit was brought by the estate of Donald Leon Ellis, a 49-year-old alcoholic who died December 9, 1971, after his arrest and sentencing on a public drunkenness charge. G. L. Spence, Attorney for the estate, brought the suit under Wyoming's Wrongful Death Statute, claiming that the city was negligent in failing to provide medical treatment or proper food and sanitary conditions during Ellis's incarceration.

During the trial, witnesses testified that Ellis went through delirium tremens, was given only wine and aspirin, and allowed to remain on a concrete floor. In addition, Ellis suffered from advanced liver cirrhosis. No medical help was called prior to his death.

A jury of seven men and five women returned a verdict against the city February 1 in the Laramie County District Court. The verdict was not appealed.

Robert A. Moore, M.D., Medical Director of Mesa Vista Hospital, San Diego, Calif., an expert witness in the case, wrote AR that "the monetary aspect was not the issue but rather the attempt to prevent future mistreatment of alcoholics in jail." Its outcome, he added, "is certainly a hopeful sign and it might encourage lawsuits in other areas where the Uniform Act [1] still has not been passed into law."

Comes now Peter Fong, a physicist at Emory University, with a cure for almost everything:

Double the corn crop acreage. Use the corn starch to make ethanol (say 20 percent) with gasoline. There goes the energy crisis. Feed the protein and oil from the corn to animals. That lowers the price of meat. Use the liquid effluent from sewage plants to fertilize the cropland. So much for water pollution. To handle the farm chores, move the hard-core unemployed from the ghetto (ending slum problems) and establish them on the corn farms, where each family would distill its own alcohol from its own crop.

"With an abundant supply of alcohol available, the only problem left," he said, "is to prevent ourselves from drifting into a nation of drunkards. But this seems to be the least of all evils."

Dr. Fong presented his utopia, seriously, at the national meeting of the American Physical Society in Washington.

In *Powell* v. *Texas* 392 U.S. 514 (1968), the Supreme Court affirmed the status of alcoholism as a disease, even though Powell's conviction was upheld since the record failed to show that he was unable to avoid being intoxicated in public. The Court deplored the inadequacy of the governmental response to the national problem of alcoholism and the severe shortage throughout the country of facilities for the treatment of indigent alcoholics.

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[1] In Task Force papers submitted, See "Status on Uniform Act."

XV

EPIDEMIOLOGY

The precise figure on alcohol and drug abuse is an elusive one. The very fact of the "Denial Syndrome" among alcoholics and the question of legality in other drugs makes the figure, as previously stated, a very elusive one, since most of the individuals who have these problems escape the statistical sources which would generate a national total.

At this point the sources of information on alcohol and other drug usage are numerous but of unequal quality and usefulness (M. Lookout—Alcohol Technical Reports, 10/75). Random investigations, vital statistics, hospital records, court records and fragmented records of existing alcohol treatment centers can be and have been used for a determination of use and abuse. No single agency collects information on all aspects of the problem among Indians and Native Alaskans, nor does one agency have access to all sources of information which may be available. (M. Smith, testimony—Sioux City, p. 86; Comparative Studies and Their Problems, J. Westermeyer, M.D. Ph. D.—News Letter, Association of American Indian Physicians, 6/76)

Do we know why there is a reported higher incidence of alcohol problems among Indians, as compared to other races?

We would make three (3) recommendations:

1. Division on Alcoholism, Alcohol and Other Drug Abuse

Establish a distinct function, within the Indian Governmental Structure, which would have a stature commensurate with the magnitude of the problem with which this new entity would deal. Consequently, the likelihood of obtaining the funding necessary to effectively attack the Alcoholism, Alcohol and other Drug Abuse problems will be immeasurably increased. This Organization would also have the visibility necessary to provide a strong program of public education and to develop public attention to and concern about this problem. In addition it would have a permanent status which would assist in the development of the most qualified staff possible in Indian self-government structure.

(*a*) Convene a National Advisory Council (Indian) to establish guidelines and criteria to act in a policy definition and oversight capacity to this function. Composition could possibly be 40 percent Tribal Government and Treatment Providers; 60 percent Consumers.

(*b*) Establish an Indian evaluation board to periodically monitor and evaluate the programs.

(*c*) Set up structure that would establish permanent programs and positions for personnel.

(*d*) Provide operation and maintenance moneys.

(*e*) There must be a balanced and parallel thrust between research and programmatic approach.

2. Research

This could provide a foundation of facts on which intelligent, planned alcohol and drug treatment programs might be based. Intense and better-financed studies are critical in these areas. *But we cannot refuse to formulate tentative programs until such studies are carried out. The problem is present, severe, and demands immediate attention.*

No clear-cut definition of "Alcoholism" exists among Indians. Perhaps the body of knowledge and expertise about "alcoholism" now being disseminated is not relevant to Indians. The etiological definitions enunciated by Jellinek (and subsequently amended and developed) does represent a body of knowledge; but it is based on studies within the industrial societies where it was carried out. It is the result of "white" research, "white" criteria, "white" program goals, and "white" nomenclature. Consequently, the expertise and treatment-response based on such knowledge may be inappropriate, even if programs are "adapted" and "interpreted."

The projection of service programs for Indians is not and cannot be adequate until concise operational definition of "alcoholism" is available. (We are now utilizing such expertise by sending "simplified" instructional literature to illiterate (in English) communities.)

Do we know "what and how" we are going to prevent and educate? We recommend that the "Plan A" be instituted (found at the end of this section).

3. *Programmatic*

The continuum of care for the individuals with these problems is almost non-existent, primarily because of the lack of resources, both financial and staffing.

We would recommend that the programs follow the recommendations as set out in the "Accreditation Manual for Alcoholism Programs" as promulgated by the Joint Commission on Accreditation of Hospitals.

What is considered the core unit of a continuum of care is the "Intermediate Care Unit" (Half-way house). (The standards as promulgated by the Association of Half-Way Houses of North America could be utilized).

These are only general guidelines and the implementation of the therapeutic modalities *within each unit must be at the direction of the local unit.*

Standards (as we know them) must be established for accreditation and certification. J.C.A.H. criteria may be used and the certification as advocated by Region VI and John Mackey's committee may be used. (The National Indian Board on Alcohol and Drug Abuse is in the process of formulating these measures)

These areas could be addressed in conjunction with the respective task forces:

Task Force No. 5—Curriculum. Student rights, specifically when students are expelled for alcohol or other drug abuse problems, where do they go for help?

Task Force No. 6—Training or re-training of staff to gain insight of patients with these problems—"Attitudes." Research into "Fetal Alcohol Syndrome." (Preliminary paper by B. Albaugh, att.)

Task Force No. 7—Should industry have built-in programs to address these problems?

Plan "A"

An important objective of Task Force 11 is to delineate the role of alcohol in the life of American Indians, in particular to examine (1) Indian drinking patterns, (2) the effects of Indian alcoholism, (3)

drug abuse problems, and finally determine the effectiveness of treatment programs for alcohol and drug abuse.

The most suitable mechanism for this investigation would be a cross sectional survey of the American Indian population designed to examine the role that alcohol plays in the life of the American Indian. A number of anthropological and sociological surveys and studies have been conducted among selected tribes. These studies have a number of limitations; among them their incompleteness, and limited scope; a major deficiency of these studies is that they were conducted by non-Indian social and medical scientists. In keeping with the objective of this Commission, which is to have Indians examine and document the condition in Indian country, we recommend that such a survey be conducted by Indian people utilizing professional experts in the areas of alcoholism research, sociology, and survey research. The following is our suggested plan for this survey.

ANTICIPATED DIFFICULTUES

A number of problems have plagued attempts to conduct social surveys among the Indian population and to measure problem drinking among this population. They are:

1. Language barriers

There are literally hundreds of Indian languages, and it is estimated that approximately 25 percent of the population to be surveyed is not fluent in the English language, and would have to be interviewed in their native tongue.

2. Cultural difference

The studies of alcoholism and definitions of alcoholism that have been developed for the general population are culture bound. Indian style of life, values, environment and drinking patterns differ significantly from the general behavior patterns, and survey instruments developed to measure the general population use of alcohol and problems relating to alcohol, are not appropriate to significant proportions of the Indian population.[1]

3. Population dispersion

The Indian population, except for a number of urban segments, is widely scattered in rural and reservation areas. Previous studies have not had the time and money necessary to complete interviews in far reaching parts of the country.

4. Difficulty in interviewing Indian population

Indian interviewees generally have a difficult time relating to non-Indian interviewers or to interviewers of another culture. Furthermore, the Indian population is understandably suspicious of Indians and non-Indians who represent the "Power Structure."

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[1] No clear-cut definition of "Alcoholism" exists. Perhaps the body of knowledge and expertise about "alcoholism" now being disseminated is not relevant to Indians. The etiological definitions enunciated by Jellinek (and subsequently amended and developed) does represent a body of knowledge; but it is based on studies within the industrial societies where it was carried out. It is the result of "white" research, "white" criteria, "white" program goals, and "white" nomenclature. Consequently, the expertise and treatment-response based on such knowledge, may be inappropriate, even if programs are "adapted" and "interpreted."

77-466—76——2

5. Interpretation of study findings

Most previous studies have been interpreted by non-Indians not familiar with the unique situation of the Indian population.

6. Diversity of Indian population

The Indian population is not a uniform ethnic group. Style of life and culture vary significantly among tribes. Some studies have been limited to one tribe or a few tribes, and their applicability to the general Indian population is suspect.[2]

With these major obstacles, we recommend the following plan: The survey team would be comprised of the following kinds of specialists:

1. Indians learned in the social sciences.
2. Indians possessing expertise in the field of alcohol and drug abuse.
3. Experts in the field of alcohol and problem drinking research, preferably scientists who have conducted cross sectional surveys to identify and measure the extent of problem drinking.
4. Survey research specialists who can deal with the problems of sampling, interviewer training and recruitment, survey data productions and statistical analysis.

INTERVIEW CAPABILITY

There are 151 NIAAA funded centers covering at least 90 percent of the Indian population. This field force represents a potentially unique facility for conducting survey research among the Indian population. They are trained counselors who are themselves Indian and members of the Indian community to be served. These counselors are already equipped to operate on a bi-lingual basis. The counselors are not part of the general tribal power structure, but are respected members of the community with whom the people have rapport. We feel this staff could be recruited and trained to conduct cross sectional surveys among the population they service; however, we fully recognize that any such group will encounter some difficulties in completing all interviews necessary and obtaining valid information. A question that we have is whether by being defined as alcoholic rehabilitation counselors they might inhibit honest and fair responses about drinking behavior. It was the general consensus of the Task Force that this problem would be minimal. We recommend, however, that this assumption be tested by conducting a pilot study where interviews are conducted by counseling staff, and by staff of recruited and paid interviewers. Results of these two forms of interviewing would be compared to attempt to determine the extent of difficulties to be encountered by utilizing the staff, and to determine the extent to which the staff might be better interviewers than other types of interviewers.

SECONDARY RESEARCH

An extensive review of the literature on Indian drinking behavior has been made by the Task Force. From this review, a delineation of Indian drinking behavior would be made which could be tested by the survey itself.

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[2] Knott, David H. M.D., Ph.D. A Comparative Evaluation of Several Current Issues, Submitted to Task Force 11, May 21, 1967.

SURVEY TASKS

Task 1—Establishing a sampling plan

In developing a basis for sampling the Indian population, a key question to be resolved is whether the sample will be the general Indian population or a series of samplings among tribes representative of Indian cultures. This determination would be made by the Commission. The development of a sample universe will involve obtaining most readily available information compiled by Task Forces 2, 6, 7 and 8 concerning the distribution of the Indian population.

Task 2—Drawing of the sample

An area probability sample of the Indian population would be drawn based upon the decision made in Task 1. This area of population sample would be drawn to conform to the general location of NIAAA funded programs. We do not feel this would be a difficulty, as the NIAAA program distributes as the Indian population distributes. Each of the drawn primary sampling units, map areas and other descriptive materials would have to be obtained for household selection within each Primary Sample Unit. We would assume that a great deal of this information is already available.

Task 3—Sample design and sample size

A determination of total sample size would be made based upon the specific objectives of the study. On the basis of which approved general cross sectional Indian population or selected tribes was chosen for the purpose of this document, we are assuming a sample size of at least 2,500 interviews. The sampling would be of full probability design with a random systematic selection of households and enumeration of households in designated areas. Furthermore, the selection of a respondent within a household would be on a random basis. Our intention is to limit the sampling population to those 16 years of age and older. Numerous call backs would be made to complete interviews with designated respondents.

Task 4—Recruitment and training of interviews for NIAAA centers

All interviewers to be utilized in this project would be trained in the execution of the questionnaire and sampling procedures to be used by a field training supervisory team.

The questionaire would be developed and tested by relevant consultants, and its objectives approved by the Commission. We would anticipate an extensive structured personal interview questionnaire which would probably take an hour to administer. A small pilot study would be conducted to test the instrument and test the abilities of the interviewers as noted above.

Task 6—Processing the data survey

Questionnaires would be coded and key punched in preparation for statistical analysis.

Task 7—Survey analysis and report

The survey data would be analyzed and reported by the Commission, utilizing appropriate consultants.

SECTION I

INTRODUCTION

I. INTRODUCTION

A. Task Force No. 11

The Congress passed Public Law 93–580 on January 2, 1975, a Joint Resolution, establishing the American Indian Policy Review Commission. Its purpose was to "conduct comprehensive review of the historical and legal developments underlying the Indians' unique relationship with the federal government in order to determine the nature and scope of necessary revisions in the formulation of policies and programs for the benefit of Indians."

The vehicle of investigation was to be through small task forces working independently in different areas of Indian affairs, such as trust responsibility, tribal government, education, and health. Although primarily a health problem, a separate task force was created to determine the scope of the destructive use of alcohol and other drugs by Indian and Alaska Native people.

The most important responsibility of Task Force No. 11 was to provide the basis for the Commission to make recommendations for necessary program, policy and legislation changes which would be more responsive to the needs of the Indian people who do, or will have, alcohol or drug use problems. This could only be accomplished by looking at the full spectrum of the Indian way of life and those external factors which influence their environment. Toward this end, the Task Force held field hearings and on-site visits to alcoholism programs, conducted an extensive literature and research review, examined existing and proposed legislation, analyzed federal, state and local alcoholism and drug programs, and used whatever means it could to determine the scope of the problem.

B. Scope of the Problem

1. HISTORICALLY

The use of alcohol and drugs is not a new phenomena among American Indians and Alaska Natives. However, early usage was primarily limited to ceremonies and religious rituals in a closely controlled social setting. Early frontiersmen and traders offered distilled beverages as gestures of friendship; unfortunately, the riches of the new land soon led those not so scrupulous to the exploitation of the Indian people by offering whiskey, rums, or brandies in return for hard-earned possessions. Many were induced to consume the liquor until they reached complete intoxication, then their goods were simply taken from them.

Historians note the terrible effects upon the Indian community from use of the alcohol beverages. Although acts of aggression to the family and community were common, the Indian community had no traditional way of coping with the actions of their people while under

the influence of liquor. While not socially accepted, the intoxicated person was not considered in control of his actions, and the tribal system was unprepared to administer strong restrictions or mete punishment to individuals drinking or intoxicated.

Congress passed legislation in 1832 prohibiting liquor traffic to and among the Indian people in an attempt to stem the increasing flow of problems attributed to the misuse of alcohol. Enforcement efforts of those laws were unsuccessful, and bootlegging and smuggling only became another form of exploitation by the non-Indian people.

The Indian people were given full citizenship by 1924; however, it was still illegal to serve an Indian liquor until the repeals of the federal-Indian liquor laws in 1953.

The ill effects of the introduction of distilled beverages into a socially unprepared society and resultant measures at control by a dominant society have played an important role in the formation of destructive drinking patterns by Indian people.

2. TODAY

The past twenty years have seen a growing awareness by all people of the United States of the devastating effect of alcoholism and alcohol and drug abuse upon it as a society. Alcoholism and alcohol abuse, a social, mental and physical disease, has a total effect almost immeasurable. It is estimated that there are nine to twelve million problem drinkers in the United States today—approximately 3 percent of the population. Also, the use of drugs has increased sharply in the past ten years and is now beginning to receive recognition as a major social and health problem, as well as a criminal action.

Nowhere is the effect of alcohol and drug misuse more prevalent and visible than among the American Indian and Alaska Native.

In a report by Indian Health Service (1970), it was stated that "Alcoholism is a costly proposition in every sense of the word. Personal health may be impaired by cirrhosis and its complications; neuropsychiatric disorders; and nutritional deficiencies. The majority of accidents, especially the fatal ones, are associated with alcohol, as are nearly all homicides, assaults, suicides and suicide attempts among Indians. The vast majority of all arrests, fines and prison sentences in the Indian population are related to alcohol. The loss of personal freedom and productivity, the breakup of families, the hardship and humiliation involved are considerable, although not easily measured."

Task Force No. 11 has found estimates ranging from 20 percent to 80 percent of some tribal populations (15 years old and above) as having drinking problems. Arrest rates for alcohol and drug misuse are far and above that of the general population. Death rates attributed to alcohol use are as much as 5.5 times that of the United States in general. Toxic inhalants which are highly dangerous have been found to be used by children as young as six years old, in one test group.

C. Summary of Findings

The Indian people, individually, and through their tribal leadership and health boards, have identified the destructive use of alcohol and drugs as the most important and pressing problem which they

face today. It has an adverse affect upon all aspects of their health, cultural, social and economic existence.

The federal government has a special legal relationship with the Indian people and has consistently, through Congressional appropriations, acknowledged a responsibility for the health of the American Indian and Alaskan Native. This is evidenced by the comprehensive health delivery system administered by the Indian Health Service. However, program efforts in the Indian alcoholism field did not begin until the Office of Economic Opportunity began funding some alcoholism programs operated by the tribes and other Indian groups in the late 1960's. The passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act in 1970 established the National Institutes of Alcoholism and Alcohol Abuse under Health, Education and Welfare to address the needs of America's problem drinkers.

Today, NIAAA funds approximately 153 Indian alcoholism programs through their special projects branch. These programs are funded as "start-up" grants and funding presumably lasts from three to six years.

The National Institute on Drug Abuse (HEW), which was established in 1973, funds 14 Indian drug treatment projects through the grants mechanism.

The Task Force finds awesome the totality of unmet need, particularly in the area of research, development of a valid data base, development of standards of performance, training of counselors and professionals, developing of management capabilities, building of facilities, designing of new and and innovative approaches, preventive education, etc.

The Indian Health Service conducted a study in 1970 that best expresses the difficulty in dealing with alcoholism and drug abuse problems and issues. "Alcoholism is an exceedingly serious problem everywhere in the nation, but virtually nowhere is it getting the attention it deserves from health workers, not to mention other professionals and community leaders. Its roots are many and complex. It is called a disease by some; a symptom by others; and apparently is totally ignored by a substantial number. Parts of the problem are in the domain of many different professional and non-professional groups. Yet, leadership and the full cooperation and participation of all are essential for its effective control. Although health workers have a part to play, perhaps a leading part, alcoholism is no less the responsibility of the clergy, teachers, law enforcement officers, courts, welfare agents, social workers, and perhaps most of all, the community itself. Alcoholism is harmful not only to the physical and mental health of individuals, but to family relationships, economic functioning and the whole fabric of society. It is a problem that demands attack on many fronts."

The investigations of the Task Force over the past several months have continually reinforced this statement. The Task Force has collected data, statistics and reports from federal agencies (NIAAA, IHS, BIA, LEAA, and others), from state agencies (the New Mexico State Highway Patrol, for instance), from the states with high concentrations of Indian people, and from tribal and other local entities. Alcohol-related disease rates, deaths, suicides, homicides, arrests rates, school drop-outs, wife and child abuse, welfare, etc., are all so exceedingly high that one could almost conclude that the use

of alcohol and drug causes 80 to 90 percent of the problems of Indian people. Seemingly, if they were not drinking, the incidents would not occur. This conclusion, while having some validity, unfortunately does not get at the real issue of what prompts the Indian people to consume alcohol in this clearly destructive manner.

Alcoholism has been recognized as a treatable disease (a health problem) and some efforts in the health fields have been made for treatment and curative methods. However, most of the programs now in existence for Indian people are structured primarily for the treatment of alcoholic persons and even then, in most cases, act only to arrest the progress of his disease temporarily. Thorough research by the Task Force indicates that while the alcoholic in need of medical care cannot be neglected, the only long-range approach to negation of the ill-effects of the extreme high rate of alcohol use among Indian people is in prevention and provision of alternatives.

This is supported by responses to a Task Force No. 11 questionnaire, wherein tribes, programs, and individuals identified prevention and preventive educational programs as the most needed services. The second most frequently expressed need was for "returning to traditional heritage and culture, and utilizing the Indian culture and treatment programs." The hearings conducted by Task Force No. 11 also indicated a growing interest of many Indian people in joining the Native American Church which has a strong traditional background and exerts strong social controls on the use of alcohol and drugs.

The Task Force therefore recommends that priorities of long-range strategy be placed upon prevention and emphasis upon traditional heritage and culture. This strategy must include further research into the identification of causative factors, the betterment of education programs, the creations of training programs, jobs and recreational opportunities which address the prevention of alcohol-related problems, and the provision of alternatives to drinking.

Research into causative factors also proved to be a complex task, with identification of causes including physiological, group drinking patterns, federal dominance, acculturation, poverty, lack of education, "feel good," aggression, anxiety and lack of self-esteem. At present, there is not even a clear-cut working definition of alcoholism. *The only one-hundred percent positive cure for alcoholism, drug addiction or other substance misuse is total abstinence.* There is no other simple way. The causative factors of both alcohol and drug misuse are varied and complex, with most being more symptomatic of larger and broader influences such as unemployment, lack of education, poor housing.

Alcoholism is both a social and mental health illness and only becomes a "medical disease" when the individual is suffering from alcohol addiction, cirrhosis, delirium tremors, and other disease syndromes which are alcohol-related.

In the world of the Indian people, however, circumstances and forces brought to bear by a non-Indian civilization, culture and government and the resultant forced-dependence on top of all "normal" pressures that a citizen is subjected to, have created a compelling push-pull anxiety wherein alcohol has become a primary coping mechanism. A successful, long-range strategy to combat the destructive use of alcohol and drugs would have to be formed with respect to this premise.

The Task Force has found in its investigations that the total program effort by federal, state and local entities falls far short of coping with the needs of the Indian problem drinker and drug user, with the existing programs fragmented and of uncertain duration. In order for the federal government to address the dysfunction of alcohol and drug misuse to the health and social well-being of the Indian people, the Task Force recommends:

1. Giving the prevention and comprehensive treatment of alcoholism, alcohol-related problems, and drug-misuse the highest possible health priority at all levels of federal Indian policy and programs.

2. The passage of a Joint Resolution by Congress for the purpose of establishing a long-range continuing commitment for whatever resources are necessary to eliminate this major problem.

3. The development of a distinct national Indian alcohol and drug abuse entity designed to pull together the multitude of resources, programs, and professional expertise in a coordinated way. The new entity would need the status commensurate with the magnitude of the problem with which it would deal.

A broader discussion of these and other issues and problems, along with more specific recommendations will be included in Section II of this report.

SECTION II

ISSUES, PROBLEMS, AND RECOMMENDATIONS IN THE INDIAN ALCOHOLISM AND DRUG ABUSE FIELD

A. Federal/State Relationship and Policies
B. The Indian People, Alcohol and Drugs
C. Scope of the Problem
D. Alcohol and Drug Abuse Programs
E. Recommended Legislative Actions
F. Other Issues:
    1. Community and Social Impact
    2. Economic Impact
    3. Prevention and Preventive Education
    4. Indian Representation
    5. The Law, Alcohol, Drugs and the Indian

II. ISSUES, PROBLEMS, AND RECOMMENDATIONS IN THE INDIAN ALCOHOLISM AND DRUG ABUSE FIELD

A. Federal/State Relationships and Policies

The Indian people have a direct unique federal/Indian relationship as well as being eligible and entitled to the same services, state or other, which are extended to any citizen.

The federal/Indian relationship is a historical one, predicated upon treaties and laws, and special federal programs have been established and operated over the years specifically to serve Indian people. The Bureau of Indian Affairs and Indian Health Service are two such programs. The Snyder Act (25 U.S.C. 13) of 1921 set forth authorities for the Bureau of Indian Affairs to expend such moneys for the benefit, care and assistance of Indian people *throughout* the United States for, among other things, general support and civilization (including education), and the relief of distress and conservation of health.

The Transfer Act of 1955 gave recognition to the special health needs of the Indian people and the Alaska Natives by transferring the health functions of the Bureau of Indian Affairs to the Department of Health, Education and Welfare. The establishment of the Indian Health Service, as a separate entity, gave it a national visibility necessary to deal with the major health problems of the Indian people. Although the authorities to serve Indian people *anywhere* are set forth in the Snyder Act, the scope of IHS services was and still is defined by the annual appropriation process of Congress. The IHS program provides services for approximately half of the estimated total number of Indians in the United States. These services are normally provided to those Indians living on or near federal Indian reservations and in traditional Indian country, such as Oklahoma and Alaska.

While the federal responsibility toward the health and general well-being of the Indian people is well-established, the states are not bound by this historical relationship. The consequences of this dual citizenship of the Indian people—that with the federal government and the states—are far reaching but generally misunderstood or ignored.

1. PROBLEMS

The states and some local governments have long regarded the Indian people as wards of the federal government, thereby absolving the state and local government of any responsibility. The Federal Government, on the other hand, assumes that, as citizens and residents of the state, the Indian people will be able to tie into the delivery systems of the states. These assumptions have caused a multitude of

problems in all fields, as well as in alcoholism, alcohol and drug misuse, and other health areas:

(*a*) State allocations for alcoholism monies not given to eligible Indian programs supposedly because they have supporting NIAAA funds;

(*b*) State and local hospitals refusing services to Indian people, directing them to go to "their own" hospitals, even if this means traveling 100 miles;

(*c*) Counting of Indian people to qualify for federal block grant funding, but not using the money specifically for Indian programs;

(*d*) An endless list of incidents between state institutions and Indian individuals perpetrating a fear by Indians toward any kind of state control.

The federal policy of serving only those Indian people "on or near" federal reservations has created a division between the "urban" and "reservation" Indian. Eligibility is not the issue—all Indians are *eligible*. However, this criteria used for provision of services has caused factionalism among brothers, tribes, and those programs designed to serve Indian people. The resulting fight for the "dollar" is destructive, renders many programs ineffective, and is degrading to the Indian people.

2. CONCLUSIONS

There is a federal responsibility and also an expressed authority for federal agencies to provide services for Indian people. This was confirmed in the Snyder Act and Transfer Act. Health is one of the services for which Indian people are eligible, and alcoholism, alcohol and drug misuse are health problems. The Indian people have also identified alcoholism and alcohol-related incidents as their No. One health problem.

The Indian people are citizens of the United States and therefore are eligible for whatever services or benefits any other citizen is eligible for. The refusal to provide such services on the basis that Indian people are wards of the federal government and the responsibility of the federal alone is unlawful.

3. RECOMMENDATIONS

(a) That a revised formal policy be issued reaffirming and clarifying the federal responsibility and facilitating the implementation of those authorities contained in the Snyder Act which provide for services to Indian people wherever they may reside.

(b) Every measure must be taken to protect the basic rights of Native Americans as citizens. States must be cautioned that abrogation of these rights is unconstitutional and will be dealt with in federal courts.

B. The Indian People, Alcohol and Drugs

There are many reasons why a person uses alcoholic beverages or drugs. A few of these reasons are "to get high," "to relax," "to forget my problems," and "have fun with my friends." In a highly complex industrial society such as the United States, these are common, understandable, and for the most part, normally acceptable. The question then becomes: When does the use of alcohol become a

problem? *Any* use of alcohol or drugs which affects or interferes with *anyone's* health or well-being is a problem. Further discussion only deals with varying degrees of severity. It progresses from a social or mental illness to a "medical disease" when the individual suffers from addiction or other disease syndromes.

The American Indians and Alaska Natives are some of the most deprived, isolated, and misunderstood people in the United States. Before the advent of the European settlers, the Native Americans were proud and culturally secure people and were at peace with themselves and the land on which they lived. They were rich in every sense of the word. Historically, their causative factors were positive, limiting alcohol and drug usage (such as peyote) to ceremonies and spiritual rituals. It permitted their "spirits to soar," gave them "vision." Deviance from this controlled usage was not permitted.

The steamrolling effect of the "civilized society" upon the Indian people has wreaked a havoc which extends far beyond that of loss of material possessions. The American Indian and Alaska Native are caught in a world wherein they are trying to find out who they are and where they are, and where they fit in. The land which was once their "mother," giving them food and clothing, was taken. Their spiritual strengths were decried as pagan, and familial ties were broken. Their own forms of education, i.e., that of legends, how to live, how to respect themselves and others, were torn asunder by the "white society's" reading, writing, and arithmetic. No culture could, or can be, expected to be thrust into a world different from its own and adapt without problems of cultural shock. Also, the Indian people were not even given citizenship until 1924. An 1832 federal Indian law prohibiting the sale of liquor to Indian people remained in effect until 1953 and could have been instrumental in the formation of the "hidden group," "drink until it's gone," and "quick" drinking patterns that Native American people exhibit. The Indian people of today are proud of their heritage and are fighting to maximize its influence upon their lives in a dominant white world. Many have succeeded. Many have not.

The problems of alcohol and drug misuse among Indian people are much the same as in any society, only magnified by the need for self-identity and freedom from values and controls forced upon them. The non-Indian society is one they know they must exist with. However, they want the right to choose whether to join or reject it.

In any case, destructive use of alcohol and drugs among Native American and Alaska Native individuals, families and communities is inextricably interwoven into all aspects of their lives and any effort to alleviate the problem must be comprehensive in scope and with the full commitment of the Indian people and that of the federal government to support them in any way necessary.

1. PROBLEMS

(*a*) Existing research, as yet, has been unable to successfully put alcoholism into one specific classification such as physiological, mental, or whatever, although there are proponent of each. Some research projects have even attempted to prove that Indians genetically have inherited traits which make them susceptible to the ill effects of alcohol.

77-466—76——3

(*b*) Unless a high priority is put on research on *Indian* alcohol and drug use, legislation such as Public Law 94–371, which extends NIAAA's authority for another three years and carries authorities for expanded alcohol research, will not allocate sufficient monies to specific Indian alcohol research projects.

(*c*) Although the destructive use of alcohol and drugs has been recognized as a major social health problem, the causitive factors are varied and complex. In the illness of alcoholism, for instance, the various stages can be classified as mental, social, behavioral, addictive, and nutritional. This makes diagnosis and treatment of just this single alcohol-related disorder alone difficult, at best.

(*d*) Years of forced dependence upon the federal government through the "reservation system", and being treated as second- or third-class citizens by the rest of society, have built drinking patterns among Indian people that are highly destructive and will take a concentrated and comprehensive effort to alter.

(*e*) Alcoholism and destructive alcohol use are not the same and this difference is crucial. Alcoholism is the physical disease. The treatment or handling of the two are not necessarily the same. Drug misuse (i.e., marijuana, LSD, heroin, barbituates and others) is illegal. Past the point of legality, only addiction and disease syndromes are the "medical disease."

(*f*) In spite of being recognized a health problem and identified as the Indian people's highest health priority, alcoholism, as a field and as the treatment of such, has not reached a level of professional status, and is treated as an afterthought by most health programs, if at all.

(*g*) Most of society, although familiar with "the drunk," is ill equipped to handle those in need of assistance. Also, most medical facilities neither have detox units, nor are the personnel trained in the counseling or treatment of the alcoholic or inebriated.

(*h*) The illegality of drug use and the reluctance of the individual to admit to having a dependency or making excuses for deviant behavior while under the influence of either alcohol or drugs makes the measurement of the precise figure on alcohol and drug misuse an elusive one. This same denial factor makes it difficult to plan a strategy of *prevention* before the "crisis" stage is reached.

2. CONCLUSIONS

The American Indian and Alaska Native is caught in a search for self-identity and a struggle for control of his own destiny. These frustrations, coupled with lower health levels, higher unemployment, poor housing, lower education levels, poverty-level income, and isolated living conditions, have made their society ideal for the development of destructive alcohol and drug use. Until these underlying problems are addressed, the task of changing the drinking and drug use patterns of the American Indian and Alaska Native is a monumental one.

There is a continuing need for more research into both positive and negative factors of problem drinking and drug usage, particularly to the high destructive patterns of drinking exhibited by the Indian people. Inherent in this research would be the development of new and innovative methods of treatment tailored to the needs of the Indian people.

3. RECOMMENDATIONS

(a) That sufficient appropriations be designated for a comprehensive and scientific research study into both the positive factors and negative factors of the destructive alcohol and drug usage among Indian people.

(b) That such a study would, at the same time, make recommendations, based on their grass roots research, for the development of new and innovative methods of treatment which are specifically designed to meet the needs of the Indian people.

C. Scope of the Problem

That alcoholism and the destructive use of alcohol and drugs is one of the most serious health problems facing the Indian people today, is a fact now clearly recognized by both the Indian people and the federal agencies responsible for their well-being.

Measurement of the extent of the Native American and Alaska Native alcoholism, alcohol and drug usage problem is extremely difficult. The "denial syndrome" among alcoholics and the question of legality in other drugs makes the figure elusive, since most of these individuals escape the statistical sources which would generate a national total.

Existing sources of information on alcohol and other drug usage are numerous but of unequal quality and therefore of questionable value.

No single agency collects information on all aspects of alcohol and drug usage. As stated in the Indian Health Service Task Force Report on Alcoholism (1970):

> Unfortunately, those with the closest contact with Indians are often the least scientific in their judgments, while those who set up a rigorous study design occassionally have insufficient knowledge of Indians and their ways. Adding to the confusion are differing definitions of the problem, different patterns of drinking in the various Indian groups.

The Indian Health Service goes on to make a very important point which is often overlooked by outside agencies: ". . . the North American Indians are a heterogenous population with a great diversity of cultures, attitudes and religious persuasions."

The material and statistics gathered by the Task Force reflect this lack of uniformity. Statistics have been pulled from IHS reports, individual studies, testimony from individuals, tribes and alcoholism programs. Some of the following figures reflect the extent and serverity of the problem:

In calendar year 1973, on the twenty-four federal reservation states 6.9 percent, or 399, of the total Indian and Alaska Native deaths were primarily attributed to alcoholism, alcoholic psychosis or cirrhosis with alcoholism. This number makes the overall mortality rate for deaths primarily attributed to alcoholism 51.9 per 100,000, or an increase of 23 percent over the rate of 1972. As seen from data over the past few years, the Indian and Alaska Native suffer a death rate from alcoholism of 4.3 to 5.5 times that of the United States—all races.

Of the total deaths *directly* attributed to alcoholism, 59 percent were the result of cirrhosis with alcoholism; 39 percent due to alcoholism; and 2 percent from alcoholic psychosis. These figures do not

take into consideration deaths *indirectly* attributed to alcohol which include a large portion of accidents.

Of the 1,000 deaths from accidents for 1973, a substantially large percentage were due either directly or indirectly to alcoholism or excessive drinking. The mortality rate for accidents in fiscal year 1975 for Indians as compared to the U.S., all races, was 163.2 per 100,000 and 51.7 per 100,000 respectively, again with a large portion alcohol-related.

Accurate data on the percent of accidents which are alcohol-related is difficult to obtain largely because many are not recorded as being directly related to alcohol, but instead, to the immediate cause of injury or death.

Since very little data exists showing the total extent and patterns of the Indian and Alaska Native peoples' excessive use of alcohol, specific populations must be observed. For example, in one central plains reservation, 70 percent of the population over 15 years of age reported that they drank. This included 82 percent of the men and 55 percent of the women. When broken down into age-specific groupings, 99 percent of the men, age 20 to 29, drink and 72 percent of the women. In the age group 30 to 39, 93 percent of the men and 85 percent of the women were reported drinking. Drinking, as seen from data, reaches its peak between the ages of 25 to 44. Percentages of drinkers varied in different tribes from 73 to 85 percent in men, and 20 to 68 percent in women.

In this same community, children were reported as beginning to drink between the ages of 9 and 17. In the age group of 15 to 19, 60 percent of the boys and 40 percent of the girls reported drinking. Out of 74 persons over 18 in one small Great Lakes Indian community, only 7 did not drink or drank moderately.

In Minnesota, where the Indian population is 35,000, 40 percent or 14,000 people have a serious problem relating to alcohol.

Boston, which has an Indian population of approximately 3,500, estimates that from 400 to 800 people are suffering severe incidence of alcoholism.

Statistics from the National Institute of Mental Health for 1973 show that 75 to 80 percent of all suicides among Indians are alcohol-related. This rate exceeds that of the general population by two to three times. The National Center for Health Statistics states that as of 1972, suicide was one of the three fastest rising causes of death among Indian people.

In the Ambulatory Patient Care Report for IHS hospitals and contract facilities for fiscal year 1975, out of 851 suicide attempts (first visit), 391, or 46 percent, were alcohol-related

The crude death rates of suicide of Indian people on reservations to United States, all races, in fiscal year 1975 was 21.8 per 100,000 to 12.1 per 100,000 respectively, with a ratio of 1.8.

The homicide rate for American Indians, although declining over the last decade, while the national rate has increased, is still three times the national average.

One of the many other problems indirectly linked with excessive use of alcohol is that of child and wife abuse. Very few statistics can be found relating to these problems, mainly due to the fact that they are not recorded as such in hospital records, but instead are lumped with other categories such as accidents. If child and wife abuse are recorded

as such, again, many times they are not linked to alcohol which is oftentimes the cause of injury.

In the Ambulatory Patient Care Report for IHS for fiscal year 1975, battered child injuries number 84 first visits, 32, or 38 percent of which are alcohol-related. No such data was available on wife abuse.

Figures for the arrest rate of alcohol-related crimes range from 7 times to 22 times higher for Indians than non-Indians. No consistent number could be found, although it can be assured the rate is definitely higher for Indians considering population differences.

In Salt Lake City, Utah, where Indians make up approximately one-third of one percent of the population, about 40 percent of the arrests for public intoxication were Indians. For alcohol-related crimes (driving under the influence, liquor law violations and drunkenness) for 1975, Indians comprise 21,069 of the urban arrests and 2,131 of the rural.

In New Mexico, the Indian population is only 7.1 percent of the total, yet 7 percent of the juvenile arrests and 19 percent of the adult arrests were of Indian people in 1974.

In 1971 reports on city arrest data, 75 percent of all arrests among Indians were alcohol-related, compared to 33 percent among all arrests for non-Indians. This would make the ratio of Indian to non-Indian 2.27.

For juveniles, 18 years and younger, city arrest data for 1971 shows Indians having 25.1 percent of all arrests alcohol-related compared to 7.2 percent for non-Indians.

When discussing arrest rates for juveniles, it is reported in a study by LEAA that more than half of the nation's juvenile delinquents come from families containing alcoholics. This study states that in approximately 50 percent of the nation's divorces, which can be a contributing factor in delinquency, the use of alcohol was a major factor in the separation. It further states that at the present time, there is an estimated 28 million children affected by parents with drinking problems.

Drug abuse is seen to be on the increase among Indian people, especially youth. In the first quarter of calendar year 1974, the number of drug abuse cases seen in mental health programs has increased by almost 50 percent (reported by Indian Health Service).

In Minnesota, there are 8,750 Indian youth from ages 11 to 18 years old using abusive chemicals. Sniffing is on the increase and now makes up 73 percent of all offenses for American Indian youth in Minnesota as compared to 15 percent for non-Indian youth.

Testimony and studies received by the Task Force indicate that solvents used for sniffing purposes and marijuana usage are definitely on the increase, with these two substances being the most common, except for alcohol.

Since destructive usage of substances other than alcohol is on the increase and relatively new to the Indian people, especially youth, data is particularly unavailable. With the recent funding of 14 Native American drug abuse programs through National Institute on Drug Abuse, the statistics which are needed to ascertain and evaluate the problem of drug abuse among Indians should become available within the next few years.

The data referred to on these pages is expanded into charts and tables available in the Appendix on Statistical Information.

D. Alcohol and Drug Abuse Programs

Although the problem of alcoholism is not a new one, it has only been in the last seven years that any significant federal effort has been mounted to deal with it. The first apparent recognition of alcoholism as a high priority health problem came in October, 1968 when the Indian Health Service appointed a Task Force to review the extent of alcoholism on Indian reservations and communities, evaluate existing programs and resources, and *provide guidelines and plans of action to assist in meeting the problem.* In its report (1970), IHS stated:

> It is the policy of the Indian Health Service that services and programs for the prevention and comprehensive treatment of alcoholism be given the highest possible priority at all levels of administration.

In 1970, the President's message on American Indians further emphasized the need for program efforts. Monies from the Office of Economic Opportunity ($1.2 million) and the National Institute of Mental Health ($750,000) were pledged in an interagency cooperation and 39 alcoholism projects were funded by OEO and NIMH through IHS. Subsequently, the National Institute on Alcohol Abuse and Alcoholism was established pursuant to the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970. This Act gave NIAAA the sole authority and mechanism for funding Indian alcoholism funds for six years. On July 26, the President signed into law Public Law 94–371, which extended NIAAA's authority for another three years. The authorities of NIAAA do not authorize funds specifically for Indians; in fact, the law, as renewed, only designated them as an emphasis. As succinctly stated in the Report of the Committee on Interior and Insular Affairs, United States Senate, on the Indian Health Care Improvement Act:

> The decision to allocate a portion of NIAAA's funds for Indian programs and to establish an Indian desk within NIAAA to assist in the administration of these programs was purely discretionary, and therefore, neither constitutes a guarantee that alcoholism monies will be available for Indians, nor indicates that the federal government has any responsibility to provide alcoholism programs for Indians.

Additionally, the grants administered through the Special Projects Branch are considered as "demonstration" or start-up grants, lasting from three to six years. It can readily be seen that an ongoing alcoholism priority is difficult to sustain under these conditions.

The National Institute on Drug Abuse, established in September, 1973, currently supports 14 treatment projects in which Indians are provided assistance. However, here again, NIDA has no specific legislation for Indians and the funding of Indian projects is discretionary.

Other agencies which either have specific legislation for Indian people (BIA and IHS), or impact upon the delivery of services (DOL, ONAP, OE, LEAA, HUD), as well as state agencies, often point to NIAAA as having the lead responsibility. IHS's role is limited to providing liaison with Indian communities, identifying critical needs and assisting with technical expertise when interfacing with the health system. BIA quickly points out that it also does not have any legislative authorities. The Bureau does recognize that alcohol abuse is a major socio-economic and health problem among the Native American population, and therefore established a position (Alcoholism Program Specialist) essentially to keep the BIA apprised of "what's happening" in alcoholism.

Federal direction in the past decade has been moving toward decentralization and the funding of block grants to the states, with the corresponding elimination of categorical programs. This direction has been dramatically confirmed by the administration's proposal to consolidate the NIAAA project and state formula grants programs into a massive block grant scheme with the monies going to the states.

President Ford reaffirmed this position while reluctantly signing the legislation which extends NIAAA authority for three years. He said that the law was "based on a policy of perpetuating the maze of categorical federal health programs." He also indicated that his proposed block grant health plan has not been laid to rest and the signing of the alcoholism renewal legislation was so "that in the interim, assistance will be provided for these important programs."

The Task Force reviewed the state alcoholism plans for those states which had large concentrations of Indian people. Most state alcoholism efforts were under the umbrella of the mental health programs and did not appear to receive planning or funding priority.

State alcoholism and mental health programs distribute formula grant funds on the basis of population and not needs. The Indian or "minority" is sometimes identified as a special target group, but rarely do funding priorities in distribution follow. The stated emphasis and plans "sound good" but somehow, the effort is not reflected at the local level. Testimonies indicated that if the programs had to depend upon the states, they could not exist.

Many states feel that the federal government should have total responsibility for the Indian people and that since the Indian programs are primarily (and most of the time, solely) funded by NIAAA, they do not need to give the Indian programs any funding.

One state issued a memorandum which blatantly stated this position and the money was held up. A call to the Civil Rights Commission somehow brought a quick reversal. The Indian people historically have fought this battle with the states and their fear of the administration's block grant proposal seems well founded.

1. PROBLEMS

(*a*) There is no specific authority for Indian alcoholism and drug abuse programs, only discretionary authorities and funds.

(*b*) Agencies which have specific authority to provide services to Indian people are looking to NIAAA which does not provide leadership.

(*c*) In the game of "who is responsible?," the alcoholic, or problem alcohol or drug user is the one who suffers and does not receive the help he needs.

(*d*) The *stated* high priority by both federal *and* state programs far exceeded the funded priority that actually reaches the programs.

(*e*) The states count the Indian people for basing their formula grant proposals but not for the allocation of funds.

(*f*) The programs are fragmented, often duplicated, and suffer from poor communications up *and* down.

(*g*) Existing programs are underfunded.

(*h*) Most of the federal grant monies are intended as seed money or start-up money. After three to six years, the programs are to have

identified alternative resources, but unfortunately in the Indian communities, there are no alternative resources.

(*i*) Short-term funding and planning make long-range planning, program, and client commitment difficult.

(*j*) The relative newness of the programs and the difficulty in collecting information on Indian people has created a lack of a reliable data base. This makes effective evaluation and application of standards almost impossible.

(*k*) The lack of fixed program responsiblity has resulted in many substandard programs as evidenced by lack of accountability to funding sources, the client, and the community.

(*l*) Lack of adequately trained personnel at all levels.

(*m*) The programs are open to both men and women; however, the treatment and rehabilitation services are geared to men.

(*n*) Alcoholism and drug abuse programs are normally separate although certain similarities would make it feasible for combining at least the prevention, rehabilitation and administration components.

2. CONCLUSIONS

(*a*) There is a demonstrated need by the Indian people for alcoholism and drug abuse programs.

(*b*) The evidence of fragmented federal and state program efforts in which the clients "fall into the cracks" indicates a needed change in strategy.

(*c*) The local alcoholism programs generally lack the funding and training which is necessary to conduct a comprehensive alcohol or drug abuse prevention and treatment program.

3. RECOMMENDATIONS

(*a*) *Make the legislative changes necessary to reflect a continuing commitment to combat the problems of alcoholism and the destructive use of alcohol and drugs among the Indian people.*

(*b*) *Strengthen the Indian alcoholism and drug abuse programs by upgrading their administrative and professional staff capabilities.*

set standards of performance;
fix responsibilities;
provide for further training of staff.

(*c*) *Force accountability of the programs to the funding source—the tribe, the community, the clientele—through contract and grant compliance.*

E. Recommended Legislative Actions

Section 2 of the Indian Health Care Improvement Act reads: "The Congress finds that—federal health services to *maintain and improve the health of the Indians are consonant with and required by* the federal government's historical and unique legal relationship with and *resulting responsibility to*, the American Indian people" [emphasis supplied] and further: ". . . a major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."

The testimony, the statistics, the loss of life, health, and dignity clearly demonstrate the need of the Native Americans and Alaska

Natives. Through their tribes, health boards, and individually, they have identified alcoholism and the destructive use of alcohol and drugs as their number one health problem.

1. CONCLUSION

History has shown that short term funding and verbal commitments, however well-intentioned, lead to false hopes and frustrations. Accordingly, the Task Force feels that a long range commitment by both the Indian people and the federal government to combat the adverse effects of alcohol and drug use is the only way they can be alleviated.

2. RECOMMENDATIONS

(a) *Congress demonstrates its commitment to the upgrading of the health of the Indian people and alleviating the adverse effects of alcohol and drug use by establishing a Joint Resolution which will:*

(1) Set forth a national statement of policy which will acknowledge its appropriate role and responsibility for all Indian people.

(2) Provide maximum community involvement at all stages of planning and implementation in concert with the principles of "self-determination" as set forth in PL 93–638 and the proposed Indian Health Care Improvement Act (S. 522).

(3) Provide the needed authorities and resources to evaluate the long-range goals of the Indian alcoholism and drug programs.

(4) Develop the criteria, provide the authorities and appropriations necessary to create a comprehensive national Indian alcoholism program. This program would have as its goal: *The reduction of alcohol and drug use among all Native Americans and Alaska Natives everywhere.*

The program would be designed to interrelate the health care aspects with other components of a comprehensive alcohol and drug abuse program and would insure that the development and implementation of an alcohol and drug abuse program be a joint effort of the alcohol and drug users, tribe, community and the federal government.

NOTE.—A draft of an alcoholism program which is built around a comprehensive health model is included in the Appendix.

This program entity would have to provide for a broad range of prevention, training, rehabilitation and research. The program would have to be given a separate and equal status, commensurate with the magnitude of this major health problem. It would need the legislative authority to deal specifically with the problems of the Indian people, coordinating the broad range of health programs in Indian Health Service and the social welfare and law enforcement services of the Bureau of Indian Affairs in addition to acting as advocate and liaison with all other federal agencies which impact upon Indian alcoholism and drug programs.

(b) *The Task Force has given much consideration to the appropriate placement and location of this program. The Task Force feels strongly that past efforts in this area from BIA, IHS and other agencies has lacked the comprehensiveness, scope and initiative necessary to encourage the most effective prevention, treatment and rehabilitation services. An analysis of the administration's position of categorical programs and the proposed Indian Health Care Improvement Act would lead us to recommend the most advantageous place in which to locate this program entity*

would be within the Indian Health Service. A word of caution accompanies this recommendation, however. (1) The program must address the problems of all Indian people; (2) the IHS must work hand in hand in making its full range of health programs and facilities responsive to the alcohol and drug user and programs.

(c) Provide for the development of a long range (ten to fifteen year) plan which would involve a coordinated effort of the Executive Branch and the Office of Management and Budget during appropriations hearings.

(d) Provide for annual Congressional oversight hearings to monitor the growth and performances of the alcohol and drug abuse programs.

F. Other Issues

1. COMMUNITY AND SOCIAL IMPACT

The importance of one's environment and the social pressures brought to bear upon an individual cannot be over emphasized. The ties of family, friends and community create a bond that is both the strength of the Indian people and yet many times, the nemesis of the alcohol and drug user. Too often the community ignores the weaknesses and only points to its strengths whether it be the people or economic and social successes. Nevertheless, not only does the individual have a responsibility to the community, but the community has a responsibility to the individual.

The alcoholic, the problem drinker and drug user affects every aspect of community life—welfare, health, family, economy, child adoption, to name a few. As pointed out in an earlier section, 70 to 80 percent of all suicide attempts, 90 percent of all arrests, 50 percent of marital difficulties, 38 percent of the cases on child abuse, and most associated social disorders are done while drinking or using drugs. Incidents such as these only create further misunderstandings in the community as to the needs of the alcoholic, problem drinker, or drug user. This magnitude of social decay cannot be ignored by the community.

Many times, the first reaction of the community is to ignore its ills or perhaps to reject them. Then again, the prevalence of destructive drinking or drug usage in some Indian communities has become almost socially accepted and a ready excuse for deviant behavior.

The Indian culture is built upon an individual's oneness with himself, family, tribe and universe. Economic and social pressures may disrupt this balance and contribute to the individual becoming a problem alcohol or drug user. This can occur while the individual is away from home, whether it is in an urban or rural area, or at home. If the individual is away and is unable to cope with the disruption of his universe, the sense of belonging to a community will kindle the desire to return "home," to familiar grounds and family or friends. Unfortunately, the individual often returns to the same economic and social pressures which may have perpetrated his problems with the use of alcohol or drugs. This is also true of the "client" who has just returned from a treatment center.

(a) Problems

(1) The alcoholic and problem drinker is an acknowledged problem within the community, but in most cases, the community either does *not want* to or does not know *how* to address the problem.

(2) There is too little effort to educate the community in the problems of the alcohol and drug user and include it in the planning of alcohol and drug abuse programs.

(*b*) *Recommendations*

(*1*) *That planning and implementation of preventive education, strategies and alcohol and drug abuse programs be built around the community and tribal entities.*

(2) *The building of new, and the strenghtening of existing, community development programs requiring that alcoholism and drug abuse strategies be built into their priorities.*

2. ECONOMIC COSTS OF ALCOHOL AND DRUG USE

The economic drain upon the individual, family, community, state and federal entities due to alcoholism, alcohol and drug use is monumental. Alcohol World Research, 1975, estimated the total overall economic cost to the American economy to be $25 billion per year.

There has not been a cost/benefit analysis in the Indian communities; however, a recent study by NIAAA on alcoholism treatment centers would give an indication of the enormity of the cost. NIAAA tried to assess the impact of the treatment programs from three viewpoints: that of the national economy, community economy, and that of the individual client. Specific benefits spotlighted were reduced hospitalization, increased earnings, decreased motor vehicle accidents and decreased criminality.

The results of the study indicated that for every dollar expended in the program, the national economy realized a return of $2.96. The community would benefit $11.46 for every dollar spent. (It was pointed out that the higher figure for the community was based on the fact that the federal government paid for a major portion of the program.) The cost benefit ratio for the individual client's economy was $6.21 for every dollar spent.

In Indian communities, the additional weight of the alcohol and drug users only compound already severe economic woes.

(*a*) *Conclusions*

Even though there has not been a cost/benefit study done on the Indian alcoholism programs, a projection from the study by NIAAA of A.T.C.'s would support a further conclusion that the benefits of alcoholism and drug abuse treatment programs far outweigh the costs to the national economy, the community, and the individual. Caution must be exercised, however, in relying solely on monetary values to measure benefits. It is difficult to measure the worth of *savings one's life*, the preventing of a child from being taken from his family, or the restoration of one's dignity.

(*b*) *Recommendation*

That cost/benefit analysis be used to emphasize the added benefits in the prevention of alcoholism, and the destructive use of alcohol and drugs.

3. PREVENTION AND PREVENTIVE EDUCATION

Many of the Indian alcoholism programs have indicated in their testimony at Task Force #11 hearings such things as: they were

pressured by their tribes to "show results"; "they couldn't be very effective . . . look at all the drunks at the jail or on the street"; "most federal grant programs concentrate on the treatment aspects of alcoholism programs in their funding priorities"; "the individual rarely admits to having a drinking problem or to being addicted to drugs until he reaches the crisis stage."

The above comments and situations depict typical attitudes and situations that prevail in the field of alcoholism and drug abuse today. The social concept of having a drink of two with friends is an old one among the non-Indian society and one that continues to be a part of the life of the "typical" American. In contrast, the "obnoxious drunk" who becomes loud and boisterous, or "passes out" from too much liquor and the alcoholic who cannot control his drinking and becomes wracked with delirium tremors ("DT's" or the "shakes") becomes a social outcast to be avoided.

On the other hand, the Indian cultures, historically, have had difficulty in developing strong social controls for the usage of alcohol when not used in a spiritual context. The development of usage patterns was based on the propensity of the alcohol or drug to transport the individual into a world different from the one that he lived in. Prior to the arrival of the Europeans, the use of crude wines and drugs such as peyote were used primarily in ceremonies or religious rituals.

Subsequently, forced removal from traditional lands, restrictions to federal reservations and other subjugations to the "white civilized society" created different inducements to drink—to forget, to release inhibitions and vent angers, to dull pain and to avoid the necessity to face a world which no longer was theirs or that they could control.

For the most part, the Indian cultures, while not condoning it, did not attempt to socially control this form of drinking. The person was not in control of his actions and thus could not be blamed for deviant behavior and was tolerated.

Any form of prevention, or the development of preventive education, will have to do far more than show films on what sustained usage of alcohol does to the liver or what the drug addict goes through in withdrawals. Attitudes and patterns of living will have to be altered in order to ultimately result in a reduction of incidence. The community, which can and should bring tremendous pressure upon the individuals which live in it, cannot either ignore its ills or expect the alcoholism programs to come out each morning and sweep the streets, clean the bars and jails of their drunks, take them to their detox or treatment center, dry them out and expect them to come forth the following day, shiny-faced and full of bright expectations. It will not happen! The real shame is that both the white society and the Indian communities intuitively know that crisis-oriented programs are doomed to failure in the long run. As stated in the Report on the Indian Health Care Improvement Act (S. 522, May 13, 1976), underlying social, economic and cultural causes of alcoholism make it an extremely difficult health problem to remedy, particularly when it competes for scarce health care resources with the numerous other health problems, many of which respond better, more quickly and with less expenditure of funds. The report could also have added "more easily seen."

The Indian child who is born and raised in an environment of drinking, broken homes, or sent to Government boarding schools far away from home, already has a higher probability of ending up

with a drinking problem, dead, or in jail. Add to this the many other influences which exert pressures upon him. The self-image quest that each must go through is a difficult one. The "old way" clearly defined the roles of the warrior, the hunter, and the woman; they only had to prove themselves. Today, the youth must look to what is around him for direction. For instance, most of what he sees in and on the news media is news of robberies and killings. Say for instance he enjoys sports. He turns on the T.V. and what does he see? The "macho" image that is projected by such televsion commercials as "Lite" beer depicting favorite sports figures spending fun-filled evenings in the local taverns drinking "Lite" beer. This cannot be construed as a good influence.

The future rests in the young people, but it is the responsibility of the adults and elders of the community to shape their attitudes. The community must assist them in finding alternatives to drinking and using drugs.

The Task Force found it encouraging to receive indications from testimony and studies that there appeared to be a growing interest and movement among the young people back to the "old ways", seeking the strengths of the Indian culture. An example of this movement is the growth of the Native American Church. Not only does it advocate a complete spiritual peace with oneself and the Mother Earth, but the Native American Church exerts strong social controls upon one's actions. While peyote is used in ceremonies such as "sings" to heighten the spiritual experience, both the use of peyote or alcohol outside of the ceremonies is restricted.

(*a*) *Problems*

(1) The majority of alcoholism and drug programs concentrate on treatment *after* the individual already has a problem.

(2) Existing treatments are primarily detox and counseling. While this is necessary, the individual must return to the same situations, problems and environment which caused him to drink in the first place

(3) Community attitudes toward the individual with a drinking or drug use problem are permissive in nature.

(4) There exists a general lack of knowledge by both the individual and the community about alcohol and drug usage. This is in spite of the highly visible death, morbidity, suicide and homicide rates, not to mention the arrest rates, broken homes and child abuse which can be attributed to problem drinking and drug use.

(5) Most behavioral patterns are learned and can be classified as "educational" in nature. Children learn from their environment both the *good* and the *bad*.

(6) The removal of the children to foster homes or sending them away to government boarding schools many times fosters anxieties which are conducive to drinking or using drugs. Most of the federal boarding schools have been criticized as compounding drinking and drug usage problems.

(7) Many communities do not now have or have attempted to provide alternatives to drinking and drug use. Examples would be: recreational opportunities, involvement in community projects, cultural heritage programs, and work programs.

(8) The definition or concent of prevention is too narrow.

(9) Although the majority of people with alcohol and drug problems are men, the increasing incidence among women and youth is often ignored.

(*b*) *Conclusions*

(1) Most existing programs are primarily crisis-oriented treatment centers, and a far more effective use of limited resources would be to put at least as much emphasis on prevention in the community and the development of preventive educational materials for Indian youth.

(2) A prevention program which does not begin at the community level is not comprehensive in nature, and does not build its strategy upon the changing of behavioral patterns and those factors which influence them, and will ultimately fail.

(3) The growing movement of the Indian people toward the "old way" indicates a need for self-image. The building of preventive strategies must emphasize such values as exhibited by the Native American Church.

(*c*) *Recommendations*

(1) *Give the building of a comprehensive prevention and preventive education strategy a high priority, stressing the community leadership and involvement in changing behavior patterns and development of alternatives to drinking and drug usage.*

(2) *Build prevention strategies emphasizing the strengths of the Indian culture.*

(3) *Build strategies, programs, and formulate preventive education on emphasizing women and youth as well as men. Build upon familial and community ties.*

4. INDIAN REPRESENTATION

The concept of Indian self-determination centers around the recognized need for Indian involvement, from the beginning planning stages to the eventual management of their own programs. This is particularly true of the Indian alcoholism and drug abuse field. Conventional programs are designed to serve the general population and do not take into account the unique cultural needs of the Native American and Alaska Native. Too often this results in the prevention of Indian people from participating in and benefitting by many otherwise successful program resources.

Existing Indian input into federal and state programs is through local advisory boards, state or regional commissions, elective national organizations (National Indian Board on Federal Agencies), tribal health arms and other Indian organizations which are federally or state funded under contracts or grants (American Indian Commission on Alcoholism and Drug Abuse and National Indian Health Board). These are both effective and ineffective, depending upon whether the limitations of such bodies are recognized.

There is a continuing need for "Indian input" in the planning and administration of the Indian programs.

(*a*) *Problems*

(1) Programs which do not have Indian people involved in the planning stages as well as the administration are usually formulated on non-Indian criteria and standards and in ignorance of cultural differences and needs.

(2) Federal and state agencies often make policy decisions on non-Indian programs which may still impact heavily upon the Indian community.

(3) Task Force No. 11 in its hearings and on-site visits found voiced concern that representative organizations do not represent their interests and were: (1) politically chosen; (2) always traveling; (3) gave them feedback; and (4) were not accountable.

(4) Advisory bodies often complain that their advice is not taken by federal and state agencies.

(5) Many federal and state agencies feel that the advisory bodies just complain and get into areas that are not germaine to their responsibility.

(*b*) *Conclusions*

(1) There are over 250 major Indian tribes in the United States and many more Indian communities. It must be recognized that each has its own individual needs based on its community, culture, and geographical location. No *single organization* can hope to represent all Indian people.

(2) Many of the problems involved in the solicitation, submission and use of "Indian input" arise from the unclear delineation of responsibilities which are given to the advisory bodies. If their duties and powers and limitations are not clearly explained in their charters, they will be confused not only of what they can or cannot do, but will become angered if their recommendations are not taken.

(*c*) *Recommendations*

(1) *That "Indian input" must continue to be solicited and used in the formation of legislation, policies, and programs which impact upon Indian people.*

(2) *Federal and state agencies look to accepted community leaderships for consultation and participation with respect to alcoholism and drug abuse programs. The reservation-based programs cannot exist without involvement and support of their tribal leadership.*

(3) *Representative Indian bodies under contracts or grants must be held accountable for actions and funds to their constituency and to the funding agency.*

(4) *Federal and state agencies clearly delineate authorities, responsibilities and limitations in their contract or grant agreements with representative Indian bodies.*

5. THE LAW, ALCOHOL, DRUGS AND THE INDIAN

The legal systems of the United States are established for the protection of community and individual rights. The Indian people fall within the jurisdiction of several legal systems—federal, state, local and tribal—and this network of systems has not always proven responsive to the needs of the problem drinker or drug user.

The use of drugs and the traffic of same is still illegal and therefore a criminal offense of varying degrees in nearly all areas. This makes the responsibilities of the law enforcement agencies slightly different than when handling the alcohol user.

Since it is *not illegal* to consume alcohol (if of legal drinking age), the alcoholic or alcohol user theoretically does not come within the legal system unless he has committed some act which endangers the

well-being of others, himself, violated a civil statute or has committed a criminal offense. This, many times, permits the law enforcement official and courts "open season" on the alcoholic or anyone using alcohol who has angered them. The Task Force has received testimony citing cases of police brutality of not only the alcoholic or person under the influence, but gross mistreatment of the individual for just being "Indian." It is interesting to note in this context that the Utah State Director of Indian Affairs states: "Approximately 41 percent of all arrests in Salt Lake City for public intoxication are Indian people and we comprise only about ⅓ of one percent of the population." Not all Indian law enforcement relationships are negative, however, legal authority makes it convenient to mistreat the alcoholic or alcohol user rather than attempt to help him. Aside from simple intoxication or public drunkenness, criminal offenses, accidents, suicides, child abuse, and other marital disorders also bring the legal systems into close contact with the Indian alcoholic or alcohol and drug user. It has been estimated that 90 percent of all arrests of Indian people are alcohol or drug related. Many state and federal prisons have substantial numbers of Indian prisoners.

Recent decriminalization in many states has greatly reduced the cases of Indian people being arrested for simple intoxication.

Also, the tremendously high law enforcement costs of drug prevention have now raised the issue of legalization of marijuana. Although the research studies have not conclusively proven marijuana habit forming or harmful to your health, the use of "grass" or "pot" seems to be following much the same legal patterns as did alcohol during prohibition days. "If you can't stop it, legalize it, tax it, and try to control it!"

The Task Force has found in testimony and also field studies such as a survey done of the students at Fort Sill Indian School in Oklahoma that there is an increasing use of marijuana and other drugs among Indian people.

(*a*) *Conclusions*

(1) Treatment by arrest satisfies the legal situation but is punitive in nature and does not contribute to the helping of the individual.

(2) If an estimated 90 percent of Indian arrests are alcohol or drug related, it would appear that the relationship of the legal systems, community, and Indian individual need further study.

(3) Legal systems (including law officers, jails, prisons, courts, probation officers) are uniquely suited to contribute to the prevention, treatment and rehabilitation of the alcoholic and the problem alcohol or drug user.

(*b*) *Recommendations*

(1) *Require that responsible agencies such as the Bureau of Indian Affairs set up programs with the federal, state and local law enforcement officials which woild: (a) Provide for the referral of the "simply inebriated" to a detox center or Indian cultural center; (b) If a person has committed a lesser criminal offense, require the Indian offender to participate in an alcoholism or drug treatment program; (c) set up Indian alcoholism and drug abuse programs within federal and state prisons.*

(2) *Initiate a Congressional study into the possibility and ramifications of legalizing marijuana.*

SECTION III

APPENDICES

A. The Snyder Act of 1921
B. Historical Information
C. Excerpt From the Report of the Indian Health Service Task Force on Alcoholism, 1970
D. Drug Usage Summary
E. Summary of Letters Received by Individuals, Programs, and Tribal Representatives in Response to Questionnaire
F. Statistical Information
G. Program Description of Federal, State, and Local Agencies
H. An Alcoholism Program Built Around a Comprehensive Health Model
I. Veterans' Administration Study on the Feasibility of Combined Alcohol and Drug Treatment Program
J. Excerpts from "The Alcoholism Report"
K. Excerpts From Report of the Committee on Interior and Insular Affairs, United States Senate
L. Summary of Task Force Hearings

77-466—76——4

A. Snyder Act of 1921

25 U.S.C. 13, EXPENDITURE OF APPROPRIATIONS BY BUREAU OF INDIAN AFFAIRS

The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:

General support and civilization, including education.

For relief of distressed and conservation of health.

For industrial assistance and advancement and general administration of Indian property.

For extension, improvement, operation, and maintenance of existing Indian irrigation systems, and for development of water supplies.

For the enlargmenet, extension, improvement, and repairs of the buildings and grounds of existing plants and projects.

For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges, and other employees.

For the suppression of traffic in intoxicating liquor and deleterious drugs.

For the purchase of horse-drawn and motor-propelled passenger-carrying vehicles for official use.

And for the general and incidental expenses in connection with the administration of Indian affairs.

(November 2, 1921, c. 115, 42 Stat. 208)

B. Historical Information

The native people of North America (with the exception of a few tribes) before the coming of European settlers to the New World in the 15th and 16th centuries, were unacquainted with liquor in any form. The first Native Americans to come in contact with the substance were obviously those along the eastern seaboard, with the peoples further inland not experiencing contact until the 17th, 18th and even 19th centuries in the western-most regions.

Tribes such as the Pimas, Papagos, Apache and Havasupai, located along what is now the Mexican border and somewhat to the north, were known to have a crude form of liquor used for religious ceremonies. Papagos used their crude form of liquor, cactus fruit wine, in a ceremonial context particularly to produce rain. These tribes and many in the same area, also came into early contact with Spanish explorers but there is no documented evidence available to show any ill effects in regards to alcohol use from this period. This was to occur later in their history from westward expansion of European settlers.

The initial avenue of contact of liquor to the Native Americans was to come from the fur trappers and traders moving westward in search of more game. At first used as a gesture of friendship or article of trade, the sharing of liquor soon degenerated into a powerful weapon which white entrepeneurs used to their distinct advantage and the Indians' disadvantage. Trading for the most part was preceded by drinking sessions after which the intoxicated Indians "blithely traded away valuable possessions to maintain their inebriated glow. Most of the respectable traders discouraged the use of alcohol as regular payment for furs, largely because drinking obviously lowered productivity but partly because they could see all too clearly how disruptive it could be in a society with no traditional means of coping with it."

It is from these traders, trappers and later miners and cowboys out of the western frontier that Indians formed a style of drinking. Because of having no contact with the substance before the invasion of the whites, they had no norms by which to regulate drinking sociably. They also had no one but these traders, trappers and other frontiersmen as examples upon which to base their drinking patterns. As stated in the article "Drinking on the American Frontier," these American pioneers disregarded learned social sanctions for drinking in an untamed land. Their reliance on whiskey was in direct proportion to the hostilities encountered on the frontier. The Indians developed a kind of emotional dependence

on alcohol. "Like other westerners, they found that their world seemed more attractive when viewed under the influence of firewater."

Liquor was also given as a form of payment for services rendered. Military aid given by the Indians to both the British and French was paid for by quantities of liquor. Scouts enlisted by westward expeditions and later American military forces were reimbursed with "firewater."

Even the Indian Whiskey itself ". . . was a vile potion that was usually drugged and diluted to best serve devious ends." Drugs such as strychnine and laudanum were added and justified on the grounds that aggression would be diminished. But this was not to be the case, as aggressive acts came to be the outcome of heavy drinking bouts. Men, women and even children drank huge quantities rapidly with the sole purpose of becoming totally inebriated. Other characteristic drinking patterns included:

No solitary drinking;
Food and alcohol were never mixed;
Drinking until the supply was exhausted or until the drinkers passed out;
The sharing of beverages if in short supply;
Breaches of Indian codes of good conduct excused while under the influence;
Development of a high cultural expectancy for the value and effects of alcohol; and
A marked release of hostilities.

It is from this last characteristic of drinking—a marked release of hostilities—which served to reinforce the white man's view of the savage Indian who, they thought, due to physiological differences, transformed upon drinking from stoical, reserved, circumspect behavior to that which was erratic, destructive and terrifying.

In the far north, the initiation into the use of alcohol came from the whalers and traders who dealt with the Alaskan Natives. Starvation was sometimes the result, as "a whole fishing or hunting season might be dissipated in drunkenness."

Indians, themselves, were not unaware of the destructive use of alcohol in their culture. As early as the 17th century, pleas from Indians to traders and others concerning the liquor traffic were heard, but in vain. Early Indian religious prophets such as Handsome Lake (Seneca), and Wewoka (Paiute), as well as Nativistic movements, including the Ghost Dance religion and the Native American Church condemned drinking as the most evil and damaging introduction by the white men. In these specific movements, the Indians sought a solution to the destructive use of alcohol. They also were to seek aid from the federal government.

As early as 1802, a verbal plea was made to President Thomas Jefferson from Chief Little Turtle to regulate the sale and traffic of intoxicants into Indian country. This plea culminated in the Act of March 30, 1802 (Sec. 21, Stat. 139) "to take such measures, from time to time, as to him may appear expedient to prevent or restrain the vending or distribution of spirituous liquors among all or any of said Indian tribes," but this Act alone did not suffice to effect general prohibition. This prohibition came about gradually with the passing of the Indian Intercourse Act of July 9, 1832, which made it *illegal* to sell liquor to Indians anywhere in the United States. "By 1844, traders were not allowed to enter Indian camps. By 1850, most American Indian tribes had become sufficiently disorganized in terms of social, political and religious organizations, and of values and beliefs, to arrest the attention of health and welfare groups".

A more comprehensive system of prohibitions and enforcement measures evolved gradually, culminating in the Act of July 23, 1892 (27 Stat. 260), as amended in the Act of July 15, 1938 (52 Stat. 696), which was in effect until 1953. Under conditions of the law, any disposition of intoxicants to Indian country was made a federal offense punishable by imprisonment and heavy fines.

Many tribes forcefully relocated to reservations after defeats in war during the 1860's, and those tribes already living on those specified tracts of land, came under the control of both Indian agency superintendents and military commanders, some of whom "issued spirits to the Indians as part of their regular rations." The reservation, although encased by specific boundaries, was still so vast and thinly populated that bootleggers and smugglers of liquor and other articles were never effectively controlled by the available enforcement officers and therefore left to flourish.

Prohibition for Indians was to continue past the repeal of the 18th Amendment in 1933 even though they were granted full citizenship in 1924. The bootlegger and smuggler continued to peddle their intoxicating wares at great expense to the Indian people, both financially and legally. It is from this prohibition era in

Indian history that many of both the patterns of drinking and causative factors for that drinking can be seen emerging. Gulp drinking and rapid ingestion of alcohol, as particular drinking patterns of the American Indian, are said to evolve strongly from this era. The very illegality of the drink "may have in fact increased its appeal, especially for the adolescents and young adults."

In the post-repeal eras after 1953, a few tribal councils decided to continue the prohibition of liquor on certain reservations, or to strictly regulate its sale. On some, the law remains in effect until the present day. It is thought by some that this discriminatory, though well meaning, prohibition of liquor to Indian tribes for over 120 years only made the problem of alcoholism among Indians even more rampant.

In more recent history, programs for the Native American alcohol abuser have become available through funds from the Office of Economic Opportunity in the late 1960's. President Nixon recognized the magnitude of the problem in his message of July 8, 1970, when he added additional funds from the National Institute of Mental Health to Indian projects. Later that same year, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in compliance with the Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970, "was established to coordinate all federal activities in the alcohol field, to administer all DHEW alcohol programs and to develop project grants and contracts for the alcohol programs."

Native Americans, their problems with alcohol, and their programs received priority emphasis in June, 1972, at which time funds from the Office of Economic Opportunity were no longer available. The continuation and support of these projects was then assumed by NIAAA, which is currently supporting 151 Native American Programs (as of fiscal year 1976). The annual operating level of these programs is $15.6 million: $3.6 million for the 52 urban projects and $12.0 million for the 99 reservation projects. There are also 12 NIAAA funded Indian alcoholism training programs at a cost of $1.6 million, which brings the annual cost of all the federal support to Indian alcohol programs to $17.2 million.

In regards to drug use (excluding alcohol) there is no conclusive evidence of destructive use of such substances until approximately the last decade. Certain Indian groups "had experimented with the hallucinatory properties of the cactus and other plants" before the coming of the white man. Over the past centuries, peyote has been used in various nativistic movements but largely only in a religious context. It is only in recent history and present day that there exists a problem of destructive use of drugs among Indians, particularly Indian youth. This abuse today includes primarily the sniffing phenomenon: glue, gasoline, and other toxic substances.

There are currently 14 Native American substance abuse treatment, prevention and rehabilitation programs funded through the National Institute on Drug Abuse.

C. Excerpt From the Report of the Indian Health Service Task Force on Alcoholism—1970–

THE PATTERNS AND EXTENT OF INDIAN DRINKING

In one central plains reservation, 70 percent of the population over 15 years of age reported that they drank. This number included 82 percent of the men and 55 percent of the women. In the age group 20 to 29, 99 percent of the men and 72 percent of the women were drinkers, whereas in the age group 30 to 39, the figures were 93 percent and 85 percent respectively. After age forty, there was marked decline in the percentage of women drinking and a smaller decline for the men.

In the 15 to 17 age group, 50 percent reported drinking: 60 percent of the boys and 40 percent of the girls. Drinking began between the ages of 9 and 17, with an average of 15 and one-half; of those under 17, 88 percent reported that most of their friends drank. In this study, 31 percent of the total sample were abstainers; 45 percent drank less often than 3 times a week; and 24 percent drank three or more times a week. Evidence was presented to show that both sexes, but especially the women, were drinking more in this generation than in the last.

In a small Great Lakes Indian community, only seven out of 74 persons over 18 could be classified as non-drinkers or moderate drinkers. Most youths began drinking between the age of 14 to 16.

In a study of high school students in a plains tribe, 84 percent of the boys and 76 percent of the girls claimed they drank. Thirty-seven percent claimed they drank frequently.

Among southwestern Indians hospitalized for various reasons, 78 percent of men and 48 percent of women described themselves as drinkers. Two-thirds of these men and one-half of the women considered themselves "heavy drinkers," with a percentage of 86 percent in the men and from 20 percent to 68 percent in the women.

In a study of an Indian village in the southwest prior to repeal of the liquor laws, 105 out of 614 adults were observed to be regular drinkers and about half were estimated to be at least occasional drinkers. The male to female ratio was 3 to 1. After repeal, the pattern did not change noticeably.

Although it is unsafe to generalize, what few studies have been done on drinking patterns in Indians have a certain consistency. Drinking is widespread, reaching its peak of frequency in the age groups 25 to 44. Males usually outnumber females by a ratio of at least 3 to 1. By the age of 15, most youths of both sexes have tried alcohol and some are drinking regularly. After the age of 40, there is a noticeable decline in the number of drinkers and the extent of drinking. Many Indians of all ages are total abstainers.

For the most part, drinking occurs in peer groups or extended family groups. Alcoholic beverages, most often beer and wine, are freely shared within the group. Drinking usually is associated with happy or festive occasions, such as weekend social events, pay-day, pow-wows, or the end of a work season. Intoxication is a common but by no means inevitable outcome of these episodes.

Alcoholism and its effects

The adverse effects of excessive alcohol use may be approached through an examination of general mortality and hospitalization statistics, special studies, and welfare, court and police records.

In calendar year 1967, there were 183 Indian deaths primarily attributed to alcoholism, alcoholic psychosis, or cirrhosis with alcoholism in the 24 federal reservation states, for an overall mortality rate of 33.1/100,000. These deaths made up 3.8 percent of all Indian and Alaska Native deaths that year. A substantial but unknown percentage of the 1,000 other Indian deaths from accidents were due directly or indirectly to the problem of excessive drinking.

In a lower plateau tribe, there were 56 deaths directly associated with drinking and five others indirectly associated with drinking in a population of 1,581 in an 11-year period. Of the 61 deaths, 47 were males and 14 were females. The cause of death included: 12 suicides, 12 over-consumption of alcohol, 11 auto accidents, 8 other accidents, 6 murders and 12 miscellaneous.

On the same reservation, the Service Unit Director states that 38 percent of all hospital days for 1967 were attributed to the use of alcohol.

In a northern plains community of 3,500, there have been 42 deaths attributed to excessive drinking in a 4 year period. Ten of these were homicides and another six were suicides.

A study of adult Indian autopsies in the southwest showed an incidence of fatty, nutritional cirrhosis of 12.8 percent, about four times the national average. This condition may be related, though not necessarily, to excessive drinking.

In an Indian community of 2,300 persons in the northwest, a register of accidents and their relation to drinking was kept in fiscal year 1968. Forty-five out of 56 auto accident injuries, 56 out of 181 other accidental injuries, 30 out of 32 fights involving injury and all 35 suicide attempts were related to drinking. These figures were felt by the IHS staff to be conservative. In a study of suicide in a southwestern Indian tribe, 47 percent of cases involved intoxication at the time of or just before the act.

Since deaths must ultimately be assigned to only a single cause, many a victim of chronic alcoholism or acute intoxication is listed as a death from accident, suicide, homicide, bronchopneumonia, or a host of other causes. Hospitalization data have many of the same limitations, especially if only the primary or immediate cause of hospitalization is considered. Many hospitals, in fact, will not admit a patient suffering from the effects of alcohol unless there is another justification for admission as well. Diagnostic fashions are another source of confusion in this area. Hospitalization rates will be affected by the beds available, local hospital policy, recognition of the relative importance of alcoholism as a health problem and the attitudes of the local people toward their hospital.

For the period July 1, 1967 through June 30, 1968, there were 1,415 discharges from all Indian Health Service and contract hospitals with the primary diagnosis of simple alcohol intoxication and another 1,372 discharges for the various other forms of alcoholism. These totals account for 1.7 percent and 1.6 percent respectively of the total discharges from these hospitals. For the Indian Health

Service Hospitals in the Window Rock, Phoenix, Aberdeen and Billings areas in the period July 1, 1968 through December 31, 1968 when more detailed information was available, simple intoxication was listed as one diagnosis on 3.2 percent of all discharges and other forms of alcoholism on another 1.3 percent. For males aged 20 to 44, where the problem of alcoholism is primarily concentrated, these figures become 12.4 percent and 5.0 percent respectively. The overall sex ratio (M/F) for discharges for which simple intoxication was listed as 2.51/1.00. For cirrhosis with alcoholism, the sex ratio was 0.87/1.00 and for delirium tremens it was 5.63/1.00.

The records of the local police, courts and prisons provide one of the most useful and graphic sources of information on the extent and impact of alcohol problems in a population. In many Indian communities, they are often the only sources which have been explored. In interpreting such information, however, a word of caution is necessary. Police and courts, whether tribal, municipal, county, state or federal, are inclined to deal more harshly with Indians who are found intoxicated than they would with non-Indians. An Indian usually runs a far greater risk of being arrested and locked up for drunkenness than a non-Indian would under similar circumstances. Arrest and conviction figures for Indians, therefore, are somewhat inflated when compared with those of the general population. Even when these allowances are made, however, the figures are still an impressive testimony not only to the extent of drinking, but to the social and family disruption, the loss of productiveness, the loss of self-respect, and the accidents and ill health caused by the excessive use of alcohol.

The figures that follow are chosen to be fairly representative of a considerable mass of available information:

In 1960, Indians were arrested 12.2 times as frequently for alcohol-related offenses as the U.S. population generally. Whereas 43 percent of all arrests in the U.S. were related to drinking, the comparable figure for Indians was 76 percent. Drunkenness alone accounted for 71 percent of all Indian arrests. The arrest rate for non-alcohol-related offenses was found to be only slightly above the U.S. average.

In a central plains reservation, there were in one year 2,585 arrests for "disorderly conduct with drunkenness" in a population of 4,600 adults.

Over a three-year period, 44 percent of males and 21 percent of females had been arrested at least once for a drinking-connected offense. Of these, ⅔ had been arrested more than once and 1/10 more than 10 times. Of all juvenile offenders (under 18) one-quarter had been booked at least once for disorderly conduct or a drunken driving charge. Thirteen percent of the entire population aged 15 to 17 had been booked at least once on a charge related to drinking.

In the southwest, a reservation reported that 70 percent of crimes on the reservation were alcohol-related. In an off-reservation town nearby, there were 750 arrests per month for drunkenness, 90 percent of which were Indians.

In one state penitentiary, Indians made up 34 percent of the inmates whereas in the state, they comprised only 5 percent of the population. A large majority of the crimes were committeed while under the influence of alcohol. In 1959, all 36 Indian prisoners at a federal prison had been convicted of murder or manslaughter which had occurred while the individual was intoxicated.

On a northern plains reservation with a total population of 3,500, there were in fiscal year 1968, 1,769 arrests resulting from excessive drinking—10 percent of them juveniles. Further in the northwest, there were 445 disorderly conduct arrests and 72 liquor possession arrests in one year in a population of 2,300. Male adults outnumbered both female adults and juveniles by a ratio of 5:1.5.

The excessive use of alcohol clearly has a tremendous impact not only on the lives of individual Indians and their families, but on the tangible and intangible resources of their communities. Nearly every person, whether a drinker or not, is touched in some way by alcoholism. A poignant example comes from a reservation where a recent survey of high school students showed that no less than 339 out of 350 persons disliked living in their own community because of excessive drinking!

D. Summary on Indian Drug Abuse

"The recent experience of the Indian Health Service Mental Health Programs has disclosed an alarmingly rapid increase in the occurrence of drug abuse among Indian people—particularly children, adolescents, and young adults. In the first quarter of calendar year 1974, the number of cases seen increased by almost 50 percent over the preceeding six months. In many communities, a majority of the children are all regular users of toxic inhalants and there are indications that

broader, more expensive drugs are being introduced. The same factors which have produced several generations of alchohol abusers may today be producing a generation that abuses alcohol as only one of a variety of dangerous substances."—INDIAN HEALTH TASK FORCE.

Testimony received by this Task Force as well as preliminary studies such as a 1975 survey of "Drug Use Among Young People at Zuni" done by the Indian Health Service, and a 1975–76 study of Fort Sill Indian School students done by the Human Ecology Learning Program, Inc., indicate that the use of marijuana and solvents is increasing among young Indian people. A recent study of 15,634 students in grades 6 through 12 in Anchorage, Alaska, revealed that a "higher percentage of Native [referring to Aleut, Eskimo, and Indians] than any other racial group indicated that they used at least one drug other than alcohol or tobacco" (P. 663, JAMA 223(6), 5 Feb. 73). The most commonly used other drugs were solvents and marijuana. It appears, then, that drug experimentation is an increasingly common occurrence among young Indians.

The dangers of drug experimentation fall into at least two categories: (1) harm to health and life, and (2) illegality of the drugs. The distinction between these two types of dangers is clear where solvents and marijuana are concerned.

Inhalants such as aerosol sprays, gasoline, and paint thinner are legal, though the injurious effects of their inhalation are well documented. Hundreds of children have died or suffered serious tissue and brain damage from this practice. Recent reports also point to a link between inhalant use and aggressive or destructive behavior. Much more attention must be given to this problem which is particularly prevalent among poor reservation youth. The dangers of aerosol sprays should be thoroughly explored before such substances are allowed to be marketed. The introduction of an irritant to the solvents, as was done with glue when glue sniffing was prevalent, should be seriously considered. School personnel must be taught how to deal with the problem, and an educational campaign against inhalants is necessary to combat this growing problem.

In contrast to studies on solvent use, research on marijuana has not proven that is is harmful to health. Strict laws against use and possession, however, lead to arrests and imprisonment of Indian youth. In 1972, the National Commission on Marijuana and Drug Abuse, after an exhaustive two-year study, found that marijuana was not as dangerous as once believed. While not advocating usage, it did recommend continued research into marijuana use and decriminalization of the user (Drug Abuse Council, July 17, 1974). The Council also recommended the removal of all criminal penalties for marijuana possession and personal use.

The incidence of Indian arrests and convictions already far exceeds the number commensurate with the population of Native American people in this country. This Task Force does not view substance abuse as a criminal problem, but rather as a medical or social problem. Efforts should be made to keep Indian people out of jails and prisons which introduce Indian people into criminal society and only increase our problems. As stated by Dr. Bryant, President of the Independent Drug Abuse Council, "even if marijuana were eventually shown to be as dangerous as alcohol or tobacco, giving a criminal record to the user only exacerbates the potential harm."

E. SUMMARY OF LETTERS RECEIVED BY INDIVIDUALS, PROGRAMS AND TRIBAL REPRESENTATIVES IN RESPONSE TO QUESTIONNAIRE

SIZE AND SERIOUSNESS OF PROBLEM

All responses ranked alcoholism as within one of the top five problems of the American Indian population within the community. Many said it was the number one problem or at least one of the most important problems. Typical responses were: "Alcohol directly affects 50 to 70 percent of the population and indirectly affects all of them", (STOWW); "With a total population of approximately 3,200, my estimates are 75 percent of the adult population use alcoholic beverages, of them 60 percent are abusers or alcoholics" (Governor of Pueblo De Acoma).

Reasons given for the seriousness of alcoholism were:

Unemployment or leaving the job because of drunkenness; disruption of work; arrests, trouble with police; health failure—destruction of mind and body; death;

deterioration of family; child neglect and/or abuse; loss of self-respect; non-participation in the community; auto accidents.

Examples of statements were:

"90 percent of job terminations are due to alcohol" (the United Tribes Educational Technical Center of North Dakota);

"73 percent of all arrests over the past year were directly related to alcohol abuse" (Hopi Tribal Police Department);

"A recent study showed 57 deaths among Zunis in a 54 week period of which 34, or 60 percent were alcohol related" (Community Health Education Zuni PHS Indian Hospital).

CAUSES AND CONTRIBUTING FACTORS CITED

Lack of employment was the reason most often mentioned. This was often seen as related to loss of individual self-esteem and to lack of activity, which were other commonly cited reasons for alcoholism. Loss of Indian culture was also mentioned as contributing to feelings of inadequacy and lack of self-esteem. The drinking example set by other Indians was an often-cited reason and was frequently mentioned in conjunction with community lack of understanding, or apathy toward the problem. Also mentioned were splits between the old and young people and children going away to boarding schools. It was stated that since the children were in boarding schools, the adults did not feel they had to be good examples for their children.

	Number of times cited
Unemployment, poverty	23
Boredom, lack of alternatives, recreation	18
Drinking example set by tribal leaders, parents peers, or program staff (drunken Indian stereotype)	18
Loss of Indian culture	14
Community apathy about alcoholism	13
Lack of good education and skills	12
No self-esteem, pride	12
Family problems (including broken homes and loss of family ties)	11
Lack of alcohol (preventative) education	10
Lack of good treatment personnel	5
Lack of adequate treatment facilities	6
Availability of alcohol	5
Desire to feel good	4
Mismanagement of program funds	3
Prejudice or oppression by whites	3
Psychological predisposition towards alcoholism	3

SERVICES

No one felt that services provided were adequate. Two programs said they had adequate programs but needed to reach more people and extend preventive services.

Services already provided included:

Counseling	14
Half-way house	11
Alcoholics Anonymous	10
Detoxification	6
Family services	4
Outpatient and follow-up service	2
Prevention, educational program	12

Prevention programs were mentioned, but they were often seen as inadequate. Treatment most often consisted of a counseling program of some kind. Many people said that services were not readily accessible or appropriate for Indian people, such as an A.A. program many miles away in a white community. Another problem often mentioned was that, though services were available through various different agencies, most of the community was not aware of these services.

Services Wanted

Prevention, educational programs	20
Teaching or restoring traditional heritage and culture	15
Good counselors and counselor training	13
Recreational programs	8
Community center and community organization	7
Medical care and detoxification	6
Family services (to family of alcoholic)	6
Half-way house	5
Outreach program counselors	4
Coordination of services and funds	4
Indian support groups (including prayer groups)	4
Research	4
Employment	4
Good follow-up programs	2

Even though these responses represent many alcoholism treatment programs, the most often mentioned need was for prevention and education programs. A need was also frequently expressed for returning to traditional heritage and culture, and utilizing the Indian culture in treatment programs.

LIST OF INDIVIDUALS, PROGRAM, AND TRIBAL REPRESENTATIVES RESPONDING TO QUESTIONNAIRE

1. *Blackfeet:* Blackfeet Alcoholism Program and Detoxification Center
2. *Seneca Nation:* Mike Myers
3. thru
6. *United Tribes of North Dakota:*
   Warren Means, Executive Dr. Educational Technical Center
   Russel Gillete, Halfway House Manager
   Curtis LeBeau, Director Alcoholism Program
   Luis Little Owl, Counselor
7. *Rincon Band, San Luiseno Mission Indians:* Max Mazzetti, Tribal Chairman
8. *Warroad Indians, Minnesota:* Rose Johnson, Tribal Member
9. *Crow Agency, Montana:* Marilyn McIntosh, VISTA Volunteer
10. *Mason County Washington Indian Community:* Marlei Peterson, Community Member
11. *Small Tribes Organization of Western Washington:* Donald Galanti (STOWW), Alcoholism Program Director
12. *Four Holes Indian Organization, S.C.:* Diane Davidson, Manpower Aide
13. *New England Schaghtioke Indian Association, Massachusets:* Princess Necia, Secretary
14. *Hopi:* James Brenneman, Director Hopi Alcoholism Program
15. *White Earth, Minnesota:* Robert T. Rutter, Program Administrator White Earth Chemical Dependenty Program, Inc.
16. *Golden Hill Tribe, Paugussett Nation, Connecticut:* Aurelis H. Dyer, Chief
17. *Omaha Reservation:* Bob Shelly, Executive Director of Macy Alcohol and Drug Abuse Board, Macy Industry.
18. *Ya-Ka-Ama Indian Educational Development, Inc., Healdsburg, California:* John Foster, Executive Director
19. *United Tribes Council, Sacramento, California:* Virginia Card for Health Committee
20. *Tanana Chiefs Conference, Inc. Alaska*
21. *Kaibab-Paiute Tribe, Arizona:* Mrs. Geneve E. Savala, Community Health Representative
22. *Shoshone-Bannock Tribes:* Fort Hall Alcohol and Drug Program Proposal
23. *Turtle Mountain Counseling and Rehabilitqtion Board*
24. *Riverside Indian School, Anadarko, Oklahoma:* Robert Lawrence, Pupil Personnel Director
25. *Pueblo of Acoma, New Mexico:* Merle L. Garcia, Governor
26. Gilbert Ortiz, Alcohol Treatment Center Client
27. *Navajo Area, Fort Defiance Agency*
28. and
29. Tribal Chairmen

30. Case worker
31. *Region X Indian Alcoholism and Drug Abuse:* Helena Andree, Rural Coordinator Counselor
32. *Bad River Chippewa Indian Reservation:* Arthur P. Dashner, Counselor
33. *Bad River Chippewa Indian Reservation*
34. and
35. *Native Americans for Community Action, Inc., Flagstaff, Ariz.:* Mae Helen Tyman, Counselor-Coordinator
36. *Yukon-Kuskokwin Health Corporation:* (Affiliate of the Alaskan Federation of Natives)
37. *Aleut League:* Irene Moller, Acting Health Director
38. *Stockbridge Munsee Alcoholism Program of Wisconsin:* Aught Coyhis, Director
39. *Zuni Tribe:* Morris Dyer, Community Health Education, P.H.S. Indian Hospital
40. *Copper River Native Association:* Stewart Nicolai, Alcoholism Counselor Gayle Nelson, Regional Technical Assistant
41. *Wyandotte Tribe of Oklahoma:* Leonard N. Cotter, Chief.
42. *Oneida Tribe of Indians of Wisconsin:* Purcell Powless, Tribal Chairman
43. thru
49. *Yankton Sioux Tribe:* Community Members
50. *Juell Fairbanks Aftercare Residence for Native Americans, St. Paul, Minnesota:* Edward P. LaFromboise, Director
51. *Huslia, Alaska:* Rhoda Stertzer
52. *Squaxin Island Tribe, Shelton, Washington:* Madge Whitener, Tribal Health Manager

F. Selected Statistical Information and Charts

MORTALITY AND MORBIDITY FOR THE AMERICAN INDIAN ARREST RATES

DEATH RATES FOR SELECTED CAUSES OF DEATH (INDIANS AND ALASKA NATIVES ON RESERVATION STATES AND UNITED STATES, ALL RACES), FISCAL YEAR 1975

Selected causes of death	Crude Death Rates [1]		Ratio of Indians and Alaska Natives to United States, all races
	Indian and Alaska Native	United States, all races	
Accidents	163.2	51.7	3.2
Cirrhosis	66.7	15.0	4.4
Homicide	31.7	10.5	3.0
Suicide	21.8	12.1	1.8

[1] Rates per 100,000 population.

Note: 1975—Indian Health Service saw almost 50,000 patients with problems relating to alcohol.

Source: IHS Justification of Appropriations for fiscal year 1977.

Cause of death	Indian deaths per 100,000 population		Percent increase or decrease (—) in Indian rate since 1955
	1955	1973	
Accidents	156.2	174.3	12
Heart disease	135.2	131.0	—3
Malignant neoplasm	62.1	62.0	0
Cirrhosis of liver	16.0	45.5	184
Cerebrovascular disease	46.1	42.8	—7
Influenza and pneumonia	92.2	41.1	—55
Certain disease of early infancy	70.5	19.6	—72
Diabetes mellitus	14.1	20.4	45
Homicide	15.0	25.5	70
Suicide	9.4	19.4	106
Congenital malformations	17.9	10.1	—44
Tuberculosis	55.5	6.8	—88
Enteritis and other diarrheal disease	39.5	5.5	—86

Source: Indian health task force.

ALCOHOLISM DEATHS AND DEATH RATES

Alcoholism is one of the most serious health problems facing the Indian people today. The alcoholism death rate for the Indian and Alaska Native during the past few years has ranged from 4.3 to 5.5 times the U.S. All Races rate. In 1974, there was a 2 percent increase in the alcoholism death rate from 1973. This, however, was considerably less than the 23 increase of 1973 over 1972.

Approximately 59 percent of the alcoholism deaths among the Indian population are the result of cirrhosis of the liver with mention of alcoholism. Another 39 percent are the result of alcoholism with the remainder due to alcoholic psychoses.

ALCOHOLISM DEATHS AND DEATH RATES—INDIANS AND ALASKA NATIVES IN 25 RESERVATION STATES AND UNITED STATES, ALL RACES

	1966	1970	1973	1974
Number of deaths—Indian and Alaska natives in 25 reservation States:				
Alcoholism	55.0	97.0	159.0	164.0
Alcoholic psychoses	5.0	8.0	5.0	7.0
Cirrhosis of liver with mention of alcoholism	128.0	167.0	235.0	246.0
Total	188.0	272.0	399.0	417.0
Alcoholism death rates—Indians and Alaska natives in 25 reservation States:				
Alcoholism	8.9	13.8	20.7	20.8
Alcoholic psychoses	.8	1.1	.7	.9
Cirrhoses of liver with mention of alcoholism	20.7	23.8	30.5	31.1
Total	30.4	38.7	51.9	52.8
Alcoholism death rates—Indians and Alaska natives in 25 reservation States:				
Alcoholism	1.6	2.1	2.2	(1)
Alcoholic psychoses	.3	.3	.2	(1)
Cirrhosis of liver with mention of alcoholism	4.8	5.5	6.0	(1)
Total	6.7	7.9	8.4	(1)

[1] Not available.

AGE SPECIFIC DEATH RATES—INDIAN AND ALASKA NATIVES AND UNITED STATES, ALL RACES

Age group	Homicide			Suicide		Cirrhosis of liver	
	Indian and Alaska Native	United States, all races	Ratio	Indian and Alaska Native	United States, all races	Indian and Alaska Native	United States, all races
1 to 14	3.7	1.3	2.8	0.3	0.3	0.3	0.1
15 to 24	30.3	13.9	2.2	44.4	10.9	4.5	.5
25 to 34	70.0	19.0	3.7	43.2	16.6	57.7	4.1
35 to 44	43.8	15.8	2.8	21.2	18.1	137.9	20.1
45 to 54	35.8	10.8	3.3	13.4	20.2	190.8	41.1
55 to 64	25.2	8.5	3.0	9.2	20.0	128.4	49.9
65 to 74	14.6	4.8	3.0	18.3	18.5	69.4	43.3
75 to 84	17.8	4.6	3.9	26.7	22.3	62.3	32.4
85 plus	27.3	2.9	9.4	----------	14.9	27.3	18.3

NUMBER OF OUTPATIENT VISITS FOR ALCOHOL CONDITIONS, IHS AND CONTRACT FACILITIES, FISCAL YEAR 1975

Condition	Total	IHS	Contract
Alcoholism, acute or chronic	18,419	17,076	1,343
Cirrhosis due to alcohol	2,102	1,893	209
Total	20,521	18,969	1,552

THE NUMBER OF DISCHARGES WITH A PRIMARY DIAGNOSIS OF AN ALCOHOL-RELATED CONDITION FROM HS AND CONTRACT HOSPITALS, FISCAL YEAR 1975 [1]

Conditions	Total	IHS hospitals	Contract hospitals
All conditions	5,414	3,958	1,456
Alcoholic psychosis (291)	490	312	178
Alcholism (303)	4,314	3,198	1,116
Cirrhosis due to alcohol (571.0)	536	401	135
Toxic effect of alcohol (980)	65	41	24
Adverse effect of alcohol in combination with other drugs (979)	9	6	3

[1] Provisional estimates.

LEADING CAUSES OF DEATH, SELECTED STATES, CALENDAR YEARS 1972–74

Alaska:
- Accidents
- Diseases of heart
- Malignant neoplasms

New Mexico:
- Accidents
- Diseases of heart
- Malignant neoplasms

North Dakota:
- Accidents
- Diseases of heart
- Malignant neoplasms

Utah:
- Accidents
- Diseases of heart
- Cirrhosis of liver

Nevada:
- Diseases of heart
- Accidents
- Cirrhosis of liver

Oregon:
- Diseases of heart
- Accidents
- Cirrhosis of liver

Wyoming:
- Accidents
- Diseases of heart
- Cirrhosis of liver

Washington:
- Accidents
- Diseases of heart
- Cirrhosis of liver

Oklahoma:
- Diseases of heart
- Malignant neoplasms
- Accidents

Nebraska:
- Diseases of heart
- Accidents
- Cirrhosis of liver

Colorado
- Accidents
- Diseases of heart
- Cirrhosis of liver

Source: Vital Events Branch, OPS/DRC/IHS, January 2, 1976.

PERCENT OF PERSONS WHO DRINK ALCOHOL

[1 Central Plains reservation]

Selected age:	Total	Male	Female
15 to 19	50	60	40
20 to 29	(1)	99	72
30 to 39	(1)	93	85

[1] Not available.

Source: IHS Task Force Report on Alcoholism, 1967.

AMBULATORY PATIENT CARE REPORT—FISCAL YEAR 1975, SELECTED EXTERNAL CAUSE OF INJURY, TOTAL FIRST VISITS, AND PERCENT ALCOHOL RELATED

External cause of injury	Total 1st visits	Percent alcohol related [1]
Motor vehicle	9,073	
Alcohol related	2,783	30
Water transport	170	
Alcohol related	21	12
Accidental poisoning	760	
Alcohol related	56	7
Accidental falls	37,404	
Alcohol related	2,831	7
Fires and flames	2,279	
Alcohol related	175	8
Environmental factors	6,062	
Alcohol related	361	6
Drowning and submersion	61	
Alcohol related	8	13
Cutting and piercing objects	13,520	
Alcohol related	1.262	9
Firearms accidents	478	
Alcohol related	98	21
Machinery	2,396	
Alcohol related	56	2
Suicide attempt	851	
Alcohol related	391	46
Injury purposely inflicted	14,129	
Alcohol related	8,068	57
Battered child	84	
Alcohol related	32	38
Other causes	29,938	
Alcohol related	1,758	6
Total injuries	122,997	
Alcohol related	18,158	15

[1] Percent calculated from crude figures by task force.

Source: Indian Health Service,

NUMBER OF ARRESTS BY TYPE OF OFFENSE, AMERICAN INDIAN—JUVENILE AND ADULT, STATE OF NEW MEXICO—CALENDAR YEAR 1974

Types of offenses	Juvenile (under 18)	Adult (over 18)	Total
Offenses against property	217	293	510
Offenses against persons	55	515	570
Offenses against public safety	1,531	9,455	10,986
Total offenses	1,803	10,263	12,066

Source: New Mexico Uniform Crime Reporting.

NUMBER OF ARRESTS BY SELECTED OFFENSES AGAINST PUBLIC SAFETY, AMERICAN INDIAN—JUVENILE AND ADULT, STATE OF NEW MEXICO—CALENDAR YEAR 1974

Offenses against public safety	Juvenile (under 18)	Adult (over 18)	Total
Narcotic drug	47	48	45
Marihuana	25	34	59
Synthetic drugs and other dangerous drugs	22	2	24
Driving under the influence	33	787	820
Liquor laws	243	574	817
Drunkenness	151	4,568	4,719
Disorderly conduct	416	2,516	2,932
Vagrancy	1	2	3
Curfew and loitering violations	332		332
Runaways	99		99

Source: New Mexico Uniform Crime Reporting.

NUMBER OF ARRESTS BY SELECTED OFFENSES AGAINST PROPERTY, AMERICAN INDIAN—JUVENILE AND ADULT, STATE OF NEW MEXICO—CALENDAR YEAR 1974

Offenses against property	Juvenile (under 18)	Adult (over 18)	Total
Burglary—breaking and entering	39	52	91
Larceny—theft	134	102	236
Motor vehicle theft	8	33	41
Fraud	3	28	31
Stolen property—buying, receiving, possessing	7	5	22
Vandalism	26	51	77

Source: New Mexico Uniform Crime Reporting.

NUMBER OF ARRESTS BY SELECTED OFFENSES AGAINST PERSONS, AMERICAN INDIAN—JUVENILE AND ADULT, STATE OF NEW MEXICO—CALENDAR YEAR 1974

Offenses against persons	Juvenile (under 18)	Adult (over 18)	Totals
Murder and nonnegligent manslaughter	2	6	8
Aggravated assault	19	150	169
Other assaults	21	135	156
Offenses against family	6	138	144

Source: New Mexico Uniform Crime Reporting.

"WHITE LIGHTNING AND THE REDMAN"

CITY ARREST DATA

	All offenses	Liquor law	Driving	Drunkeness	All alcohol related
Indian reported arrest as proportion of all reported arrests (percentages):					
1970	2.1	1.9	1.0	5.9	5.1
1971	2.2	1.8	1.8	6.2	4.9
	Non-Indian		Ratio of Indian		Proportion of non-Indian
All alcohol-related arrests as a proportion of all arrests (percentage except for col. 3) among Indians:					
1970		76.4	30.7		2.17
1971		75.0	33.0		2.27

CITY ARREST DATA– 18 YR AND YOUNGER

	All offenses	Liquor law	Driving	Drunkeness	All alcohol related
Indian reported arrest as proportion of all reported arrests (percentages):					
1970	0.8	1.9	1.5	4.3	2.7
1971	.9	1.8	1.3	5.2	3.0
	Among Indian		Non-Indians		Ratio of Indian proportion to non-Indian
All alcohol-related arrests as a proportion of all arrests (percentages except for col. 3):					
1970		23.3	7.0		3.33
1971		25.1	7.2		3.49

RURAL ARREST DATA

	All offenses	Liquor law	Driving	Drunkeness	All alcohol related
Indian reported arrests as proportion of all reported arrests (percentages):					
1970	3.8	2.7	3.7	8.9	6.2
1971	2.8	2.7	2.5	6.5	4.4

	Indians	Non-Indians	Ratio of Indian proportion to non-Indians
All alcohol-related arrests as a proportion of all arrests (percentages except, for col. 3):			
1970	59.0	35.2	1.68
1971	53.9	33.6	1.60

	All offenses	Liquor law	Driving	Drunkeness	All alcohol related
Rural arrest data—18 yr or younger Indian reported arrests as proportion of all reported arrests (percentages):					
1970	3.8	3.2	3.5	16.6	6.3
1971	3.2	3.0	3.2	15.7	5.8

	Indians	Non-Indians	Ratio of Indian proportion to non-Indian proportion
All alcohol-related arrests as a proportion of all arrests (percentages except col. 3):			
1970	23.6	13.9	1.70
1971	25.1	13.6	1.85

ALCOHOL WORLD RESEARCH, 1975

Total overall economic cost to the American economy is estimated at $25 billion/year. This has been broken down into the following cost areas:

Cost area:	*Billions*
Lost production	$9.35
Health and medical	8.29
Motor vehicle accidents	6.44
Alcohol programs and research	0.64
Criminal justice system	0.51
Social welfare system	0.14
Total	25.37

G. Program Description of Major Federal, State, and Local Agencies Impacting on Alcoholism and Drug Abuse

Reporting on:
- National Institute on Alcohol Abuse and Alcoholism
- Indian Health Service
- Bureau of Indian Affairs
- National Institute on Drug Abuse
- National Institute of Mental Health
- Office of Education
- Office of Native American Programs
- Law Enforcement Assistance Administration
- Department of Labor
- Veterans Administration
- State Alcoholism Service Plans in States with Large Native American Indian Populations
- Local Programs
- The Alcoholism Report

The National Institute on Alcohol Abuse and Alcoholism

Special approach for the Indian population

In 1969, an Indian Health Service Task Force on Alcoholism stated that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76%)." As a part of the President's message to the American Indians in July of 1970, additional dollars were committed to begin development of needed special programs. These programs are carried out in cooperation with the NIAAA and have as objectives to increase public understanding and awareness of the problem; to change community attitudes; to support rehabilitation sources; to develop preventive programs for Indian youth; and to design education and training programs in the field of Indian alcoholism. The Institute's projects are designed to provide residential care, individual counseling, job placement, referral service, group therapy, Indian AA groups, recreation and self government. The essential aspect of these projects, however, is the integration of the Indian cultural patterns into working through individual tribal mores, and emphasizing the Indian's image of himself.

The problem of alcohol abuse and alcoholism among Indian people requires intensive and specialized technical assistance in developing Indian alcoholism programs, training for Indian people, research into psycho-social variables of alcohol abuse and alcoholism among Indian people, and sufficient funding in order to deal effectively with this major health problem. The Indian Health Service and the NIAAA are in agreement on this approach, together with the Indian community whose input helps clarify what the objectives should be and who will assist in setting national policy with respect to the delivery of more effective alcoholism services to the American Indian and Alaska Native communities.

The purpose of the American Indian and Alaskan Native Program of the NIAAA Division of Special Treatment and Rehabilitation Programs is to assist Native Americans, local communities, states and other branches of the federal government concerned with American Indians and Alaskan Natives in providing the best available alcohol abuse and alcoholism treatment and rehabilitation services.

The division's basic method of approach to accomplish this purpose has been the early and continuous support of the concept of Native American self-determination and control. From its inception the Division established an Indian Desk with an Indian experienced in Native American alcoholism as its Chief, an all Indian grant review committee, and program guidelines and criteria which stressed Native American development and control of services. Simultaneously, the Division has worked actively and cooperatively with the growing movement for more mutual inter-tribal cooperative ventures (Pan-Indianism) as it related to the problem of Native American alcoholism. NIAAA has recognized and works with the National Indian Board on Alcoholism and Drug Abuse.

The Division further adopted an approach which seeks to reduce communication barriers between the Indians and the federal bureaucracy. The Indian Desk and its Chief were delegated responsibility and authority to serve as the focal point for Native American concerns and interests in alcoholism. DHEW procedures and forms were followed but were simplified and made more accomodating to assist the development, start-up and operation of services.

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The Division has also worked cooperatively with other federal agencies dealing with Native American alcoholism to promote more effective utilization of existing resources and in the shaping of more effective national policies regarding Native American alcoholism. An example is the pending NIAAA–IHS Memorandum of Agreement by which NIAAA and IHS will work closely together to develop more effective alcohol services and to maximize existing resources.

The Division has carried out its basic methods of approach at community level, supporting Native American's ideas of programming and services which represent their own organization, staff and control; programs designed to provide a variety of services which may include residential care for problem drinkers, individual counseling, job placement, referral services, group therapy, Indian AA groups, didactic lectures, work therapy, recreation, self-government and cultural support activities, public education, training of Indian people and development of community services.

INDIAN HEALTH SERVICE

The Indian Health Service (IHS) is a component of the Department of Health, Education, and Welfare's Health Service Administration (HSA), which is working to improve health services and promote better health for all Americans. The responsibility of the Indian Health Service is to 518,000 American Indians belonging to more than 250 tribes and 38,000 Natives living in 300 Alaska villages.

The problems that these citizens encounter in preserving health and obtaining needed health care exceed those of most other Americans. The goal of the Indian Health Service is to raise the health of the Indian and Alaska Native people to the highest possible level and assist them in every way possible to achieve a better quality of life. Interacting with other HSA activities in many mutually beneficial ways, and with public and private agencies, the IHS is developing innovative ways of dispense health services, utilize manpower, stimulate consumer participation and apply resources. In this effort, the IHS has three major objectives:

To assist Indian tribes in developing their capacity to man and manage their programs through activities such as health management training, technical assistance, and human resource development and provide every opportunity for tribes to assume administrative authority through contracts and delegation.

To act as the Indians' and Alaska Natives' advocate in the health field to generate other interests and resources which can be utilized.

To deliver the best possible comprehensive health services, including hospital and ambulatory medical care, preventive and rehabilitative services, and to develop or improve community and individual water and sanitation facilities and other environmental factors affecting good health.

Organization of the services

Headquarters.—The staff of the Indian Health Service headquarters includes health and administrative professionals and clerical staff who support overall operations and provide advice and guidance to field offices. The organizational strucutre and activities of the staff are geared to serve as a resource for field staff personnel in management, administrative services and various health disciplines.

Field Administration.—The field service is divided administratively into eight area offices and three program operations. Each area and program office is responsible for operating the health program within its designated geographical area, utilizing Indian Health Service or contract facilities, to provide comprehensive health care services.

Service Units.—Areas are broken down into service units to facilitate operation of the program. A service unit is the basic health organization in the Indian Health Service Program, just as a county or city health department is the basic health operation in a state health department. These are defined areas, usually centered around a single federal reservation in the continental United States, or a population concentration in Alaska. A few units cover a small number of reservations; some large reservations are divided into a number of units. The Navajo Reservation, which covers 24,000 square miles in three states and has a service population of approximately 98,000, is divided into eight service units. Most service units encompass a hospital or health center staffed by competent teams.

Research and Training.—The Office of Research and Development in Tucson, Arizona, combines the Service's Training and Health Program Systems Centers, and the Papago Reservation Health Programs. There, new methods and techniques for health care delivery, reporting systems, and manpower resources and utilization are being developed to provide new insights into the improvement of health care planning, programming, implementation and evaluation.

Indian Health Service comprehensive health program

The Comprehensive Health Services Program is designed to cope with the observed and stated health needs of Indian people and Alaska Natives. It provides a broad scope of primary care and preventive and rehabilitative services through a system of expanding facilities, manpower, and health programs. Planning and implementation of all phases of the health services program reflect the cooperative efforts of a highly proficient health and administrative professional staff and consumer representation of the Indian people and Alaska Natives. Tribal health boards, advisory boards, community development activities, Indian training and manpower recruitment programs, and local health activities all help to assure consumer input. These activities and other provided through tribal contracts provide the resources to enable Indians to man and manage their own program.

In recent years, a number of private, state and other federal governmental health resources have been mobilized to assist IHS in its mission to improve the health status of Indian people and Alaska Natives. These include programs of other constituencies of the Department of Health, Education and Welfare, the Department of Housing and Urban Development, the Office of Economic Opportunity, the Bureau of Indian Affairs, the Department of Labor, and the National Council on Indian Opportunity; a number of states; individual Indian tribes, and intertribal groups; and private and voluntary Indian interest groups.

Facilities and Services

The program is carried out through a system of 51 hospitals, ranging in size from 6 to 191 beds, 3 of which are referral, teaching and research centers; 86 health centers including 26 school health centers; and more than 300 health stations and satellite field health clinics. Additional medical and dental clinics are held at appointed locations on a regular schedule, daily, weekly or monthly. Special clinics are held intermittently, as needed. Contracts are also maintained with over 300 private or community hospitals, more than 18 state and local health departments, and some 1,600 physicians, dentists and other health specialists to provide hospitalization and specialized diagnostic and therapeutic services. The contract program is used in locations where there is no Indian Health Service facilities, health professional, or alternate resource to provide the required service.

Most service units have a hospital or health center and a number of satellite clinics providing inpatient care and outpatient services through preventive and curative clinics. Special services include prenatal, postnatal, well-baby, family planning, diabetes, heart disease, trachoma, tuberculosis and immunization programs. Added services are provided by public health nurses, community health medics (physician assistants), tribally employed community health representatives, nutritionists, health educators, mental health workers, social workers and sanitarians who are engaged in home visits, in follow-ups on discharge tuberculosis patients and newborns and mothers, in health education conferences and in environmental health endeavors.

School health programs are conducted in boarding and day schools operated by the Bureau of Indian Affairs, Department of the Interior and public schools on reservations.

Dental services are provided at hospitals, health centers and health stations, and in mobile dental units. In some locations where the Public Health Service has no facilities, care is provided under contract with dentists in private practice. In Alaska, dental teams travel to remote villages by charter plane taking equipment with them.

Dental care for persons under 17 years of age is given priority, a policy that began in 1968 when the D MF rate (decayed, missing and filled teeth) for Indian children showed a decline for the first time in 13 years. Expanded resources, increased efficiency and the addition of dental assistants have contributed to a steadily decreasing DMF rate since then. Reaching all children and providing care for an increasing number of adults are continuing aims.

Environmental health services provided under the direction of Indian Health Service sanitarians are an integral part of the IHS total comprehensive health program. In concert with the health staff, the sanitarian works to combat unhealthy environmental conditions and practices, poor and crowded housing, lack of safe water supplies and inadequate waste disposal facilities, all of which contribute to a high rate of infectious disease.

New directions

Consumer Involvement.—The increasing number of Indian people, especially in leadership roles, has been one of the most significant developments in recent years.

A Division of Indian Community Development has been established to make the IHS more responsive to the health needs of Indian people and their changing role in managing their own health programs.

The National Intertribal Health Board of 12 Indian leaders representing all areas and program offices, Indian health boards and other committees, is helping to develop policy, determine health needs, establish priorities and allocate resources at each administrative level throughout the Indian Health Service. In addition to health programs, social, economic and other aspects of better health and quality of life are being emphasized. Existing problems are being identified and new resources and health related programs are being developed to bear upon the problems of health services delivery. The involvement and subsequent contributions of Indian groups have led to changes in health services delivery methods and more effective adaptations of health services in a number of IHS locations.

New community initiative

Indian and Alaska Native people have taken the initiative to develop and operate a variety of local programs to meet their most crucial needs. Many individuals have taken leadership training in health affairs which they are utilizing in their respective reservations and communities. The effectiveness of local action has been demonstrated in direct community health services activities such as programs in nutrition, accident prevention, alcoholism control, suicide prevention, mental health, improved housing and other areas of community action and economic development.

Indian self-determination is rapidly emerging as a working concept. It is uniquely evident in California and southeastern United States where Indians are managing their own health affairs.

The California Rural Indian Health Board, under agreement with the Indian Health Service, is arranging the delivery of a variety of health services to Indians living in 16 project areas composed of 34 counties. The United Southeastern Tribes Intertribal Council is managing health care for Indians residing in Mississippi, North Carolina, Florida, and Louisiana, through Indian Health Service and contract facilities in those states.

Special programs

The level of health today among Indians and Alaska Natives is in many respects similar to that of the general population about a generation ago. Physicians encounter a greater variety of clinical conditions in Indian Health Services facilities than in other health programs in the country. Special health needs are met in varied ways with activities keyed to removing the source of the problem.

Mental health

As the Indian people have been caught more and more in the conflict between their old traditional culture and the demands of modern American society, mental health problems have increased. The seriousness of mental health problems among Indians and Alaska Natives is demonstrated in age adjusted suicide rates which are 1.9 times as high as that of all races and a homicide rate 3.1 times as high. Indian deaths from alcoholism, alcoholic psychosis, or cirrhosis with alcoholism are 6.2 times as high as in the general population.

Emotional problems and behavioral disorders are frequent among Indian children in their struggle for identity and achievement of self-sufficiency in a new social set-up. There is increasing need for the mental health component in child guidance and counseling, and for the development of new and effective methods to prevent further trauma to the growing child.

As of this fiscal year, professional mental health teams are working in all Indian Health Service areas. A pilot inpatient mental health program has been introduced, a model dormitory project is being conducted, and training of Indians as mental health workers and technicians has been expanded.

The Indians themselves have undertaken innumerable projects, especially in alcoholism control.

Otitis media

Otitis media has always been a serious health problem among Indians and Alaska Natives and in the last decade, has replaced tuberculosis as a major health problem inflicting serious and often permanent damage.

The extreme prevalence of the disease with the accompanying demands for prolonged treatment, curative and restorative surgery and rehabilitation created a workload that was impossible to meet out of regular program resources. In 1970, Congress appropriated additional funds especially for an otitis media program,

making it possible for the Indian Health Service to institute the kind of program necessary to bring this serious problem under control.

Nutrition

Mild and moderately severe nutritional deficiencies are relatively common among Indians and Alaska Natives, especially in infants and preschool children and women in the child-bearing years of 15 to 44. Malnutrition, a problem in itself, also is a contributing or complicating factor in a wide variety of other health problems and illnesses. To help improve the nutritional status of Indians and Alaska Natives, the IHS conducts a family-centered nutrition service program of intensive education, adapting proper principles to the food habits and cultural practices of Indians and Alaska Natives.

Additionally, through the nutrition program of the Center for Disease Control, four Indian tribes and the Alaska Federation of Natives have grants to conduct demonstration programs to better nutritional health by improving food supplies, training Indian workers, increasing participation in food assistance programs and providing practical information to Indian and Alaska Native people.

Maternal and child care

The high rate of illness and death among infants in the first year of life is met with emphasis on early prenatal care for the mother and continuing care after she and the baby leave the hospital. Health education activities are conducted to teach the mother proper ways to feed, bathe and care for her family within the often limited resources of her home, how to recognize illness, and why it is important to observe good health habits and make regular visits to the clinic.

A nurse midwife program was recently introduced to reach mothers living in isolated areas. The first such program was initiated in Alaska in 1970 to expand and improve the health care of mothers and children and to demonstrate the role a nurse midwife can play in reducing maternal and infant deaths. Similar programs have since been instituted in Shiprock, New Mexico, and in the Fort Defiance, Keams Canyon and Chinle Service Units in Arizona. Nurse midwifery services are also being developed in Pine Ridge, South Dakota, and Lawton, Oklahoma. In cooperation with the Schools of Nursing, University of Utah, and John Hopkins University, the program is being expanded to other areas.

BUREAU OF INDIAN AFFAIRS

The Bureau, in its Washington office, employs *one full-time alcohol and drug abuse specialist* who serves as liaison between the Bureau and other agencies and organizations which specialize in alcoholism or drug abuse information, services or programs.

With the exception of the staff activity referred to above, this Bureau does not operate alcohol or drug abuse programs for Indians. Essentially, this is because the Bureau is not provided funds to operate such programs. All federal funds related to alcoholism are channeled by law (Public Law 91–616) directly to the National Institute for Alcohol Abuse and Alcoholism, Department of Health, Education and Welfare, which in turn, is responsible for the total federal alcoholism effort. This arrangement has been reaffirmed by the Office of Management and Budget on those occasions when the Bureau has requested funds for alcoholism programs.

Curriculum—Bureau of Indian Affairs schools

For purposes of the BIA, curriculum is defined simply as the planned activities of the school with special emphasis on what takes place between the teacher and the student. Curriculum development is the shared responsibility of a number of individuals including the teacher, principal, student, parent, Area Office and Central Office. Each level of BIA education has a different responsibility.

At the Central Office, curriculum development is vested in the Director of Education who in turn assigns it to divisions. Each Central Office division has some responsibility in curriculum development. For instance, the Division of Continuing Education works with special education as related to physical and mentally handicapped. The Division of Evaluation, Research and Development works with traditional content areas and with special programs that are being implemented in schools. For instance, this Division of School Facilities has responsibilities for curriculum developments as related to new facilities.

Basic responsibility for curriculum development at the instructional level is delegated to Area Offices who in turn work with Agencies and schools. Areas assume responsibility for the actual instructional program. It is at this level that

teachers are hired, that curriculum content is reviewed and determined, and basic matters relating to the students carried out. In effect, Area Offices operate as school districts whereas the Central Office serves the role of a traditional state department of education.

Regarding drug and alcohol abuse in the school program, general education goals are developed at the Central Office level of operation. These are further refined at local school levels of operation. In this case, drug and alcohol abuse would be covered under the general goals pertaining to "Health and Nurtition". It would be at the Area Office and school levels of operations that general goals would be translated into the specifics of a particular program.

The BIA does not have a specific policy or allocation of funds in support of "Affiliation Agreements." This type of approach to alcohol and drug abuse is expensive and is not a categorical program for educational purposes. On the other hand, there is involvement of the Indian community in educational drug and alcohol abuse programs which may or may not include affiliations made at the school level of operation.

Policy in Indian affairs, including BIA education, emanates from a number of sources but primarily the Congress and the administration. These two sources have endorsed the policy of self-determination which adds a third source . . . Indian tribes.

Policy statements developed at the Central Office level pertaining to education are broad and general so as to accommodate the differences found among Indian tribes. Area Offices add another dimension and finally, at the community or school level, it applies to immediate needs of Indian children. The self-determination policy requires that the Bureau be responsive to Indian tribes; hence, specific programs such as drug and alcohol abuse are determined at the local level.

Improvement in the system will come from having funding sufficient to take care of specialized needs such as drug and alcohol abuse. While BIA schools have a great deal being offered in drug and alcohol abuse, categorical funding would improve the situation greatly. The specialized needs of Indian children/youth are such that education programs cost more than in comparable non-Indian situations. Bilingual needs, special health problems, alcohol and drug abuse and education of the handicapped are examples of types of education programs that need to be expanded but are hampered by insufficient funds. Some form of categorical funding that would be available for a limited start-up time then become a part of the regular base, would be helpful.

NATIONAL INSTITUTE ON DRUG ABUSE

Since its establishment in September 1973, the National Institute on Drug Abuse (NIDA) has become increasingly aware of and involved in the problem of drug abuse among American Indians. In this brief eighteen-month period, the Institute's commitment to this particular area of drug abuse has increased from the support of fifteen projects at a total federal cost of $486,000, to twenty-five projects involving Indians totaling over $1.5 million, with another $300,000 designated for new projects before the end of fiscal year 1975. In addition, the scope of NIDA's efforts has grown from supporting simple prevention and treatment projects, to more recent efforts in training, demonstration and research. At the same time, NIDA has attempted to insure that a coordinated approach be maintained by consulting with federal agencies already involved with relevant services to Indians as well as with various Indian associations themselves. This method will soon be formalized by the establishment of a collaborative consultant group composed of individuals representing such agencies and organizations as the Indian Health Service, the National Tribal Chairmen's Association, and the National Indian Board on Alcoholism and Drug Abuse. The fiscal year 1976 budget will allow NIDA to continue this program at a level of effort consistent with fiscal year 1975. Examples of specific NIDA projects in this area are summarized below.

Treatment services programs

NIDA currently supports fourteen treatment projects in which Indians are provided assistance in dealing with their drug abuse problems. A grant with the Red Lake Tribal Council in Red Lake, Minnesota provides services exclusively to members of the tribe at a total annual federal cost of approximately $200,000 with treatment capacity for 150 patients. This outpatient drug free program provides the following additional services: (1) individual and group counseling; (2) remedial education; (3) preventive services with families and school groups;

(4) job training and placement; and (5) cultural and recreational programs. The program also operates four drug awareness centers for teenagers. A second program in Flagstaff, Arizona has four major Indian clinic affiliates including the Apache Tribal Guidance Clinic and the Navajo County Guidance Clinic. Services available through this program include crisis intervention, detoxification, in-patient and after-care as well as family, individual and group therapeutic services. These clinics are supported at a federal cost of about $100,000 for 60 patients.

Demonstration programs

The uniqueness of the Indian situation in the American society has led the Institute to explore new and innovative methods for addressing their drug abuse treatment needs. The Morning Star Project in Billings, Montana, supported at an annual cost of $422,000, provides a prime example of this approach. This project is attempting to effect the integration of a treatment regimen with Indian culture and philosophy, the basic assumption being that drug addicted Indians can best be rehabilitated by strengthening their connection with their culture, making use of its spiritual values, and enhancing their sense of identity. The treatment program itself is basically a drug-free therapeutic community staffed almost entirely by Indians. The inadequacy of many present alcoholism and drug abuse treatment programs involving Indians is attributed to the fact that they separate him from his culture. Another example is a $190,000 grant with the Western Nevada Indian Health Board in Stewart, Nevada, which is conducting a two-year program in the Stewart Indian School to demonstrate that increased personal and cultural awareness in Indian youth will result in a lifestyle in which the use of drugs will be avoided. The program utilizes experienced adult Indian counselors and trained student-peer counselors to assist clients in increasing personal and cultural awareness and in recognizing constructive alternatives for dealing with social and emotional needs.

Prevention programs

While service and demonstration projects are attempting to address the treatment needs of those already involved with drug abuse, the Institute is concomitantly supporting projects specifically aimed at preventing further abuse among Indians. A three-year grant for an estimated total support of $567,000 with the Small Tribes Organization of Western Washington, Inc. (STOWW) is one such program. This project provides intensive drug abuse education to the STOWW tribes, including counseling to individuals and parents, conducting rap sessions and self-awareness groups with high risk personnel, and suggesting viable alternatives to the inappropriate use of mind-altering drugs. Volunteer Indian staff are trained at the Skokomish and Nooksack Centers and, as their training progresses, the professionals gradually phase out. A similar grant with Miccosukee Tribe in Florida, funded for three years for approximately $147,000, attempts to motivate members of the tribe to develop positive attitudes and to preclude the possibility of turning to drugs. Special emphasis is given to providing education regarding the effects of drugs, to increasing awareness as to the traditions and lore of the tribe, and to develop active youth involvement in the running of the program.

Training programs

In order to develop a manpower pool of Indians trained to treat drug abusers within their population, the Institute has worked with its prime contractor, Youth Projects, Inc./National Free Clinic Council, to establish training subcontracts with Indian groups. The Keweena Bay Indian Community Health Service Center in Baraga, Michigan and the American Indian Free Clinic in Compton, California have been supported as subcontractors in this program for the last three years at a total federal cost of $127,000. Each subcontractor has developed its own training methodology to meet the specific needs of the drug abuse problem in their locality, and both send their trainers to the NIDA funded Regional Training Centers to develop approaches and ideas for the best training techniques and curricula for their individual programs.

Research programs

In an attempt to generate a better overall understanding of the drug abuse phenomenon among our Indian population, the Institute is funding a joint research grant with Colorado State University and the Indian Health Service at a total cost of $267,000. The overall purpose of the project is to obtain prevalence data on drug abuse and cognitive and attitudinal items on drug knowledge and motivation from Indian adolescents. The investigators have chosen two sampling units within the nine Indian Health Service regions based on the recom-

mendation of the tribal councils in the proposed areas. The primary data gathering instrument is a self-administered questionanire which includes items not only on drug abuse and knowledge of drugs, but also on perception of a wide range of social and psychological problems. While the study is designed to focus on those adolescents within the school system, an attempt is being made to survey school dropouts. Supervision of the administration of the instrument is by trained Indian Health Service workers rather than by members of the school system.

NATIONAL INSTITUTE OF MENTAL HEALTH—AMERICAN INDIAN

The American Indian has been characterized as the most impoverished and deprived group in our nation, in terms of employment, income, education, health and housing.

In contrast to a slow growth rate of 13 percent of the American population in the past decade, the American Indian population grew by 50 percent in the 1960's. The 1970 Census reported 827,000 American Indians and Alaskan Natives in the U.S. The Census reported that in comparison to 14 percent of all American families, 40 percent of American Indian families live on income levels below the poverty level. The median age of the American Indian in 1970 was 20—eight years younger than the national median. Almost 50 percent of American Indians are living in urban areas.

Along with the many other statistical indices of the severe plight of the American Indian, indicators of extreme and increasing psychological and emotional distress are present. The suicide rate for American Indian adolescents is four times that of the general population, with a rate 20 times the national average on at least one reservation. The 1973 overall U.S. crude suicide rate was 12.0 per 100,000 in contrast to the American Indian overall crude rate of 19.4 per 100,000. Other indicators of the significant mental health need are the extraordinary incidence of alcoholism, glue sniffing and school drop-outs.

There is a clearly documented need for mental health services especially designed to meet the unique requirements of the American Indian populations. The resolution of this problem is made difficult by a severe shortage of American Indian mental health professionals. There are, for example, only seven known American Indian psychiatrists.

Research.—In November 1972, the NIMH Center for Minority Group Mental Health Programs, assembled at a National Conference on Indian mental health issues. A major concern expressed by this group was the need for research designed and implemented by American Indians which is directly related to American Indian mental health problems. In direct response to the stated need, NIMH provided funds in fiscal year 1975 to the National Tribal Chairmen's Association and the University of Oregon to establish a National Mental Health Research and Development Center for American Indians and Alaskan Natives. The principle objectives of the Center include:

1. Conduct research which has been identified as a high priority by American Indians, Alaskan Natives, mental health/behavioral and social science scholars, and the Center's National Advisory Committee;
2. Provision of a research preceptorship for American Indians and Alaskan Natives with guidance and supervision by members of the same racial groups;
3. Monitoring and coordination of research projects relating to American Indian/Alaskan Natives, (i.e., projects which are being conducted by other institutions, agencies and programs);
4. Affiliation and collaboration with other research programs focused on studies of American Indian/Alaskan Natives;
5. Provision of technical assistance to American Indians/Alaskan Natives in the design of research and/or identification of resources for support. Upon request, technical assistance would be provided to non-American Indians/Alaskan Natives in the design, evaluation and implementation of research pertaining to American Indians/Alaskan Natives;
6. Collection, storage, retrieval and dissemination of unique mental health and social science data pertaining to American Indians/Alaskan Natives;
7. Identification of model mental health research and development resources and programs relating to delivery of mental health services, manpower development and research for American Indians/Alaskan Natives;
8. Through the Center's National Advisory Committee, Board of Directors of the National Tribal Chairman's Association, and other American Indian/Alaskan Native organizations and individuals, identification of needs and periodic evaluation of the programmatic direction of the Center.

Priority research areas will include development of culturally sensitive models for the delivery of mental health services to American Indians/Alaskan Natives among American Indian children in Indian boarding schools; development of a theoretical model for contrasting and/or evaluating the effectiveness of the medicine men and physicians as practitioners for given conditions in selected socio-cultural contexts; assessment of mental health needs of urban, inner-city and reservation American Indians and Alaskan Natives; foster child placement programs (impact on Native belief and value systems, socialization patterns, and quality of adjustment); and effects of non-Indian testing and counseling programs.

Service Delivery and Manpower Development.—By December 1974, the NIMH had made construction and/or staffing grants to community mental health centers which are to serve 60 Indian reservations in 17 states. The 39 centers have all or part of the reservations in their catchment areas. A substantial number of the centers have established full-time satellite offices so services are closer to people's homes. An effort is made, as in the Four Corners Mental Health Center in Utah, to employ Indians on their staffs.

The absence of American Indian mental health workers represents a severe handicap to the effective provision of services to American Indian populations. The NIMH has attempted to bridge this American Indian manpower gap through the funding of special social worker training projects in Arizona, Florida, Oklahoma, Oregon, Texas and Utah. American Indian mental health workers have been trained in: California, Colorado, Minnesota, Montana, New Mexico, New York, North Dakota, Oregon and South Dakota. Also, a unique nurses training project was initiated in North Dakota.

OFFICE OF EDUCATION

In May 1976, the Office of Education issued proposed regulations to carry out programs for the prevention of and early intervention in alcohol and drug abuse.

Funds would be made available to local public and private education agenies and community-based public and private non-profit agencies, institutions and organizations to send a 5 or 6-member team of educational personnel to regional training centers to learn how to develop and administer the above mentioned programs.

The proposed regulations provide for the following programs and projects:

1. For the development, testing, evaluation, selection and dissemination of materials for use in educational programs.
2. Programs focused on causes of drug and alcohol abuse, not symptoms.
3. Prevention and early intervention programs created by the use of an interdisciplinary "school team" approach, through which skills involved with planning and conducting these programs will be developed in both the educational personnel and students.
4. Preservice and inservice training programs for "teachers, counselors, other educational peronnel, law enforcement officials, public service and community leaders.
5. Community education programs—especially parent oriented.
6. Programs for recruitment, training and employment of both professionals and others for involvement in the field (to include recovered drug and alcohol abusers and former dependents).
7. Projects for the dissemination of valid and effective school and community educational programs.

The regulations also provide for training and technical assistance to both public and private educational agencies and community groups. This training would be at no cost to the participants.

The informal policy of the Office of Indian Education in regards to alcoholism education and drug education is that they are allowable categories for funding under Parts B and C, and Part A (Non-LEA) of Title IV, as components of a project. Although they are allowable areas, alcoholism and drug abuse education programs have not been considered priority areas under Title IV (Indian Education Act).

OFFICE OF NATIVE AMERICAN PROGRAMS

The Native American Program, NAP, develops innovative approaches for dealing with the special needs of American Indians, Native Hawaiians, and Alaskan Natives and provides technical and financial assistance to enable them to move toward economic self-sufficiency. The purposes of NAP include: (1) strength-

ening of tribal governments to enable them to effectively manage and utilize available resources; (2) support of a range of services to meet individual and family needs; (3) support for establishment and operation of urban centers serving Indian people living off reservations; and (4) funding to encourage self-help and community economic development efforts.

Direct-funded grantees provide services which are available to over one-half of the approximately one million eligible Native Americans in the United States. The grant program in 36 states includes 273 tribes, groups and Alaskan villages, as well as 58 urban organizations.

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION

The LEAA is primarily a block grant program which distributes its funds to individual states on a population formula basis. The funds are then distributed through the designated state agency in accordance with the state's comprehensive criminal justice plan. These funds and resultant grants and subgrant applications are therefore under the state's jurisdiction for approval or disapproval, not LEAA's. It is through the state's planning agency and comprehensive criminal justice plan that decisions are reached as to priorities and subsequent funding.

LEAA does retain a small portion of monies for discretionary funding of projects of national scope and innovative and experimental projects. These grants are not initiated by LEAA but through proposals submitted by applicants.

DEPARTMENT OF LABOR— EMPLOYMENT AND TRAINING ADMINISTRATION

Under Title III of the Comprehensive Employment and Training Act (CETA) of 1973, the Department of Labor funds direct grants to Indian reservations and other organizations. Supportive services, such as initial counseling and referral to existing alcoholism and drug abuse programs, are offered to the extent that this substance abuse affects the employment and/or training of the individual.

The Department of Labor does recognize the fact that other agencies (HEW, NIAAA) do have the mandate and appropriations to deal directly with this problem, but they, through CETA, coordinate efforts with other agencies.

VETERANS' ADMINISTRATION

The Veterans Administration sponsored a conference from September 16–18, 1974 on the "American Indian Veteran and the Problem of Alcohol", in Albuquerque, New Mexico. Central Office staff members met with representatives of 26 VA hospitals located close by sizeable populations of American Indian veterans. Strong emphasis was placed on surfacing operational problems experienced in the management of the VA's alcohol dependence treatment programs as they provided a broad range of services for American Indian veterans.

Workshops were provided for all attendees, to increase skills in outreach and case finding techniques. Participation by a number of representatives of Indian communities provided a rich resource milieu of expert consultants. A number of site visists to Indian operated alcohol dependence treatment programs were made by the conferees. Through that period of intensive training and colaboration, a sense of common purpose emerged. The theme of the conference centered on self-determination by American Indian veterans, while providing for comprehensive and appropriate health service, fully respecting their heritage and devoted service to this country. Following this conference, considerable communication continued on this program area between Central Office and our Veterans Administration health care facilities.

To improve services to American Indian veterans, a special subcommittee for Indian Veteran Health Affairs was designated, with Dr. Stewart L. Baker, Jr., named as chairman. The committee was multi-disciplinary, selected from those clinical and other supportive services which could contribute importantly to the task. Several site visits to Veterans Administration hospitals and to American Indian and other community health service facilities have been completed by this group of VA professionals, usually with participation by DHEW representatives.

A number of areas were identified which appeared to merit continuing special emphasis. Those subjects particularly persuasive for priority attention included:

1. Better coordination—between VA facilities and other community health service activities, including Indian operated clinics.

2. Improved communication—through more accurate and helpful information about VA services, about existing programs for American Indians, and through more effective use of the communication technology.

3. Focus on eligibility—with facilitation of access to VA health services by increased information about VA benefits, et al.

4. Improvements in direct health care—by reviews of patient flow sequences at VA hospitals to increase the hospital staff's awareness of and responsivity to Indian veterans in the hospital area.

5. Improvements in personnel practices—through focus on employment of American Indian counselors as specialized skill for treatment team.

6. Education—toward increased mutual exchange between VA staff personnel and the American Indian communities.

7. Advocacy programs—through recruitment of American Indian ombudsmen by VA hospitals, from American Indian communities, to assist in increasing the visibility of American Indian veterans in hospital areas, with direct support for such veterans and more effective interfacing with ambulatory care facilities for aftercare.

Recently, the Veterans Administration and the Department of Health, Education, and Welfare approved an interagency agreement to establish Veterans Administration participation in providing veterans benefits in the Navajo Indian Reservation area.

STATE ALCOHOLISM SERVICE PLANS IN STATES WITH LARGE NATIVE AMERICAN INDIAN POPULATIONS

Alaska

Department of Health and Social Services, Office of Alcoholism

For service and planning, the state is divided into three regions and twenty-two districts. The districts serve as collection points for surrounding villages and are responsible for basic counseling and education/prevention activities. The three regional centers (Juneau, Anchorage, Fairbanks) are to offer comprehensive services. The state funds twenty-two projects in eighteen communities.

At least 17 percent (approximately 51,000–78,000) of the population of Alaska is Native Alaskan and 17,000 are American Indian. Alcohol abuse is identified as being epidemic among these groups and Native Alaskans are designated as a target group in the State Plan. No specific priority action for native program development has been taken, through the Formula Grant Budget for fiscal year 1975 provided $7,500 to the Alaska Native Commission on Alcoholism and Drug Abuse; $12,500 is provided for formula grants to local communities.

Arizona

Department of Health Services. Community Programs Office (includes Mental Health and Alcohol and Drug Abuse Programs)

Six Regional Councils of Government function as planning agents for State and Federal grants. The Arizona Indian Commission on Alcohol and Drug Abuse is to provide input on Indian service problems.

The American Indian population of Arizona is large (114,487) and has been designated as a target group for alcoholism services. The state's action priorities and formula grant budget for fiscal year 1975 do not specifically mention Native Americans, however.

California

The Office of Alcohol Program Management is the single state authority.

Each of the fifty-eight counties are responsible for assessment and planning of that particular county's needs and priorities with respect to alcoholism and alcohol abuse. These plans are annually submitted by each local governing body—the County Board of Supervisors—to the Office of Alcohol Program Management for review and approval. State and Formula Grant funds are distributed to the counties through the Department of Health funding mechanism.

The state's American Indian population of 95,000 (5 percent of the California population) has been identified as a group whose alcoholism problems are severe. American Indians specifically are not designated as a target group, nor are they specified for either the formula grant budget or action priorities. Input on Native

American alcoholism is provided by the Indian Alcoholism Commission of California.

Montana

Department of Institutions, Division of Addictive Disease or Department of Health and Environmental Sciences Alcohol Services Division

In the last several years, the major portion of the state plan monies has been allocated in six equal allocations, five of these are to five geographical regions and the sixth is the cultural region delinated by Indian Alcoholism interests and administered by the Montana Indian Commission on Alcohol and Drug Abuse.

New Mexico

Commission on Alcoholism is the single state authority.

The state is divided into seven planning districts with eight area planning agencies. These agencies are designated as Regional Clearing houses and are responsible for review and comment on all applications from their District.

Formula funds are provided to communities for services. There are a number of local councils on alcoholism in the state and the community-team approach is stressed.

There are 73,000 Indians in the state which includes nineteen Peublos and four nomadic tribes. American Indians are specified as a target group, but are not mentioned in the formula grant budget or action priorities for fiscal year 1975. There are eleven Indian programs in operation in New Mexico. Most of these are funded directly from Federal grant funds. However, one program did receive $12,668 of formula grant monies. Thus far, input into the State Plan by the Indian community has been limited.

North Dakota

North Dakota Department of Health is the single state authority. Division of Alcoholism and Drug Abuse has program responsibility.

The Governor has designated eight planning regions for delivery of human services. One agency is the legal agency for service delivery in each of the regions. There are four Indian reservations in the state. 2.3 percent of the total state population is American Indian. Indians are designated target groups for alcoholism service and one of the action plan priorities for fiscal year 1975 was to develop treatment programs for Indian reservations utilizing an Indian task force. An Indian Ad Hoc Committee made up of representatives from all reservations was set up to develop treatment programs, using a formula grant at $20,000 as seed money.

Oklahoma

Oklahoma Department of Mental Health is the single state authority. The Division on Alcoholism, one of ten units within the Department, has responsibility for preparation, consultation on, and administration of the State Alcoholism Plan.

The state is divided into eleven sub-state planning districts; each district has an area coordinator. Each resides in his own district and is responsible for planning, coordination, implementation, and evaluation within that district. There is close cooperation with the area-wide health planning agencies which also review and comment upon all alcoholism application from their district. The districts are encouraged to assist the health planning agencies in developing an alcoholism component for each area-wide health plan.

Oklahoma has the largest Indian population of any state with 103,650 from 1970 Census and 108,602 by 1974 estimate. Indians are designated as a target group, but do not receive specific mention in the formula grant budget or in the action plan priorities for fiscal year 1975. There are twenty-two alcoholism programs across the state funded with formula grant monies. Approximately 13 percent of the clients provided services by these programs are Native Americans.

The United Indian Recovery Association is a non-profit Indian organization formed by Indian people to provide a collective representative strength as a means for rectifying addiction dependencies. There are nine Indian alcoholism recovery programs in the state funded directly through NIAAA. One program receives an $8,000 formula grant for a youth project.

South Dakota

Department of Health, Division of Alcoholism

There are six planning districts in the state. Treatment needs are determined for each region at the state level. Local councils are being developed in the six regions to provide local community input into the state planning process.

The Division is helping the South Dakota Indian Commission on Alcohol and Drug Abuse Incorporated to develop a plan for prevention and treatment. One of the goals is to establish treatment centers which will respond to Indian people who are unable to relate to white, middle-class treatment methods. Reservation alcoholism programs have received $42,360 from formula grants and state liquor taxes. There is no direct state appropriation for grants to programs.

The American Indian represents the largest "other than white" segment of total population (32,385). When the data from the Incidence Prevalence Survey is analyzed by ethnicity, there is a strong representation of "other than white". The Division realizes that there is a significant alcoholism problem among Indians, but up to 1975, South Dakota Indians have had little influence on the planning process. The Division is intending, however, to incorporate reservation statistics and suggestions in its 1976–1977 plan.

Washington

Department of Social and Health Services, Office of Alcoholism, (Alcoholism Program responsibility is with the Office of Alcoholism, within the Community Services Division of the Department of Social and Health Services.)

Counties are responsible for alcoholism services which may be provided directly or indirectly through contracts with alcoholism services agencies. State funds are awarded to counties on the basis of alcoholism plans and county budgets for alcoholism that are formally adopted by County Commissions.

Each county or combination of counties has adopted an alcoholism Administrative Board to advise the County Commissioners. Boards are responsible for approving funds for alcoholism agencies, preparing the county plan and making recommendations on the county budget and alcoholism program.

There are sixteen Federally-recognized Indian reservations in the state and a total American Indian population of 34,000. Alcoholism services for Indians are funded primarily through grants from NIAAA. There are presently 15 NIAAA grants to eight Indian reservations and two Indian groups in the largest cities. No systematic effort has been made by the federal or state government to formally coordinate the Indian alcoholism programs. Recently, however, Indian groups and tribes have formed a corporate body, the Washington State Indian Alcoholism Commission, for the purpose of coordinating the funding and conduct of alcoholism programs for Indians.

LOCAL PROGRAMS

Various other treatment, prevention and rehabilitation services are available to the Native American and Alaskan Native throughout the country. These local programs, although open to Indian clients, normally are not responsive to their unique cultural needs and often have high costs and waiting periods.

Examples:

Facilities	General hospitals or clinics. Private or specialized hospitals. Mental hospitals. Detoxification centers. Half-way houses.
Counseling programs	Group counseling. Individual counseling. Community alcoholism counsels. Churches.
Specialized programs	Industrial programs. Alcoholics anonymous. Al—Ateens. Al—Anon. Vocational rehabilitation.

The Task Force found that communities are more and more recognizing their responsibility to their residents and community organization such as churches,

Salvation Army, community centers, Boy Scouts of America, Chamber of Commerce—all are beginning to assist in offering information, referral and other services.

THE ALCOHOLISM REPORT, VOLUME IV, NO. 12, APRIL 9, 1972

Public Law 94–237—This bill also establishes a new White House Office Drug Abuse Policy, replacing the now defunct Special Action Office on Drug Abuse Prevention (SAODAP).

However, the Chief Executive noted his opposition, expressed in recent months, to the re-establishment of a Special White House Office on drug abuse, as provided in the bill, calling it "duplicative and unnecessary." As a result, Mr. Ford said he would not ask for appropriations to fund the new office. The legislation authorizes funding for the office at an annual rate of $2 million.

President Ford asked Congress, July 1, to rescind a $250,000 appropriation to fund the Office of Drug Abuse Policy in the White House. The office was established by legislation enacted last March extending the federal drug abuse program authorities (Public Law 94–237) (AR, April 9). It replaces the now defunct White House Special Action Office on Drug Abuse Prevention (SAODAP).

In asking that the new office not be funded, Mr. Ford said in a message to Congress that he had opposed its creation all along and believed that it constituted an "encroachment on my responsibilities as Chief Executive."

"I do not need another office with two officials with salaries of $42,000 (for the director) and $39,000 (for the deputy director)," he said.

H. An Alcoholism Program Built Around a Comprehensive Health Model

Alcohol abuse is one of the most significant and urgent problems facing the Indians and Alaska Natives today. Probably no other condition so adversely affects so many aspects of Indian life in the United States. Alcohol abuse is harmful not only to the physical and mental health of the individuals, but to the family relationships, economic functioning and the whole fabric of society. It is a problem that demands attack on many fronts, especially through the provision of adequate health care services. A comprehensive program plan to deal with the health care aspect (physical, mental, social and spiritual) of alcohol abuse is spelled out in this paper. The plan has as its goal the reduction of alcohol abuse among all Indians and Alaska Natives and addresses five major aspects—the effective and efficient administration of an alcoholism program, the provision of preventive services, the provision of treatment services, and the provisions of rehabilitative and follow-up services and training. The plan is designed to interrelate the health care aspects with other components of a comprehensive alcohol abuse program and to insure that the development and implementation of an alcohol abuse program is a joint effort of the Tribe, the community, and the Federal Government, and, of equal importance, would represent the wishes and desires of alcohol dependent persons.

I. Administration

A. Development of a data base to define and measure the problem.

1. A data committee should be established to define the data bits required to manage the program and to develop the methodology for collecting the data from the program units.

The committee should consist of three health professionals, a statistician, and a systems analyst. The three professionals should be specialists in the area of alcoholism and have some knowledge of data processing.

The committee should investigate the possibility of using existing data systems to manage the program rather than establishing a new data base, and create an alcoholism registry to allow treatment and prevention programs to be constructed and aimed directly at the patient and his family.

2. The demand made on professional time by patients with alcohol abuse problems should be determined.

The data items to answer this question should be defined utilizing an activity report form. This could be a separate data collection mechanism or be made part of I.A.1. above.

B. A Federal entity needs to be developed with the capability of managing the program. The entity should be identifiable with decentralized responsibilities and should be directly tied in with the provision of other health care services.

C. The community must be involved in arriving at a solution for dealing with with the problem.

1. It has been firmly established that an important principle in tribal leadership involvement in health programs is joint planning and understanding must take place. Under the various programs separated by agencies, better coordination and improved means of communication are needed. Tribal leaders in the past have expressed their desires to coordinate these programs on reservations and in communities through the local governing bodies. Too many times the clinic operation is unaware of alcoholism operations on the same reservation.

2. Where advisory councils now exist, if sanctioned by the tribal leadership, these councils might best monitor and evaluate the local programs. Health councils, committees and boards would evaluate problems, consult with IHS, BIA, NIHB and other groups as required, and establish means to meet problems as they arise. (a) Involved in short and long-range planning. (b) Identify problems and program deficiencies. (c) Advise and recommend.

D. Standards for treatment and program administration should be developed and technical assistance provided to assist in obtaining compliance within 1–2 years of all existing programs.

1. Qualifications required for a program director should be established including, but not limited to, program administration experience, alcoholism treatment experience, and knowledge of the fundamental aspects of the disease. Qualification requirements for other staff should also be established.

2. A federal program should require and assist individual alcoholism programs to develop plans, budget forecasts, and effectively deal with the evaluation and other components of effective program management.

3. A comprehensive program should also establish guidelines for treatment standards and insure that referrals for additional services are made in an efficient manner and on a timely basis.

E. Development of mechanisms for coordination and joint program development involving public and private agencies at all levels—local, State, regional, and Federal.

1. Resource files and directories need to be developed and maintained to document all services/programs/facilities/specialists within a given jurisdiction that might be used to meet the objectives of this program and indicate for each the point of entry, the requirements for participation, listing all resources responsive to emotional, social, physical, and environmental needs.

2. Liaisons should be maintained with all agencies having such resources and linkages should be developed for referrals, including necessary written contracts or agreements with any special terms required.

3. Coordinating committee should be established and consist not only of health agencies' representatives but also representatives of law enforcement, employment, court and institutional agencies to insure that the broadest approach is taken to all facets of the program—prevention through rehabilitation—with the focus of this particular committee being continued resource identification and coordination to effect the fullest utilization of some.

F. Develop a cadre of trained Indian professionals/paraprofessionals should be developed to deal with alcohol abuse. Utilizing the resources provided by the Indian Health Care Improvement Act, programs should be developed that will focus on the training of health professionals to specially deal with the social and medical implications of alcohol abuse among Indian people. Included in the program should be courses that provide exposure to the sociological structures of Indian communities and poverty as well as knowlegde of treatment methodologies.

II. PREVENTIVE STRUCTURE

A. Educate the public and professionals involved in dealing with alcohol abuse

1. A phased approach to alcoholism education in schools should be developed and should include the physical processes involved, the social effects of alcoholism, the mechanisms by which alcoholism produces diseases, and participation in or exposure to treatment of acute and chronic alcoholism. Educational materials should be developed and integrated into the curriculum. They should include self-instructional materials and programmed learning materials. Alcohol use and its problems could be discussed in relationship with a great many topics and could especially be an integral part of any driver education course. Health educators informed on the medical, social, and psychological ramifications of alcohol abuse should be available within each school. In addition, however, the cooperation of the BIA schools and their staff is needed so that the staff will be encouraged to take in-house service training on alcoholism, to integrate that knowledge into

the curriculum, and to be familiar with other resources available to a student with a drinking problem within the scope of a federal Indian alcoholism program so that the student will be provided with the help he needs.

2. A phased approach to public education should be developed and an awareness campaign initiated which would include all the communications media, seminars, workshops, lectures, etc. Special programs could be set up for isolated groups such as prisoners, and those living in isolated communities. Alcohol abuse personnel should be available to take part in panels, seminars, and workshops. Literature should be made available to the public and to specific groups and organizations. Displays can be developed for libraries, schools, public and professional meetings, etc. Special training courses should be developed to orient key groups in the community. Every worker in alcoholism with proper training could in effect serve as an information officer. Local communication smedia might be persuaded to donate air time to the discussion of alcohol use and misuse. Articles in the local newspapers and magazines could be used as another communications vehicle by the alcohol program staff. A public education program should focus on the nature of the illness and its magnitude; the physical, psychological, and social aspects of alcohol use; and the concept of alcoholism as a treatable disease; as well as the resources available to the alcoholic and his family.

3. A comprehensive program should include development of orientation and training materials and administration of individually tailored training programs designed to meet the special needs of professionals involved in each of the following: (a) Medicine and the allied health fields; (b) Education and counseling; (c) Religious organizations; (d) Business and industry; (e) Law and protective agencies, juvenile probation; and detention centers, etc.; and (f) Federal, state and local governments.

B. Research and Development

1. The effectiveness of alternative treatment procedures should be assessed.
2. New programs should be developed in cooperation with other agencies.
3. The effectiveness of education programs should be assessed.

C. Community services provision based on the principles of Indian self-determination and decentralization of federal administrative responsibilities

1. A broad program of educational and referral activities using existing health care programs should be conducted.

2. Active involvement of tribal leaders and the entire community in alcoholism policy setting, etc. is also necessary. Involvement of tribal leaders and the entire community in alcoholism policy setting, etc. is almost nil on many reservations. Now is an opportune time to recognize how potent a mechanism the tribal health boards and advisory committees have become for providing a high degree of Indian involvement in their health delivery system.

3. Employment counseling and law enforcement agencies should also be involved in the program.

III. TREATMENT SERVICES AND STANDARD OF TREATMENT

A. General hospital care

1. Policy and procedures should be established for emergency treatment of acute/chronic alcoholism as well as evaluation and treatment of concurrent medical problems both alcohol and alcohol-related, e.g., D.T.'s, cirrhosis, trauma, diabetes and hypertension.

2. Routine diagnostic X-rays and lab tests of alcoholics where clinically indicated to determine if complications are present.

3. Staff orientation and development of in-service training to include staff attitudinal training and sensitization to the alcoholic patient should also be provided.

B. Out patient clinical care

1. Policy and procedures should be established for treatment of alcoholism on an out-patient basis, and to establish non-medical detoxification guidelines as well as supervision of short-term medication where indicated.

2. Referral services, therapy, etc. using other local/state and federal program resources should be provided.

3. Training courses for staff should be established.

C. Detoxification centers

1. Treatment and assessment policies and procedures should be established.

2. Programs for referrals from police, court, probation agencies and other institutions should also be established.

3. Staff orientation, development, and in-service training should be provided.
4. Coordination mechanisms with other health care and social services programs should be set up and operational.

IV. REHABILITATION AND FOLLOW-UP SERVICES

A. Provision of rehabilitation services

1. Counseling programs should be set up on an individual, group, or family basis to allow those with alcohol abuse problems to talk their problems out. Other mental health services should also be provided as required. Trained workers are needed to help patients discuss rather than conceal drinking problems. As the patient gains sobriety, they must be discouraged from making hasty or unsound decisions until they are physicially and emotionally well. Alcoholism retards emotional growth. With sobriety and continuing recovery, the maturation process is renewed. Progressive sobriety and recovery depends upon the quality of the guidance and other aid an alcoholic receives.

2. Joint programs should be set up with other federal, state, and local government agencies to provide job training and employment services. A joint federal-state vocational rehabilitation program for alcoholics offers a resource for the development and expansion of diagnostic and evaluative services for the alcoholic including continuing on-the-job medical and psychiatric treatment; vocational guidance; job placement and follow up; prevocational, personal adjustment and vocational training; and many other services aimed at enabling him to secure and retain suitable employment.

3. The establishment of Indian oriented A.A. groups, Alanon groups, and Alateen groups and similar programs should be encouraged. These groups have met with considerable success in helping the alcoholic and his family to overcome a drinking problem. These groups need to be tailored to meet the needs of the Indian people.

4. Local information centers should be set up under the sponsorship of community alcoholism councils. Such centers can be run by volunteers or by one or more fulltime staff(s) if resources are avilable. The center can provide accurate information on alcohol and its effects to all who seek it as well as serving as an information resource on the services available in the community to the alcoholic and his family. The center could provide library services, lectures, telephone counseling or other services as needed and should be integrated into a comprehensive alcoholism program.

5. Half-way houses could be set up where the need for them exists. In a comprehensive alcoholism program, there is a real need to bridge the gap between medical and institutional care and normal community living. An Indian half-way house can provide an Indian alcoholic with an opportunity to start over again in an atmosphere conducive to continuing abstinence and recovery. They can be especially effective in alcoholism rehabilitation if they include a professionally oriented recovery program designed to meet the needs of the Indian people and are an integral part of a referral system with other medical treatment facilities. The federal government can assist the Indian community to train staff; organize mental health, counseling and educational programs; and in effectively utilizing federal and state employment and training resources as well as medical services as needed.

6. A comprehensive alcoholism program should also help set up and encourage referrals from court and probation programs to deal with criminal and juvenile offenders with alcohol abuse problems. Courts and probation departments and juvenile homes are uniquely fitted to contribute to an alcoholism program. Judges, magistrates, and probation officers working in cooperation with a federal alcoholism program can require an Indian offender in lieu of a fine or jail sentence to participare in an alcoholism treatment program and thereby help stem the revolving door situation that exists for many alcoholics and courts through a program tailored to meet the needs of the Indian community.

7. Agreements need to be established with mental and other specialized hospitals to treat Indian alcoholics. Indians with alcohol abuse problems who suffer from chronic emotional or physical disorders should be able to receive treatment in the facility best suited to their needs. Agreements between these institutions and the federal government need to be established to facilitate such referrals and to provide the Indian patient with easy access to the care he requires.

8. Prison programs also need to be set up in cooperation with BIA for Indian prisoners with alcohol abuse problems. Indian alcoholics who committed felonies or other indictable offenses, if transferred to a federal treatment center operating

77-466—76——6

within the prison, can participate in an intensive recovery program prior to their release and could receive follow-up services as needed upon their release.

B. Provision of followup services

1. The alcoholism registry could be used to provide followup services to those who have received treatment for alcohol abuse problems. Such services would vary in their nature depending upon the needs of the individual.

2. The involvement of those whose problems has been arrested in alcoholism prevention, treatment and rehabilitation programs should be encouraged. Though it is essential to fill all positions with people having the best qualifications, if in addition to every basic requirement sought, it is also possible to add the experience of a recovered alcoholic who has achieved stability through recovery then an added bonus and capacity is brought to that position. Recovered alcoholics can also serve as volunteers in operating information centers and in other preventative, treatment, and rehabilitative programs. The success of A.A. is proof that recovered alcoholics have much to contribute to an alcoholism program.

I. Veterans Administration Study on Feasibility of Combined Alcoholism and Drug Treatment Program

The Pilot Alcohol and Drug Abuse Treatment (PADAT) Project 1975–1976 Handbook on Evaluation of Treatment of Drug and Alcohol Dependent Patients.

Veteran's Administration---------- Department of Medicine and Surgery.

PURPOSE OF PROJECT

Traditionally, patients with primary alcohol abuse problems have been treated in settings separate from those with patients who have primary drug abuse problems, however, because of the many similarities in abuse of such substances, some authorities propose that similar causal mechanisms underlie some of those problems. If true, it should be possible to treat both individuals and either or both abuse problems in a combined setting. In addition to a conceptual justification for integrated treatment settings could also be more cost effective in terms of personnel and resources. Better utilization of single-settings programs might be achieved if admission were open to both types of patients, providing it was not detrimental to patient recovery. Also, communities without sufficient client population to support the establishment of separate treatment facilities could still address both problem areas with a smaller combined treatment approach.

PADAT is designed to determine the feasibility and to assess the effectiveness of treating drug and alcohol dependent patients in the same setting. Results of this project could have great implication for planning the treatment of these two groups of patients which contribute large populations to V.A. hospitals.

J. The Alcoholism Report, Vol. IV, No. 10, March 12, 1976

The House passed and sent to President Ford legislation (S–2107) establishing a new Office of Drug Abuse Policy in the White House and extending through FY—78 the state formula and project grant program authorities of the National Institute on Drug Abuse (NIDA).

The new White House Office would replace the Special Action Office on Drug Abuse Prevention (SAODAP), whose statutory life expired last June 30. A White House task force's "White Paper" on drug abuse recommended last fall creation of a Cabinet Committee on Drug Abuse Prevention as a replacement for SAODAP, but framers of the legislation wanted a White House Office for visibility and clout. It would have an annual authorization of $2 million through FY—78.

K. Excerpt From Report of the Committee on Interior and Insular Affairs, United States Senate on S. 522, May 13, 1975

Prior to fiscal year 1971, no Federal monies were spent on Indian alcohol programs. With the President's message on the American Indians in July 1970, $10 million was allocated from several departments and agencies to support Indian health initiatives to develop needed special programs. Among these monies, $1.2 million were pledged from the National Institute of Mental Health (NIMH). None of these monies were actually transferred to the Indian Health Service. Nevertheless, in fiscal year 1971 interagency cooperation was affected and 39 alcoholism projects were funded by both the OEO and the NIMH under the leadership of the Indian Health Service.

The National Institute on Alcohol Abuse and Alcoholism and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 92–554), has declared the development and implementation of Indian alcohol programs to be one of its six priority areas. Having assumed control of the existing Indian alcoholism projects, the NIAAA is presently the sole mechanism for funding Indian alcoholism programs. The role of the Indian Health Services is limited to providing liaison with Indian communities, identifying critical needs, assisting with technical expertise, and helping review, as a permanent member of an all Indian Review Committee, all program proposals received by the NIAAA.

Today, there are 153 Indian alcoholism demonstration programs totaling $12 million and 166 mini-grants for Alaska Natives totaling $1.7 million.

Despite this effort, however, a number of problems concerning the administration of Indian alcoholism programs would strongly suggest the need to increase their size and to transfer them to the Indian Health Service. The immediate concern of both the NIAAA and the IHS and of the Indian communities is what happens to existing Indian alcoholism programs beyond their July 1975 termination date. The long-term concerns are set out below:

Under the present policy of the Department of Health, Education, and Welfare, National Institute on Alcohol Abuse, and Alcoholism, Indian programs are considered to be for demonstration purposes only. This interpretation is based on one of the enumerated purposes of NIAAA projects, which is "to conduct demonstration, service and evaluation projects" (P.L. 93–282, Section 111). During hearings held by the Senate Subcommittee on Alcoholism and Narcotics in March 1974, Administration officials explained their interpretation of this phrase. Dr. Morris E. Chafetz, Director of NIAAA, stated that "there was never an understanding by the Department that support from the funds provided through Public Law 91–616 would be an ongoing commitment in all categories of project grants support." Dr. John S. Zapp, Deputy Assistant Secretary for Legislation (Health), Department of Health, Education, and Welfare, said, "At this point the Federal Government is saying the usefulness and purpose and validity of these projects has been demonstrated, and we feel it is now you (the local community's) responsibility."

In a letter to Senator Edward M. Kennedy dated August 8, 1974, Dr. Chafetz reiterated this position, but did recognize the need for an ongoing responsibility to provide this support:

"While it is still my position that continued support of time-limited projects grants is not an ongoing commitment of this Federal agency under present legislative authority, I also recognize that there are some programs, which for a variety of reasons, will not be able to procure non-Federal support upon the expiration of their project period, and that the Federal government does have a responsibility for their continuation."

The Federal Government has a trust responsibility to provide for the health care of American Indians, and the Indian Health Service is the agency having the primary responsibility for Indian Health care. Yet, the Committee has discovered that neither the IHS nor any other federal agency is legally obligated to provide Indian alcoholism services; no existing statute makes this specific requirement. Public Law 91–616, as amended by P.L. 93–282, does not authorize funds specifically for Indians; in fact, the law does not even mention Indians. Thus, legally, Indians receive a portion of NIAAA funds because of their status as U.S. citizens, not because of their status as Indians. The decision to allocate a portion of NIAAA's funds for Indian programs and to establish an Indian desk within NIAAA to assist in the administration of these programs was purely discretionary, and therefore, neither constitutes a guarantee that alcoholism monies will be available for Indians nor indicates that the Federal Government has any responsibility to provide alcoholism programs for Indians.

Due to the failure of the Congress to place a specific responsibility on the IHS or any other Federal agency for the treatment of alcoholism among Indians, no Federal agency has undertaken a continuous program for the control and treatment of Indian alcoholism. This situation was described in the March 1974 GAO Study, Progress and Problems in Providing Health Services to Indians:

"According to IHS, alcoholism probably adversely affects more aspects of Indian life than any other health factor and has been an Indian health problem since the 17th century. IHS reports that alcoholism causes cirrhosis, disintegrates family relationships, and adversely affects the economic functioning of the whole Indian society. Most accidents, homicides, assaults, and suicide attempts are associated with drinking. IHS officials have stated that a significant part of their

medical services workload can be traced to alcohol abuse and alcoholism. However, IHS has done little to explore the nature of extent of, and solution for the alcohol problem in most Indian communities. . . .

We have found that, although IHS provided medical treatment to alcoholics, almost all the funds for projects to prevent drinking problems or rehabilitate alcoholics were provided by Office of Economic Opportunity until July 1972 and thereafter by HEW's National Institute on Alcohol Abuse and Alcoholism.

IHS headquarters and service unit officials said they had little data on the magnitude of community alcoholism and had no data on how effectively the projects were dealing with the alcohol problem. IHS officials believed these programs, for the most part, to be incomplete, fragmentary, and lacking substantial impact on the problem.

TESTIMONY—ANCHORAGE, ALASKA, APRIL 26, 1976

Summary and main points of each speaker

Daisy May Lamont, Bethel Community Health Representative: Includes 57 Villages in the Bethel Area.

In Bethel itself, 90% of population is Native. "Alcohol and drug abuse is the highest and top priority problem we have." The population at Bethel is approximately 3,000 and about 70–80% of population have alcohol problems. There are presently nine people working the alcoholism program of the city council. The main problem is no finance which is necessary for the program to expand. There is a need for more staff training and more facilities. The facilities available now are a sleep-off center and the PHS hospital. A half-way house is needed; more help is needed in the villages where there are few, if any, resources. "There is a high percentage of marijuana in young people."

Trefon Angason, President of South Naknek Village Council and Corporation.

South Naknek is approximately 70% Eskimo. "In our village, we have a potential alcohol problem of up to 90%." Alcoholism facilities are needed. South Naknek has a population of approximately 175 people in the wintertime and about 2500 people in the summertime. "We don't have year-round employment, and as a result, there is nothing to do but sit there and draw your welfare and drink." There are 29 villages in Briston Bay and South Naknek is only one of the villages. It does not have any form of services. There are some services in Bethel, the center of the region, but in many of the villages, such as South Naknek, there just isn't anything.

Cyrus Peck, Jr.,—Juneau Area Alcoholism Counselor.

In Juneau, there is a treatment facility which is white-oriented and a crisis center. The crisis center program was cut back and as a result, there is difficulty in getting the alcoholic to the treatment center; lack of transportation is the main problem.

Education of children is very important, as well as getting the community involved in problems of alcoholism. The population of Juneau is approximately 17,000. There aren't any alcoholism facilities in Juneau which are run by or geared to Natives. "There's no effort being made to understand the culture, the (Native) people."

Suimeon Arnikan, Rural Cultural Specialist, National Council and Alcoholism, Alaska Region.

Western culture is taking over and destroying the Native cultures. "Many minds of Yupik, Eskimo are now filled with new ideas, and the effects of these new ideas will both harm and benefit the central Yupik Eskimo. The effects of alcohol in the rural remote communities of Alaska need to be passed on in the form of information, education and prevention."

Fred Pete, Associated Village Council Presidents, Bethel Area.

There is only one alcoholism program in Bethel and none in the 57 villages in the area. There are 5,000 people in the area and they are spread out in an area of about 100,000 square miles, with no drug abuse program in the area.

Mary Jane Brower, President of Alaska Federation Native Youth Council and Representative of Artic Scope Regional Corporation.

Alcohol abuse is caused by lack of self-esteem and being taught white history in school. Native youth should be taught native subjects and be proud of who they are.

Gordon Jackson, Executive Vice-President of the Alaska Federation of Natives, is President of the Rural Alaska Community Program.

Mr. Jackson gave a brief introduction and history of the Alaska Federation of Natives which was organized in 1966, primarily to seek a fair and just settlement of the Alaska Native Land Claims Settlement Act.

He identified alcoholism as the number one health problem of the Alaskan Natives stating that "it takes away millions of manhours from not only the regional corporations, the construction of the Trans-Alaska pipeline, and other public works projects throughout the State of Alaska; it takes away our loved ones by death; it increases our crime substantially throughout the whole State of Alaska." The Native population of Alaska is approximately 75,000.

Charles Oxereok, Coordinator for the Alaska Native Human Services Department.

Within the health affairs of the AFN, the fundamental goals and values of the Alaska Native family have not been provided for the youth. "Drinking to an excess is the norm." "Figures from the Alaskan Department of Health and Social Services, Statistical Services and Office of System Development, Alaska area Native Health Services states that the 1960 death rate attributed to alcoholism was 4.7% per 100,000, and the rate in 1970 has risen to 41.4% per 100,000. The measurement in 1970 was 57.8 per 100,000. The related problems of alcohol abuse have been observed to overwhelm and incapacitate entire village populations on at least two occasions in the past year." "The total number of deaths involving alcohol would amount to over 50% of all deaths among the Alaska Native population and 18% among non-Natives. Alcohol can therefore be considered the leader among specific causes of deaths in Alaska." Since much of the treatment of alcoholism is conduced by alcoholism treatment centers, sleep-off centers, etc., the medical care system is not fully aware of the burden of this illness. No prevention and treatment facilities exist to deal with youth. Alcohol and drug abuse education in the schools is both sporadic and limited. Services are needed in rural areas and villages; a tracking mechanism is necessary within the village system.

Paula Rasmus, Alaska Native Special Alcoholism Project, North Pacific Rim Anchorage.

Most people in Alaska are taken from their village when they are brought in for treatment. They go to an urban setting which further complicates treating the person. Alcoholism treatment in Alaska is done in a non-Indian way; no consideration is given to the cultural identity of the person being treated.

Titus Peter, Outreach Counselor on Alcoholism for Episcopal Diocese of Alaska.

The alcoholism problem should be attacked by all agencies, institutions and people with the maximum effort possible, and everyone should be educated about it. Marijuana use is very widespread. More training of counselors and community about alcoholism is needed.

Evelyn Myers, Alaska Native Commission on Alcohol and Drug Abuse.

Alaska has an estimated 16,000 alcoholics. A decentralization of alcoholism components is needed so that people can receive treatment without leaving their home community. Training should be a number one priority and should be done regionally because of the differences between regions.

Strart Nicholi, Copper River Native Association Counselor.

Population served: 300–400 Athabascan. The people with decision-making power in alcoholism programs do not know anything about alcoholism.

Toretta Eakan, Project Director of Hope Center, Dotzebue. Member of Anacada Board.

The needs of the regions differ in the villages. Some of the villages need education and alternatives. More family counseling is needed in most places. We need to set up as a high priority the reestablishment of cultural values. Population of region: approximately 4,500, 95% Eskimo. Alcoholism is the number one social problem, economic problem, mental problem. The PHS treats some of the alcohol-related problems, but the majority of their cases really are alcohol-related and need to be addressed as such. Treatment needs to be localized.

Louise Oner, Regional Technical Assistant for the Mauneluk Association, Kotzebue.

Attitudes are important in dealing with alcoholism—the attitudes of the people who treat it and the people who do or do not drink. Getting the community together is very important. A community center is needed.

Jeanmarie Tarson, President and Executive Director of Cook Inlet Native Association.

Represents approximately 15,000 Natives of various nationalities in Anchorage. In Anchorage, there are ten alcoholism centers but none of them have any Natives on the staff or included Natives in the preplanning of programs. "There is $1,930,000 spent in Anchorage alone on alcoholism without any Native input into the program." However, the numbers of native people are always submitted as justification for the money.

Ralph Emarok, Rural Technical Assistant for the Aleut League.

More alcoholism assistance is needed on the Aleut Chain. There are approximately 1,900 Aleuts on the Chain, and there are insufficient alcoholism programs. The people on the Chain make up only 3% of the Native population so they are often overlooked.

Teresa Devlin, Alaska Federation of Natives, Human Science Department.

More pamphlets and brochures should be tailored to the village level. More emphasis should be placed on the village in controlling alcoholism. The medical profession is very limited in its knowledge of alcoholism. For the most part, they do not want to be bothered with it and provide very little help to the alcoholic.

TESTIMONY TO ALCOHOLISM AND DRUG ABUSE TASK FORCE NO. 11, PHOENIX, ARIZ., MAY 14, 1976

Summary of main points by each speaker:

Richard Curry, Director Alcoholism and Drug Program for the Ute Indian Tribe

"We need complete and total coordination of all human resources that are available". There must be some written affiliation agreement stating what each agency will perform for the other and how their coordination will take place.

There are six categories of need for an alcoholism program: (1) education and prevention, both for the general public and for youth; (2) detoxification; (3) treatment; (4) rehabilitation; (5) follow-up and support; and (6) personnel training. A detoxification center should have a medical staff person and have the client stay three to five days. Treatment and rehabilitation should be separate because rehabilitation is a later stage and clients will be doing different things than in the treatment phase. Personnel training should be done locally if possible.

Needed are facilities, personnnel, training and guidelines.

On the transfer of alcohol programs from NIAAA to IHS: (1) there should be an orderly transfer; (2) programs should have input as to how and when to transfer; (3) programs should have input to IHS organizational setup; (4) programs be separate entities under IHS under supervision of the local supervision director; (5) all employees must be knowledgable in the field of Indian alcoholism and drugs; (6) programs should have more input in the selection of key personnel; (7) programs be set in a priority; (8) money be available to programs for upgrading and expanding; (9) the present autonomy of the program will not be changed.

The Ute Tribe has 1,629 enrolled members; approximately 2,500 Indians.

Rick Harrison, Director, Alcohol Program at Southwestern Indian Polytechnique Institute, Albuquerque, N. Mex.

There should be more emphasis in education and prevention. "The use of alcohol and other drugs by students has been a major deterrent to their fulfillment of educational goals and position attainment and retention." Public awareness meetings with people in the community are a good idea—awareness is necessary. But education is more than that. "We need to have people grow up with it (knowledge about alcohol and drugs.)"

Ron Moore, Director of the Hopi Action Program in Oraibi, Ariz.

Total population on the reservation: 85 to 9,500. In 1975, there were 1,628 arrests of which 72% were directly related to alcohol. There were 144 juvenile arrests and 80% of those were alcohol related. There are also some arrests for sniffing and marijuana.

Our program focuses on five areas: (1) individual counseling; (2) group counseling; (3) youth prevention; (4) community education; (5) referral systems.

We need detoxification services, Indian Health Service provides it at times, but the agreement with them is too loose and they often don't have the time or room. We need a more formal agreement with them and with the law enforcement agencies.

There are six people in our program. Presently we are working with 82 individual clients, all of the school population with the Community Education

Program, various community groups, and the court sobriety program of incarcerated people working in groups. We have no treatment facility. Counseling is usually done in a home or a shared community building.

There needs to be more coordination of the various agencies providing alcoholism services and various funding sources. Ideally, there should be a single funding for Indian programs. Some consideration should be given to the problems of isolated communities who are far away from services.

Sylvia McCabe, LEAP Department, Phoenix, Ariz.

"We need to have an improvement of relationships with and between the governmental agencies because the support of these agencies is necessary if a recovery is to be achieved by the alcoholic." Population of Indians in Phoenix ranges between 16,000 to 20,000.

Education about alcohol is essential not only in prevention, but to the people who are giving services . . . from the Community Health Representative to the federal people who are major Indian employers.

Joe Hayes, Director Indian Alcoholism Program, Phoenix, Ariz.

"Guidelines for operating the Native American Program should be written by the Native Americans who are involved in the day to day running of a program . . . The need for cultural identity is of major importance and should be used as a helping hand for the residents."

Delbert Allison, Director, Cocopah Alcoholism Program

We need a detoxification unit. There needs to be a formal agreement with IHS or a local facility of our own.

"The attitude of the state people is not what it should be towards the Indian programs . . . They are ready to drop them if they don't comply with requirements."

Alcoholism and drug programs should be combined so that funds and other resources could be pooled.

The community needs to be educated about alcoholism services. Education is an important phase of the program.

Buck Kitcheyam, Chairman, San Carlos Apache Tribe

Approximately 7,000 in the tribe.

"Our main problem is with funding. The San Carlos Tribe has made a number of proposals and has received encouragement but very little in terms of funds."

The major problems on the reservation are alcohol-related. Many deaths are alcohol-related.

Most of the training sessions for alcohol staff should be local. Having training somewhere far away from the community is not training the people to deal with their community.

In the last few weeks, a number of our high school students have been arrested for possession of marijuana.

Thomas Burns, Alcoholism Consultant for IHS, Phoenix Office

"While Indian Health Service has historically accorded to alcoholism the distinction of being its number one health problem, it has not heretofore been given the resources and money and manpower by Congress to deal effectively with it. . . . As a practical result of this historical problem, IHS Hospital staff has dealt with alcoholism principally as a side issue in the provision of acute, medical care to those requesting such care. It has succeeded in placing the major burden for change into tribal programs which were ill prepared to cope with the delivery of required mental and social services that are part of the total alcoholism program. As a result, tribal programs have insulated themselves so that they can operate without much interagency support. With us impending transfer of funds, new avenues of communications must be opened."

". . . A standard reporting system needs to be worked out. IHS and Indian alcoholism programs must work together to determine methods for selecting data. There is much to be done in the organization development and implementation of a joint Health Service-Indian Alcoholism Program."

Recommendations include: (1) Congressional fiscal support to IHS over and above the amount to be allocated for direct alcohol program support and sufficient to implement a fuller alcoholism program; (2) commitment for funding of health education activities directly related to alcoholism and which would provide extra support to tribal activities in the same line. (3) Commitment of funding to

to the development of alternatives to problem drinking behavior in youth such as therapeutic recreation programs.

IHS should definitely get into the preventative program area.

Rachael Mike, Alcoholism Prevention and Education Program, Parker, Ariz.; Colorado River Indian Tribes

One of our problems is staff turnover. We can't afford to pay people to stay with the program.

Another program is IHS doctors who refuse to deal with alcoholism. The doctors should be told that they will have to deal with it if they are going to work with IHS and if they don't want to, they should not work for IHS. The doctors haven't had much training in alcoholism treatment and detoxification, even if they wanted to help.

TESTIMONY TO ALCOHOLISM AND DRUG ABUSE TASK FORCE NO. 11, BUFFALO, N.Y., MAY 7, 1976

Summary of Main Points by Speaker:

John Ginnish, Director of Community Service with Boston Indian Council

Out of 3,500 Indians in Boston, 400 to 800 suffer from alcoholism. Indirectly or directly, alcoholism affects nearly 80% of our people.

In 1974, 21 Native Americans died in Boston from alcohol-related causes. About 90% of our court cases are alcohol-related. In addition to alcoholism, many of these suffer related serious health problems.

At present, we have an alcoholism program that attempts to provide the alcoholic with a sense of pride in his past and an understanding of his present condition. The approach works well but the project has no facilities of its own and works out of Boston Indian Council offices. This is an inconvenient place for most clients to reach and we have transportation problems.

The State Division of Alcoholism does not consult or consider us. The response of the state has been that they already fund alcoholism agencies that we can utilize. But past experience with our clients indicates that Indian alcoholics are very reluctant to use non-Indian alcoholism agencies. Nearly 80% of our people are not members of federally-recognized tribes and are therefore denied services by BIA and IHS. The federal government and funding agencies like NIAAA should put pressure on the states to adequately provide funding for urban and non-recognized tribes.

Rancho, Executive Director, Maine Indian Alcoholism Program

The program comprises three state Indian reservations and two off-reservation Indian groups, approximately 4,000 people. Contract has been terminated because we could not pay for medical services under Title 20. We could not use the (Medicare and Medicaid) funds because it is restricted (Title XX) in facilities that receive Title 19 funds. Nearly all medical facilities receive Title 19 so that restriction should be done away with. Our biggest problem is no medical services. We find that they are badly needed and we get very little cooperation with Maine hospitals. We provide other types of service but the medical service is critical and we aren't able to provide it now.

We have found that there is a special need for family counseling. Our counselors have to do much more than work with the individual client. They have to provide service to the whole family. There is a lack of adequate suitable records on Indian individuals. Sometimes they go from one doctor or facility to another and receive medication in each so that they are getting more drugs than they should.

There is an unemployment rate of 80% among the clients we serve. We need funds to expand our employment program.

The bureaucratic and administrative reporting system of NIAAA is not really giving an accurate picture of our program. It's taking too much time away from the counselors for administration.

Mary Bighorse, Coordinator, Community House for Alcoholism and Abuse Service, New York City

For the first six years we served only as a community center. Now with grants from CETA and Office of Native American Programs, we have developed into a multi-service organization including counseling, employment service, cultural programs and social service referral.

Our service population tends to be transient for the most part . . . Chronic unemployment and cultural disintegration are some of the most serious problems.

The combination of almost 80 tribal groups from North, Central and South America with relatively small representation of each creates a problem in the delivery of services. Many Indians here are non-federally and non-state recognized so their problems go unmet. In a two-month period, our community services program found that housing, counseling alcoholism problems, health care and emergency aid were, in that order, the five primary requests for service.

Presently, we use New York hospitals for detox and low cost hotels for the recovering alcoholic. We need a separate facility for Indian men and women who are in the first months of sobriety. Just being together with our people is one of the first important phases of recovery. Residency is necessary for follow-up care.

We have a difficult time getting people into Public Health Service. Transportation is another.

Billy Shields, Community CETA Support Service Department

We have found a need for a facility in which to house people that have alcoholism problems.

One-third of our CETA participants have a problem with alcohol.

As soon as our client gets off the seven-day detox, we try to get him a job right away. It works for us.

Marilyn Anderson, Social Service Counselor for the Seneca Nation

Out of my case load of about 60 families, at least 40 are affected by alcoholism or drug abuse.

Some of the problems we have are: services are unavailable in the evening; there is not much for juveniles; lack of Indians with training; agencies don't relate to the Indians.

Indian people should be represented more in agencies that they work in.

Anna Devlin, American Indian Services in Detroit, Mich.

Estimated Native American population of Detroit: 5,000.

Through our NIAAA funding, we believe many positive steps have been taken in providing substance abuse services for Native Americans in our urban area. There is a critical need for the continuation of these services.

The migration from reservations to our urban area causes many problems which contribute to the high rate of alcoholism. State, county and city programs are geared in such a way that it makes it difficult for a Native American to enter them. A Special Native American Program is needed which can also serve as a liaison with other social services.

A.A. can work if it's geared to Indians, but we have other alternatives.

Merril Bowen, Vin Curry and Barney Waterman, Alcoholism Program with the Seneca Nation, Salamanca, N.Y.

We need a half-way house in our area. Without a place to stay, people go back to drinking and the drinking environment.

Marijuana is getting as bad as alcohol with the kids now. We need to start taking care of the young people.

Fleeta Hill, Tonawanda Seneca Indian

The members chosen for the American Indian Policy Review Commission come from the western United States . . . I don't know any of these people. they don't represent me . . . you can become a billionaire on Indian problems. That doesn't help Indians. The federal government wastes money. The agencies that the federal government sends money to for helping Indians don't do anything. We don't need those agencies.

Frank Abrams, Chief, Seneca Council

For the record, Miss Hill's statements are not with the views of the Tonawanda-Seneca Tribal Council.

HEARINGS, OKLAHOMA CITY, OKLA., MAY 13, 1976

Summary and main points regarding alcoholism:

Rosemary Wood, Executive Director, American Indian Nurse Association, and Assistant Professor at University of Oklahoma

"None of us (health professionals) had adequate training in the area of working with alcohol among American Indian people". In many places, alcoholism is

approached moralistically or legally rather than as a medical problem. Many times IHS refuses to handle alcoholism or doesn't know how to deal with it.

Alcoholism is caused by anxiety and difficulties in living which comes from having to live in a prejudicial society.

Bob Gardner

As stated on the intake forms for Indian inmates in the Oklahoma penal system, approximately 94% of the Indians going into criminal institutions state that they were drunk at the time they committed the crime they were convicted of.

Alcoholism is an enormous problem—there is a large area to cover, and many people to help. It will take a great deal of money to even bring the problem to an acceptable level.

Dudley Whitehorn, Osage Tribe

We need more drug programs slanted toward education. "In Osage country, we do have a drug problem. Drug education needs to start in kindergarten. Children should be taught self-worth and be educated about drugs. There is a lot of sniffing at the Indian schools. I have seen very little done in the field of education, even in alcohol. Most alcohol grants are written in for some alcohol education, but I found when I worked in the program, my counselors were too busy to do much educating."

Education about drugs and alcohol should be part of the school system. Young people should have some voice in the policies and structure of juvenile programs. A youth drug council and alcohol council should be set up.

If a study were done, it would probably reveal that there is a greater need to work with Indian people on drug abuse, especially young children in school.

Elaine Bennet, Drug Abuse Counsel Center and Human Ecology Programs, Lawton, Oklahoma. Paul Bennet, Human Ecology Learning Program, Lawton, Okla.

"In our experience in working with Indian people as well as the white people in our programs and through Indian schools, we seldom see strict alcohol or strict other drug use. It is generally poly drugs. If you get a student or client coming in who identifies himself as having an alcohol problem, you can just as well bet there is going to be another drug."

There needs to be programs dealing with all drugs, including alcohol.

The Indian does not come forward readily to the white treatment facility, so facilities should be available for just Indians.

Personnel and facilities should go to the community where they are needed instead of having the people come to them. Outreach is necessary.

"The medical field is a failure as far as drug and alcohol treatment is concerned."

Dr. McClellan, Assistant Director for Program Management, IHS

"Alcoholism is not one of our (IHS) primary areas for service; NIAAA funds the alcoholism program. We have not alcohol per se, we have mental health, but not alcohol.

"Our physicians are beginning to be more sensitized to health problems which are basically alcohol-related. They are recognizing alcoholism more and more."

John Davis, Area Director, Indian Health Service

Our health professionals sometimes do not accept alcoholism as the primary diagnosis for an individual because the community as a whole does not accept it. "I believe some limited steps . . . I guess I better put the emphasis on limited . . . are being made in this direction. I would think alcoholism problems and the aged are areas that Indian Health Service and Bureau of Indian Affairs for too many years have not addressed and we have neglected. We have a great area of neglect.

Ralph Wermy, Dallas Tribal Center, Tribal Concern on Alcoholism Program

There are approximately 15,000 to 18,000 Indian people located in the Dallas area. From 1973–74, the program served approximately 500 people who had alcohol-related problems.

It was very difficult to receive funds or any assistance from the state because they have assumed that the federal government was giving the Indian people the funds to work with.

Most agencies do not accept alcoholism as a disease. The Tribal leaders and people who must be reached to try and change their attitudes before getting to the "grass roots" level. The grass roots level now has accepted the disease of alcoholism.

We need more personnel and need to be able to have contact and referral with other agencies.

Research should be done by Indians because Indians already know what their problems are.

Ed Tanyan, Chief of the Seminole Nation of Oklahoma, President of Oklahoma Indian Health Advisory and member of NIHB

The problem of alcoholism hasn't been discussed too much in our area. It should be, I guess, but we haven't had anybody on that board that is very well versed in that field. We recognize it. It ranks high priority in our tribes.

Marvin Buckly, Director of Community Services for the Creek Nation of Oklahoma

A survey was taken by the Community Services Committee indicating major needs and recommendations. Excerpts about alcoholism are as follows: An intense education program (about alcoholism) is necessary for all levels and ages with a factual approach to avoid the escape vehicle of choosing sides with an excuse by the participant because a program as too judgmental in that particular case.

Extensive counselling and rehabilitative programs are needed to deal with alcohol and other drugs. Though alcohol is legal, many Indian people need to be taught to comply with the necessary legal restrictions.

Knowing that half of the alcoholics come from a family where one or both parents are alcoholics, it is absolutely essential that some of the root causative factors be attacked positively through and by use of active program people, by public service providing agencies with a unified effort to accomplish its goals.

Mary Crazybear, Director of the Inter-Tribal Alcoholism Program

Our program needs stability. Some kind of national standards and certification to give the program credibility. We lack credibility.

We need more community education now and most programs are crisis-oriented. The need is so great and the programs are usually so understaffed and funded that they don't get time to be involved in more educational activities.

Our programs serve about 600 alcoholics a year There are approximately 9,000 Indians in our five-county area that have alcoholism problems. We are just scratching the surface. We don't have the resources to support Indian community activity.

The needs of women alcoholics are barely being recognized let alone being met. In the whole state of Oklahoma for all programs Indian and non-Indian, there are only four programs that accept women. Women are reluctant to seek treatment for a number of reasons: one of the most threatening is the fear of their children being removed and put in foster homes.

Alcoholism needs to be recognized as the health problem it is. I think there would be many problems in combining alcoholism and drug treatment programs. Alcoholics are reluctant generally to come into programs with drug addicts . . . there is an age difference between alcoholics and drug addicts. The drug users tend to be younger. The difference in age would make it difficult. There should be a treatment program set up especially for the young people.

TESTIMONY BEFORE TASK FORCE NO. 11, SAN DIEGO, CALIF., MAY 20, 1976

Summary of main points by speaker:

M. Baba Hoof, Director, United American Indian Involvement Crisis Walking Center, Los Angeles, Calif.

My main concern is the fact that we have to rely on other agencies to provide services to our clients. These agencies are not sensitive or receptive to the American Indian or his or her problems. UAII is not a rehabilitative program. We are crisis intervention and referral. That's why I stress we have to rely on other programs. . . . (Other programs) are not dealing with the cultural problems of Indians. They are inflexible in their treatment approaches and cannot meet the needs of the Indian people. Indian programs should receive direct federal funding because it allows them to be more flexible than city, county or state funding would.

We try to change a person's drinking patterns which is a very difficult thing to do. Those people down there are hard drinkers. To them, it's not a game and it's not a form of entertainment. It is a way of life and it's an acceptable way of life. Just like you have to breathe to live, you have to drink to live down there. We stress Indian pride in the Indian culture: This is not the Indian way. And we reinforced that over and over and over again until it does start working. It is the peer pressure of the counselors matching the peer pressure of the Indians on the street. We're stronger and we last longer because we are sober and because we

are setting examples. Because we can relate culturally to these people. Because we can relate on a street level with these people.

Needs which have received little attention are: (1) a home for Indian children whose parents have alcohol problems; (2) women alcoholics, especially pregnant women whose alcoholism may cause damage to the child.

George Baker, Coordinator, Native American Indian Project, Multi-Cultural Drug Abuse Prevention Resource Center

My recommendations are very strong that the Indian people determine the state of the Indian people themselves. What program modalities that they work in. What area they work with fits that specific Indian need.

As part of prevention, the education system particularly the boarding school situation, needs to be revised to teach Indian culture.

We are finding more and more that there are numbers of drug problems that are existing, primarily the inhaling problem with our Indian youth.

We're finding much more of what we call a poly drug use in the Indian culture on the Indian society.

Rachel Nabaha, Program Director, Intertribal Council of California, Inc.

There is a need for comprehensive alcoholism services among California's rural Indian population.

The countries are not responsive to the needs of Indians, particularly the rural counties.

The federal government should continue funding Indian alcoholism programs. Each county with an identified Indian alcoholism program should be required by mandate to develop comprehensive, long-range alcoholism plans in cooperation with Indian programs. All costs for the comprehensive alcoholism plan be included as line items in the annual county health budget and that distribution of these monies for costs be through block grants directly from the state to the Indian people. The formula for allocation of these monies be based on need and not total population.

Documentation proves that the Indian people suffer disproportionately high incidents of alcoholism compared to the non-Indian population.

Additional money should be appropriated to provide more aggressive education and prevention programs, specifically, programs geared to meet the needs of our youth.

Danny Vega, Leroy Hoof, UAII

Drug use is increasing in the Indian community. There's no feasible program within the immediate L.A. area that meets the needs of Indians that have a dual or poly chemical abuse problem. They're too short-term. There are not enough people involved that are willing to help them. There needs to be education to make Indian people aware of the problem and to accept it.

In institutions in the State of California the Indian is classified as "other." He has no direct percentage set aside for him to develop programs.

I recommend that Indian religious spiritual leaders be assigned to the clerical staff of our large institutions throughout the United States and make it mandatory for the betterment of our Indian people, for their spiritual youth enlightenment. Also that alcoholism be treated on a medical and social level rather than on a criminal level.

In central L.A. 1975 statistics show that 4,533 Indians were arrested in the central skid row area alone. There is a great need for direct services, detoxification and half-way houses, not just referral and crisis intervention.

Dave Hostler, Hoopa Valley Tribe

There is a lack of awareness of the reservation population in California.

More Indians need to be represented on national level boards.

The agencies we have attempted to use, welfare and state rehabilitation, have been unresponsive to us.

Leo J. Camp, Director, Alcoholism Awareness Program, Youth Awareness Program and Turquoise Lodge, Sacramento Indian Center, Inc.

More emphasis should be placed on research alcohol treatment prevention, education, health needs and spiritual needs because in our area, we have no spiritual leader.

We need more money to run our programs and less red tape and bureaucracy to deal with.

In a survey of school kids, out of 270 responses, alcohol was rated as the number one drug; marijuana was second; and then poly drug use. There is a definite need for more youth programs.

There is also a need for programs to prisoners.

Our response and support from other agencies has been limited. The Indian community in Sacramento is not very responsive to alcoholism problems.

George G. Effman, Project Coordinator, Indian Alcoholism Commission of California

I feel that the attitude of the whole Commission (AIPRC) towards alcoholism has been very, very weak.

The need for Indian oriented alcoholism services goes far beyond the recognition that alcoholism is a major health problem among the Indian people, but California, with one of the largest alcoholism budgets of the nation, gives less than token financial assistance to programs serving this population.

There is a great deal of red tape in dealing with the state. I recommend to continue direct federal funding. Counties are simply not giving any of their local funds to Indian service programs.

Recommendations: (1) increased appropriations to fill the need; (2) continuation of direct funding for Indian programs; (3) that Indian programs be exempt from public law 93–641.

Herb Coheen, Program Director, American Indian Development Lodge, El Cajon, Calif.

I feel that one of our greatest needs at this point in time is to educate people in the alcoholic recovery field so that they can go out and help other Indian programs.

This is both in counseling, administration, house management, at nine and a half dozen areas.

Secondly, we need vocational rehabilitation programs. The state of California has the resources.

Indian health services here in California are woefully inadequate and this is certainly an area where we need support and improvement.

Cecilia I. Firethunder, Psych., Nurse, Youth Recreation

Alcoholism programs are dealing with a problem after the fact. What is needed is sports and recreation for Indian youth. There are absolutely no monies allocated for sports and recreation for Indians. There's no money for sports events because the money's going to alcoholism and other programs.

Daniel M. Forest, Jr., Director Sundance Lodge

We need a comprehensive program—an overall program, working with families.

Indians should be able to use all the resources of all the governments: state, federal, county and city.

Direct funding should be continued.

Earl Livermore, Director, Native American Alcoholism and Drug Abuse Program, Oakland, Calif.

There needs to be an increased effort to see that the legal system deals with alcoholism as a health problem. In order to treat alcoholism as a health problem, we need additional health care services. Specifically, we need a residential center to temporarily serve children of the alcoholic families.

A specific section on alcoholism should be part of the health professional's training. We need funding for community education and prevention. The staff of Indian centers should be trained to assist in the treatment of the problem.

In order to receive a fair share of funds, we need to try to stress more affirmative action in getting Indian people hired on city, county and state governments.

Alcoholism programs should be exempt from Public Law 93–641.

The Veterans Administration should provide services which many Indians are eligible for, but many of our people are not made aware of these services and consequently, they are not being utilized.

Many Indian people do not utilize the services of existing health service agencies. Indian people do not relate and are socially isolated much of the time.

As far as research is concerned, there should be Indian involvement and control on any research projects.

Willard C. Rove, Counselor, Friendship House for the American Indian, San Francisco

We work through the Christian Reform Church. The Church owns all these buildings and NIAAA funds the staff. The problem with working with the Church is that it wants to make christians out of everyone forcibly. This is against the Indian way. You can't force a man to be what he doesn't want to be.

SECTION IV

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I. Articles from Periodicals, Annuals, and Newspapers
II. Books
III. Letters and Memorandums (Unpublished)
IV. Pamphlets
V. Congressional Acts, Bills, and Supplementary Reports
VI. Special Reports
VII. State Alcohol and Drug Abuse Plans
VIII. AIPRC, Task Force No. 11 Informal Hearings Transcripts and Site Visit Testimony
IX. Letters Received From Individuals, Programs, and Tribal Representatives in Response to Questionnaire

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[1] Individuals have submitted written testimony (besides transcript testimony) which is included in the Task Forces files and will be footnoted to the source if specific information is used.

SECTION V

ADDENDUM

A. Decriminalization of Alcohol Related Offenses

SCOPE

Pursuant to the directives of Task Force II, the scope of this report covers:
1. Implication of the Uniform Alcoholism and Intoxication Treatment Act.
2. Alcoholism or Intoxication as a Criminal Defense.

I.

Implication Of The Uniform Alcoholism and Intoxication Treatment Act

In 1971, the National Conference of Commissioners on Uniform State Laws approved the Uniform Alcoholism and Intoxication Treatment Act and recommended its adoption by every State of the Union.

In 1974, Congress enacted special grants for implementation of the Uniform Act (42 USCA 4574).

In brief, the Uniform Act provides that neither the State, nor any County, Municipality or other political subdivision may adopt or enforce any law which includes drinking, being a common drunkard, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction. The Act does not apply, or in any way affect, those laws against drunken driving, driving under the influence of alcohol, or similar offenses involving the operations of a vehicle or equipment, nor does it apply to any prohibitions against illegal sale, purchase, dispensing, possession or use of alcoholic beverage at stated times and places or by particular class of persons.

In essence, the Act makes public drunkenness and closely related offenses no longer a crime. The Act further provides for the use of both public and private treatment facilities to treat the alcoholic or habitually intoxicated person as the sufferer of a disease, and not as a criminal.

As of 1975, the latest year for which full statistics were available, 24 States had enacted the Uniform Act or similar legislation. In addition, 6 States had adopted comprehensive legislation which did not specifically decriminalize the above described alcohol related offenses. Four States have either defeated the proposal in the Legislature or by Gubernatorial veto. Eight States had the Act under consideration. The balance of the States have not yet considered the Act. (The term "State" includes the District of Columbia, The Virgin Islands, Puerto Rico, Guam, American Samoa, and the Trust Territory of the Pacific Islands, in addition to the 50 States.)

For the purpose of this report, it should be kept in mind that the Indian population of The United States of America represents approximately ½ of 1 per cent of the total population. The State of Oklahoma has the largest Indian population of any State in the Union, based on the 1970 census figures. The Indian population of Oklahoma is approximately 3 per cent of the total population. While the figures reported herein may vary, percentage wise, among the States with a large Indian population, the State of Oklahoma has been selected as an example because it is a State of high Indian population, and because complete records in regard to alcohol related crimes are available, both by population breakdown and by race. For further consideration, samplings have been made from individual communities within Oklahoma to compare local conditions with the State norm.

In reviewing all arrests by age in the State of Oklahoma for the first 6 months of 1975, it was noted that some 12,446 juvenile arrests were made and some 65,172 adult arrests were made. Arrests for drunkenness represented 6 per cent of the total juvenile arrests, but 41 per cent of the total adult arrests in Oklahoma.

Further, the total number of arrests for drunkenness in Oklahoma was 27,471, of which approximately 32 per cent were Indian.

The largest single criminal item was drunkenness, and the Indian population was 10 times as likely to be arrested for that offense as were non-Indians.

Statistics further show for the first 6 months of 1975 that in Oklahoma some 12,674 Indian arrests were made, of which 70 per cent, or 8,892 arrests, were for public drunkenness.

It is, therefore, abundantly clear that decriminalization of petty alcohol crimes would substantially reduce the total arrests and criminal input of society at large, and would have a much greater impact on the Indian population.

Random samplings from individual communities and counties reveal the same general picture. In a given county with a total Indian population of approximately 10 per cent of the overall population, 34 per cent of all arrests made were of Indian people, and ⅔ of those Indian arrests were for public drunkenness. Likewise, of the total arrests for public drunkenness, although the Indian population represented 10 percent of the total, the Indian population contributed 41 per cent of the total arrests for public drunkenness.

The greatest deterent to enactment of the Uniform Act, and the greatest failure of the system once enacted, is the lack of necessary funding for qualified private and public alcohol treatment centers.

Unfortunately, the Act has not been in existence with proper funding in any given State for a long enough period of time to see long range results.

However, the impact on the Court system can be seen by the fact that arrests for public drunkenness represent approximately ⅓ of all arrests in Oklahoma for the first half of 1975. Removal of these cases from the Court Docket would have an immediate salutory effect toward the eliminating of the backlog and overflow of criminal cases at all levels.

The effect on our Indian population would be even more dramatic, reducing Indian arrests by up to ⅔.

This would remove a substantial portion of the Indian population from the jurisdiction of the criminal courts, eliminating the lengthy petty crimnal records now compiled by many of our people, and freeing them from the degrading effect of criminalization.

II.

Alcoholism or Intoxication as a Criminal Defense

The Uniform Alcoholism and Intoxication Treatment Act is intended solely to preclude the handling of drunkenness under a variety of petty criminal offense statutes, such as loitering, vagrancy, disturbing the peace, public drunkenness and so forth. It does not decriminalize offenses such as drunk driving, nor does it make alcoholism or intoxication a defense to non-alcohol related crimes.

The parallel is drawn to mental illness, that is insanity, as a defense to crime.

The general test of responsibility for crime, commonly known as the M'Naghten Rule, may be stated to be the capacity to understand the nature and consequences of the act charged and the ability to distinguish between right and wrong as to such act. (22 CJS Criminal Law, Section 59.).

The Rule has been somewhat liberalized within the last 20 years by the adoption of the so-called Durham Rule, which provides that the accused is not criminally responsible if his unlawful act was the product of mental disease or defect. (22 CJS Criminal Law, Section 58.)

Virtually every State Supreme Court has held that, generally speaking, voluntary intoxication affords no defense to a charge of crime committed while under its influence, and the Courts further hold that such a person is fully responsible, whatever may be the degree of his intoxication, or the condition of his mind. (22 CJS Criminal Law, Section 66.)

The only exception to this rule is where specific intent to commit a crime is necessary. The general rule is that "to afford a valid defense intoxication must exist to an extent rendering the accused incapable of forming the essential specific intent, or entertaining malice, and depriving him of his reason to an extent precluding his knowing right from wrong."

Generally, intoxication may afford a valid defense to a criminal charge only if it causes a mental imbalance as described above to the extent that intoxication is so extreme as entirely to suspend the power of reason, or where the intoxication was involuntary, by one being compelled to drink against his will, or through another's fraud or strategem, or by other such means. (22 CJS Criminal Law, Section 68–69.)

For this reason, it is apparent under the general rule of law, and the myriad decisions cited in CJS and elsewhere, that intoxication or alcoholism would neither of them be a normal defense to a criminal action. Further, the Uniform Act does not extend the limits of criminal defense; it simply takes certain petty alcohol-related offenses out of the category of "crime".

Conclusion

From a review of the law and statistics available on alcohol related crime, we can conclude that decriminalization of offenses such as public drunkenness will

greatly reduce the overall case load of the criminal courts, and would provide for treatment and rehabilitation of individuals suffering from the disease of alcoholism, saving them from the demeaning process of criminal arrests and prosecution.

However, decriminalization is meaningless unless funds are provided to establish and operate community treatment facilities. Further, since alcoholism is a disease to which our Indian people have especially succumbed, it is doubly important that Indian alcohol treatment centers be established in Indian country for the treatment of our people.

A word of caution must be raised: Decriminalization does not excuse an intoxicated person from the natural consequences of what would otherwise be a criminal act. The law in the United States does not recognize the defense of "not guilty by reason of intoxication." It does not appear that the law is likely to change in the near future in that regard.

Given the present state of the law and the attempts to finance State adoption of the Uniform Act, we would recommend additional Federal funding of alcohol treatment centers in those States which adopt the Uniform Act, coupled with an educational program to alert the States to the inherent benefits, not only to the Indian community, but to the population at large, in adopting such a decriminalization statute.

B. Special Report

Report to George Hawkins, American Indian Policy Review Commission, concerning the removal of Indian children from their natural homes by the court and their subsequent placement in non-Indian foster homes or adopted homes.

Item No. 1—Removal of children by court action—as in most states, Oklahoma requires a petition to the court before any action can be taken. This petition can be filed by anyone, but, in the majority of cases, it initiates from (1) the local police, (2) the local district attorney, or (3) the local welfare department (in cases of abuse or neglect). After a petition is filed, the hearing is set and the child in question is either sent home or put into temporary detention (jail), put in an emergency foster home or placed in a children's shelter. The type of placement usually depends on whether it is the child or society that needs the protection. There are no emergency Indian foster homes in the state. However, there are two Indian-operated emergency children's shelter, one in Clinton and, one in Ponca City, Oklahoma. Both of these facilities have input from state agencies. After the adjudication hearing is held, the child is declared either (1) dependent or neglected, (2) in need of supervision, or (3) delinquent. At this point, the judge can either send the child home with his parents or give custody to someone else usually, the Department of Public Welfare. The Department of Public Welfare then decides what to do with the child through the division of court related Community services. This division of the welfare department has an intake worker attached directly to the court in every county in the State of Oklahoma.

In order to gain the necessary statistics for this study, I personally discussed with these intake workers the kind of case load they handle and the dispositions that were made on the cases. In those counties with large Indian population, an average of 60 percent of the total work load for the court is dealing with Indian youths. Of these children, roughly 67 percent are before the court as the direct result of alcoholism with one or both of their parents. When I asked the court workers why such a high percent of their work load involved Indian children, they seem to think the main problem was the high visibility of the Indian children to people in authority in the community such as policemen, truant officers and welfare case workers. The reasons given for this high visibility was the fact that there is approximately an 85 percent dropout rate for Indian children through grades 1 to 12. This, consequently, puts a great number of Indian children on the streets with no jobs and nothing to do. In order to verify this, I called the superintendents of schools in several different districts having a high percent of Indian children and asked their opinion about why there are so many Indian students that drop out of school and to confirm the actual drop-out rate. All of the superintendents I talked with seem to think the 85 percent rate was correct, and they also all agreed that alcoholism in the family was one of the primary reasons for this high dropout rate.

So, now, we've followed the child from being picked up through the adjudicatorial hearing and placement of the child with a caring agency like the Welfare Department. At this point, the intake worker will call the placement unit of the Welfare Department. This unit will then discuss the particular problems the child has and what kind of setting he would do best in. By setting, I mean foster home, own home, or institutional care.

The majority of delinquent children are sent to institutional settings with the remainder placed in foster homes or back in their own homes under the supervision of a juvenile probation officer. The children, who are found in need of supervision, are sent many times to State Diagnostic and Evaluation Center for children and then placed in a foster home or back in their own home or in an institutional setting slightly different from a training school. Children who are found dependent or neglected are most always placed in a foster home, particularly if they are below 12 years of age. This foster home is usually in the vicinity of their original home, and efforts are made to work with the original family and have the child placed in their own home. If the child's family does not make an effort to visit with their child and improve their home, the child is given to the Welfare department by the court with the authority to place for adoption. At that time the child is moved to a different part of the state and prepared for placement in a permanent adoption home. In an effort to determine why Indian children are placed in non-Indian homes and more often in institutions and other children, I met with the Director of Services for the State of Oklahoma and the person in charge of foster homes. Both of these people assured me that the placement of children was solely determined by their physical and emotional needs.

The idea of the cultural or ethnic needs of a child were not considered to be part of the psychological needs and had never really been considered prior to our discussion. When I asked how many Indian foster homes were available in the State of Oklahoma, the person in charge of foster homes was unable to give me a direct answer; however, she did agree that they were extremely rare and usually over-burdened. When I asked why there was such lack of Indian foster homes, she said they had no applications to be foster parents from Indian people, and they had never had a recruiting drive or any kind of public information program directed to Indian people in order to open up a foster home system for Indian children. Upon reading the standards for foster home care issued 1–1–76 for the State of Oklahoma it was very evident that any family regardless of their race who was poor and had a large family, as most Indian families, would have an extremely difficult time meeting the standards for foster parents.

The first statement on the personal qualities expected of a foster parent are that his values and ethnical standards are conducive to the well-being of children. My past discussion with the district attorneys and particularly the Associate District Court Judges in the State of Oklahoma found a great deal of prejudice against American Indians. In fact, one Associate Judge in a very highly populated Indian county told me very pointedly that he knew no Indian home that he would be willing to allow a child to grow up in. The judge went on to say that Indians lacked any value system that was compatible with general society. I think this is pretty well widely accepted point of view, particularly in rural counties of Oklahoma where most Indian people live. As I went on reading the standards for foster homes, the number of children in the family had to be limited to five which included the foster parents' own children in addition to the foster children which would rule out many or most Indian homes. The family had to be composed also of two parents and the mother had to be home all the time. Many times, the most acceptable Indian foster home would be a grandparent's home and many times this would be just the grandmother. Even though this wouldn't meet the family composition standards, it would probably be for the emotional adjustment of the Indian child far better than going to a white foster home that had both mother and father. Also, the age of the foster parents had to be somewhere in the middle range about 30 to 35 years old and they had to be in excellent health.

The two extremely difficult standards for Indian parents to meet to be foster home parents were the physical facility standards which require a separate bed for unrelated children and sleeping rooms that are not shared by children of opposite sex regardless of their age. Also, there has to be sufficient sleeping space in the family so that no adult is in a sleeping room with any child. Additionally, the foster home has to be located where there are church and recreational facilities that are easily accessible. Many Indian families live in the country without the easily accessible recreational facilities or the room to have separate sleeping facilities. Religion was another item in the standards that would cause some difficulty for many Indian people because of their involvement in Indian religious ceremonies and the Native American Church. Both are not well accepted or understood by white welfare department case workers who are doing the foster home studies.

In summary, the two basic findings of this study have been (1) the majority of Indian children are placed in settings outside of their own home because of alcoholism in one or both of the parents; and (2) they are placed in non-Indian foster homes because Indian foster homes don't exist.

JULY 21, 1976.

GEORGE: While getting the statistical material for the Fetal Alcohol Syndrome paper, I hit a problem which shows the severity of the alcoholism here.

In order to keep my bias out of the sampling the total number of child-bearing age alcoholic women in our area (identified within the last three years) were taken off the computer by chart number only. These were then listed in a column and every fourth number picked for chart review. The first ten charts pulled showed seven had died already. The next ten pulled had three dead. It was actually difficult to find a alcoholic woman with children so the study could be done. Most of those who were still alive had had their children taken away by the court.

BERNARD ALBAUGH.

U.S. SENATE,
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
Washington, D.C., December 15, 1975.

Mr. GEORGE HAWKINS,
Executive Director, United Indian Recovery Assoc., Inc.,
Edmond, Okla.

DEAR MR. HAWKINS: Please accept my apology for the long delay in responding to your inquiry about the alcoholism program at Chilocco Indian Boarding School.

The enclosed correspondence from Mr. John A. Deering, Acting Director of NIAAA, will furnish you the information your organization needs to get the program at Chilocco operative again.

If you feel I can be of further assistance to you in this or any other matter please do not hesitate to contact me.

Sincerely,

DEWEY F. BARTLETT,
U.S. Senate.

Enclosure.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION,
Rockville, Md., November 18, 1975.

Hon. DEWEY F. BARTLETT,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BARTLETT: Thank you for your letter of October 31 on behalf of Mr. George Hawkins of Edmond, Oklahoma, requesting information concerning the possible transfer of grantee for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Indian alcoholism program in Chilocco, Oklahoma.

According to our records, the necessary papers and instructions for a grantee transfer were sent to Mr. Jimmy R. Baker, Superintendent of the Chilocco Indian School, in June 1975 and as of this date, have not been returned.

On November 10, Mr. Michael Moody, NIAAA, sent another letter to Mr. Baker, along with a duplicate set of forms and papers required before any consideration can be given this request. A copy of this letter and other correspondence are enclosed for your information. Upon receipt of the required documentation, the Institute will proceed with the evaluation of the transfer request.

I hope that this information is of help to you. If I may be of further assistance, please let me know.

Sincerely yours,

JOHN A. DEERING,
Acting Director.

Enclosures.

NOVEMBER 10, 1975.

Mr. JIMMY R. BAKER,
Superintendent, Chilocco Indian School, Bureau of Indian Affairs, U.S. Department of Interior, Chilocco, Okla.

DEAR MR. BAKER: We have received a letter dated October 31, 1975 (Attachment A) from Mr. James C. Bearskin, Chairman, Chilocco Alumni Association requesting that NIAAA Indian Alcoholism Program grant number R18 AA 00782 be transferred to Chilocco Alumni Association for the remainder of the approval project period.

Attached for your reference are copies of the May 22, 1975 letter to Mr. Red Bird (Attachment B) from Mr. Emmett Primeaux, Chairman, Chilocco Advisory School Board, and the letters to me dated May 22, 1975 (Attachment C) and June 11, 1975 (Attachment D) under your signature. In a letter dated June 18, 1975 (Attachment E) I forwarded to you the necessary papers (duplicates herein provided in Attachments F through L) which must be completed and returned to this office before the transfer of the alcoholism program to the Chilocco Alumni Association can be considered. To date, none of the necessary papers have been returned to us. Please note that we must be in receipt of all required documentation before we can proceed with the analysis of the transfer request.

Once received, the paperwork will be reviewed and you will be informed of the Institute's decision regarding the transfer. The appropriateness of a possible site visit to look at the Chilocco Alumni Association as a potential transfer grantee will be determined only after all required paperwork has been received.

If you have questions, please feel free to contact me.

Sincerely yours,

MICHAEL J. MOODY,
Grants Management Specialist,
Grants Management Branch.

Attachments.

CHILOCCO ALUMNI ASSOCIATION,
Chilocco, Okla., October 31, 1975.

Re Grant No. 1 R18 AA00782–01.

MICHAEL J. MOODY,
Grants Management Specialist, National Institute on Alcohol Abuse and Alcoholism,
Department of Health, Education, and Welfare, Rockville, Md.

DEAR MR. MOODY: The Chilocco Alumni Association is still very much interested in being considered for the remaining project period of Grant # 1 R18 AA00782–01, at the Chilocco Indian School. We would appreciate any additional information, as soon as possible, as to the correct procedure to go through in order to apply for this grant. Please contact us at this address:

Sincerely yours,

JAMES C. BEARSKIN,
Chairman, Chilocco Alumni Association.

CHILOCCO INDIAN SCHOOL,
Chilocco, Okla., May 22, 1975.

Mr. HAROLD REDBIRD,
Chief, Indian Desk,
National Institute of Alcohol and Alcohol Abuse,
Rockville, Md.

DEAR MR. REDBIRD: This is to inform you that the Chilocco Advisory School Board voted unanimously on May 20, 1975, to withdraw as grantee of Grant No. R18 AA00782–01, Chilocco Alcohol Education Program. The withdrawal is effective September 30, 1975, or sooner, if another grantee is found.

As the policy, curriculum, and program advisory board for the Chilocco Indian School, the board further decided the Superintendent of Chilocco may use his discretion to decide if the continued existence of the program at Chilocco is needed or not.

We appreciate the working relationship with staff of the granting institution but feel our time best be spent directly with the continued progress needs Chilocco Indian School.

Sincerely,

EMMETT PRIMEAUX,
Chairman, Chilocco Advisory School Board.

CHILOCCO INDIAN SCHOOL,
Chilocco, Okla., May 22, 1975.

Mr. BOB MOORE,
Arvada, Colo.

DEAR MR. MOORE: Reference is made to the withdrawal, as grantee of funds for the Chilocco Alcohol Education Program (CAEP) by the Chilocco Advisory School Board. Following the effective date of withdrawal of the Board, May 20, 1975, and my telephone conversation with you on May 21, 1975, you, suggested a report.

My analysis of events is purely from an administrator's viewpoint with some alternatives which might develop the program into a viable asset to the School. General consensus of regular staff to the program is one of concern. Records indicate that over the years many of our dormitory staff have had various training in alcohol and alcohol abuse which exceed the training had by previous and present CAEP counselors and aides. When much of the alcohol abusers began utilizing the center, records will indicate an overall increase in the frequency of the abuse, staff analysis seem to point out there was air atmosphere of shielding. Personally, however, I can point specifically to three students who did not indulge in alcohol or misbehave as before. Most of this is attributed to the boxing program. This credit must be given to the CAEP staff.

The relationship between regular staff and CAEP counselors began as a very good relationship. However, it began to deteriorate as communication between CAEP counselors and the Director became strained. Students felt the mounting pressures, as they questioned on two occasions why I let this continue. I indicated, to them, my patience with confidence it pass by. However, the eventual result was a counselor "falling off the wagon" while taking students to Nevada, the resignation of another counselor and a counselor aide. At present, the staff is composed of the Director, Secretary and one Counselor Aide.

The communication problems have been two fold. The female counselor and one aide accused the Director of autocracy with lack of managerial techniques, admonishing them where students hear him. The reverse, is the staff admonished, used students to assist them in presenting their grieve. Unfortunately, I am not able to determine which is correct. I could only present these to the school board. The result was the resignation of the two, whom various students request I intervene, and to see to it the two not resign. This resulted in an immediate situation solved with no assurance it would not happen again.

The present counselor aide was hired when an aide resigned prior to these developments. Thus two counselors and two aides have resigned or fired since October 1974. This hinders program continuity.

I have felt, and the board felt the Director traveled too frequently. I have mentioned this. The various committees and offices he holds are no doubt important positions, but without a solid subordinate staff, the Director's frequent absence hinders getting the program on solid footing.

The second communication problem is that of fund expenditure. Travel (local) disapproval created misunderstanding on what was bona fide or not. It was thus easier to remove the financial management accountability from the school's finance system than to question travel each time a voucher was submitted. The result was the Superintendent acted only as an authorization for the School Bank Teller to issue a check rather than approving the expenditure, as the School Board required. This is the present system. I thus do not approve or disapprove expenditure, and do not monitor to insure policy compliance.

The eventual result of the communication and managerial problems was the School Board's withdrawal, as they felt they spent too much time on personnel problems of the program, and neglected some important areas of the school.

The CAEP could be a viable asset to the school. As Superintendent of Chilocco Indian School, I support such a program, but cannot endorse the present program in its present form. An alternative is to revamp the program with a trained coordinator (Director) to do investigative work as the title implies.

The Chilocco Alumni Association, as an incorporated non-profit organization, are willing to explore the possibilities of taking this program over. They have a charter, by-laws, elected officers, and a Board of Directors. A significant member of this Board is an attorney, a Chilocco graduate. This is the first alternative I recommend.

The second alternative is to provide the funds to another installation who may have missed out on previous funding request with all equipment purchased turned over to them.

The Bank has a record of the inventory as purchased and the purchase price. I will consider an audit very soon in order to clear the Advisory School Board.

In conclusion, as stated previously, I support Alcoholism Education Programs and commend HEW, NIMH, NIAAA and its Indian desk for its sensitiveness to these problems. I feel, as Native Americans, can do as well or better in operating our own programs. However, when we hit a stumbling block or make a mistake, we should re-group or revamp or admit our mistake and try again.

This program could be very valuable to the school. In a boarding school setting, however, it must mesh in with all programs and not be a separate entity, but yet easily in a visible setting that it is not an unidentifiable part of the school.

Although I am not an alumnus of Chilocco, I will not serve in any capacity except that of school administrator. As usual, I will make my services available if requested.

This observation is brief in nature, and from an administrator's views. Hopefully it may be helpful in re-directing this program, which you can eventually point to and say it was successful.

Sincerely yours,

JIMMY R. BAKER,
Superintendent.

U.S. DEPARTMENT OF THE INTERIOR,
BUREAU OF INDIAN AFFAIRS,
CHILOCCO INDIAN SCHOOL,
Chilocco, Okla., June 11, 1975.

Mr. MOODY,
Park Lawn Bldg.,
Rockville, Md.

DEAR MR. MOODY: Reference is made to your telephone call and our conversation on June 11, 1975, regarding the Chilocco Alcohol Education Program, Grant No. R18 AA00782–01. As the attached letter states, the Chilocco Advisory School Board stated withdrawal as of September 30, 1975, or sooner, if another grantee was established.

Mr. Bob Moore of Arvada, Colorado, dispatched Mr. Don Moore, to Chilocco on Tuesday, May 27, 1975, to look into the situation. During this day, the Chilocco Alumni Association made verbal request to be considered as the new grantee effective October 1, 1975, or sooner. Apparently calls were made to Mr. Bob Moore and/or Bill Grant, Project Director. They (Don and Bob) informed me that since the Chilocco School Board had resigned as grantee, they and the Project Director were taking control of the funds immediately. Don Moore also advised the Board of Directors and Officers of the Chilocco Alumni Association, a chartered, non-profit organization, they were not eligible to serve as a grantee. Even though these seemed improper, I took Mr. Bob Moore's position as that of the granting institutions authority and complied with his instructions through his brother, Don, and via telephone directly with Bob. As a result, Don, through instructions from Bob Moore, receipted for an unendorsed check plus the balance of unexpended funds deposited in the Chilocco School Bank. This (the check and balance on deposit) amounted to approximately $14,000. I did not endorse the check, nor did I make any other endorsement agreement, other than to comply with instructions from Bob Moore and Don Moore, representatives of the Indian Desk, National Institute on Alcohol and Alcohol Abuse.

As you will note in my letter to Mr. Bob Moore, I relate to CAEP staff problems. I also suggested some possible alternatives. None of these alternatives were considered. The funds were removed from Chilocco, creating an image that the funds were for the benefit of the present principal investigator, rather than the students of Chilocco.

As the Executive Officer for the school board and the fact the instructions given me by what I thought authority of the granting institution seemed improper, I requested the project director in the presence of Don Moore to vacate the facilities assigned to them within 30 days. I did this as they were taking control of the funds, and I had been instructed to release all funds, knowing this instruction was not going to benefit the target population.

During the course of discussion it was mentioned a board could be appointed or selected by the Project Director. I could not see another board selected by the Project Director to undermine the legal school board. Nor would I have any legal authority with the selected board. I did not endorse this approach.

I am very concerned about the funds, as it is now under the present director's sole control as an individual, as you mention the school board is still responsible until September 30, 1975. My recommendation still remains in that the Chilocco Alumni Association be considered as a grantee. They are incorporated as a non-profit organization with direct interest in the target population. Whatever instructions you have for me will be adhered to and await your reply.

Sincerely yours,

JIMMY R. BAKER,
Superintendent.

Attachments.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
June 18, 1975.

Mr. JIMMY R. BAKER,
Superintendent, Bureau of Indian Affairs, U.S. Department of the Interior, Chilocco Indian School, Chilocco, Okla.

DEAR MR. BAKER: Pursuant to our recent telephone conversation and your letter to me dated June 11, 1975, NIAAA has today sent a memorandum to the Office of Financial Management, NIH, ordering that no further funds be released to the Chilocco Indian School Advisory Board without prior written approval from this Office, and that, if possible, a stop payment order be placed on the $14,000 check to which you referred in your letter.

Also, please be advised that neither Mr. Bob Moore nor Mr. Don Moore have any authority to act on behalf of the NIAAA Grants Management Branch, but rather to serve merely in an advisory capacity to NIAAA program staff. If you have uncertainties regarding the advisability of following their instruction on grant related matters, please feel free to contact me.

Enclosed are the necessary papers which must be completed and returned to me before the transfer of the alcoholism program to the Chilocco Indian School Alumni Association can be accomplished.

Sincerely yours,

MICHAEL J. MOODY,
Grants Management Specialist,
Grants Management Branch.

Enclosure.

It is necessary for us to have the following information before your request for change of grantee institution can be processed further:

To be submitted by the current legal grantee:

Final Invention Statement, OS–489, for the period during which the grant has resided with the current legal grantee (Attachment G).

Final Report of Expenditures, REW–489, for the period during which the grant has resided with the current legal grantee (Attachment H).

Official Statement Relinquishing Interests and Rights in a Public Health Service Research Grant, PHS–3734, (Attachment I).

To be submitted by the proposed new grantee institution:

Letter assuring that no significant changes will be made in the objectives of the original program as approved by NIAAA.

Proof of Eligibility of the proposed new grantee institution to receive a DHEW/NIAAA grant as a nonprofit institution, according to the attached guidelines (Attachment J).

HEW Form 441, Assurance of Compliance with the DHEW Regulations under Title VI of the Civil Rights Act of 1964 (Attachment K). Two copies of this completed form must be returned to this office. You may retain one copy for your files.

Booklet entitled *Regulations and Guidelines for Health Services Funding* along with two copies of the Financial Plan (PHS Form 5181) (Attachment L). One copy of this form, along with required narratives and financial statements, must be completed and returned to this office. You may retain one copy for your files.

This information must be received before additional action can be taken on your request.

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