



NIHB Health Reporter

Vol. 1. No. 3

August, 1977

President Approves 94-437 Appropriations

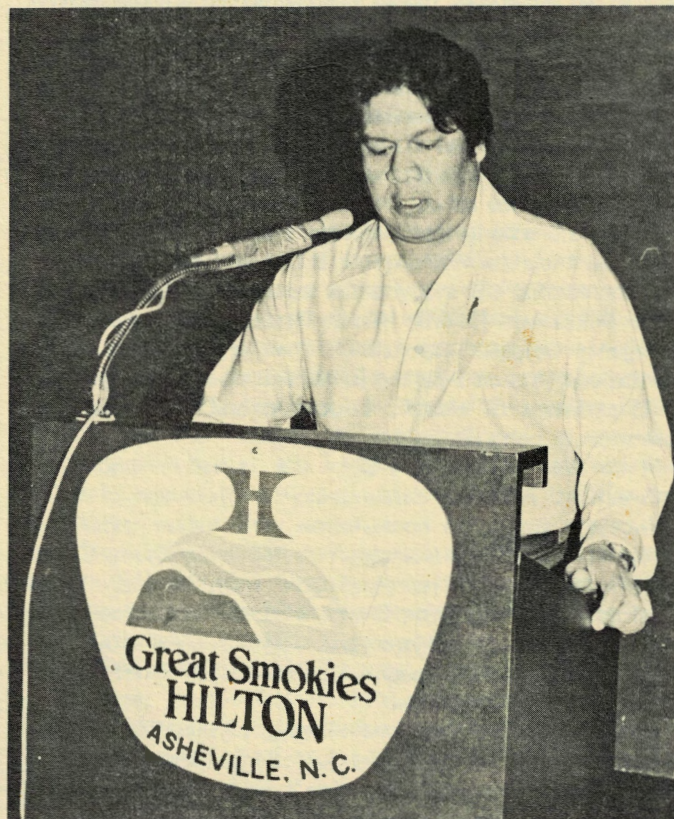
WASHINGTON, D.C.—P.L. 94-437, the Indian Health Care Improvement Act, has now been guaranteed \$94.4 million for its first year of implementation.

Approved by Congress earlier last month, the appropriations act which funds the Indian Health Service and Fiscal Year 1978 operations of P.L. 94-437 was signed into law by President Carter on July 26.

Meanwhile, the Implementation Plan for the act is already over two months behind schedule. P.L. 94-437 mandated that the Secretary of Health, Education and Welfare present the plan to Congress no later than May 28, however as reported by IHS it is still being processed by the office of the Secretary.

Final rules and regulations for the law, to have been published July 31 have also been delayed by the HEW approval process. Final regulations are presently being written by the Public Health Service General Counsel, and according to IHS, may not leave that office for another two-four weeks. The rules and regulations must then be resubmitted for clearance before reaching the Secretary for final approval.

The period for comments on the rules and regulations ended July 7. Close to 500 comments, the largest number concerned with Title I, Indian Health Manpower, were received, reports Dr. Robert C. Birch, 94-437 Project Manager. These will be addressed and included as a preamble upon publication of the final rules and regulations.



NIHB CHAIRMAN Howard Tommie addresses a joint session of the NIHB board and the IHS Council of Area Directors. (See story inside beginning on page 4.)

Major Changes Proposed in Indian Child Placements

WASHINGTON, D.C.—The Senate Select Committee on Indian Affairs heard testimony here August 4 on legislation which could play a key role in the strengthening of Indian families and return the major voice in placement of Indian children for adoption and foster care to Indian people themselves.

S. 1214, the Indian Child Welfare Act of 1977, was introduced in April by Senator James Abourezk (D.-S.D.) and is co-sponsored by Senators McGovern, Humphrey and Haskell. A number of Indian groups presented testimony urging its adoption before the Select Committee

Written testimony was submitted by the National Indian Health Board. It stressed the need for such legislation based on the currently deplorable situation in Indian child placements.

A nationwide study conducted less than a year ago by the Association on American Indian Affairs (the group responsible for drafting of the legislation) found, that Indian children are removed from their families to be placed in adoptive and foster care, special institutions and federal boarding schools at rates far disproportionate to their percentage of the population.

According to NIHB's testimony, social workers — ignorant of Indian cultural values and mores — have made wholly inappropriate decisions in judging the fitness of Indian families, frequently discovering child-desertion and neglect or abandonment, where none exists within the context of Indian family life.

Continued on Pg. 11

Upgrading for Change: Study and Indian Advisors Find AIANMS Feasible

A study conducted over the past six months "to determine the need for and feasibility of establishing a school of medicine to train Indians to provide health services for Indians" is now complete.

It finds that the primary obstacles to establishment of such a school are the need for a clear, long-term commitment to an American Indian medical school by the federal government and establishment of a university affiliation. If these factors can be met, then other obstacles can be overcome and the establishment of an American Indian medical school appears feasible.

Costs of the school are estimated to be between \$6 and \$15 million for construction and about \$18 million for operations until the school becomes fully-operational.

These are among the conclusions of Cresap, McCormick and Paget, Inc., the Washington, D.C.-based consulting firm, which conducted the study under contract to the Bureau of Health Manpower (BHM), Health Resources Administration (the agency assigned responsible). Their report, along with a separate one prepared by the BHM, will now be reviewed by the Department of Health, Education and Welfare before submission to congress.

Title VI of P.L. 94-437, the Indian Health Care Improvement Act, mandated that the Secretary of HEW conduct the study "in consultation with Indian tribes and appropriate Indian organizations." A Feasibility Study Group (FSG) composed of representatives from several Indian organizations, a representative of traditional Indian medicine, an Indian medical student and four medical educators monitored the study throughout its course and developed its own final recommendations.

The first of the final two meetings of the FSG with the contractor and BHM was held July 21 in Seattle. At that time the group reviewed the firm's final draft report and made suggestions incorporated into the final report.

National Indian Health Board
1020 15th St. — Rm. 4E
Denver, Colo. 80202
303-534-5482

Board of Directors Howard Tommie, USET,
Chairman;

James Cox, Oklahoma; Ethel Gonzales,
Alaska; Leonard Hare, Jr., Aberdeen,
Donald LaPointe, Bemidji; Lorna Patricio,
Tucson; George Platero, Albuquerque;
Elwood Saganey, Navajo; Mel Sampson,
Portland; Perry Sundust, Phoenix; Ada White,
Billings and Timm Williams, California.

Executive Director John Belindo
Program Analyst Howard Bad Hand
Public Information Officer L. Joy Bossert
Finance Officer Joan Baker
Executive Secretary/Board Coordinator Trudy Wilmoth
Clerk/Typist Mary Holden

Members of the FSG also expressed their encouragement with the final draft report. Having voiced his dissatisfaction with the contractor's work at a previous meeting, FSG chairman John Belindo remarked at Seattle's session, "this document has improved and is evolving toward a study we can support and be proud we devoted our efforts to."

At their final meeting held August 5 in Kansas City, the FSG chose to accept the contractor's final report as presented. It also approved the BHM report on the condition that it be revised to give increased emphasis to certain issues and include others not previously addressed and that it include the FSG's own recommendations.

The proposed school, even though demonstrated feasible by the study team, will not likely be accepted by congress unless it is shown that the present system does not work for American Indians and Alaska Natives.

Addressing this concern, the contractor's report found that a strong case exists for improvement of Indian health care delivery and health career opportunities and that numerous barriers currently obstruct such improvements.

One Physician per 1,031 Indian Persons

The report found that significant shortages in manpower, facilities and services prevent the health care delivery needs of Native Americans from being met. The report shows that in order to bring the physician ratio to the American Indian population served in line with the total U.S. population, IHS (the primary provider of health care services to American Indians residing on or near reservations and an important provider of services to Indians in certain urban areas) would need to acquire 370 additional physicians, an increase of 71 per cent above current levels.

Making the problem even worse, the study team found that IHS' capability to recruit and retain health professionals has decreased significantly in recent years.

The report found that there are only 79 American Indian physicians, a number 19 times lower than the proportion of physicians in the total U.S. population.

Many personal and institutional barriers deter American Indians from pursuing careers in health professional occupations, particularly medicine, as identified by the study team. These include medical college admissions test scores for Indian applicants which are somewhat below average, the limited number of medical school positions available and numerous additional factors inhibiting the orientation of American Indians toward health professional careers in the first place.

Indian Medical School Would Meet Health Care Delivery and Career Needs

The establishment of an American Indian medical school, found the report, provides a unique approach for meeting these health care delivery and health career needs of

Continued on Pg. 3

Upgrading

Continued from Pg. 2

American Indians. It states, "establishment of such a medical school will ensure that an adequate number of qualified American Indians can become physicians, will reduce American Indian dependence on non-Indians for health care, will provide a medical training program geared to the different cultures and religions of the American Indian population, and will provide a center for substantive research on American Indian diseases."

And highly important, the report maintains that the principle of self-determination, including Indian assumption of an integral role in the school's development and operation would be maintained.

Given the time required for a medical school to be developed and graduate its first class, it will be at least 1987 before the program can produce American Indian physicians. The health care delivery needs of American Indians will therefore have to be met by other means over the intervening 10 years.

It is partly with this consideration in mind that the contractors suggest three programs to complement the establishment of a medical school for American Indians.

They suggest providing spaces for American Indians at existing schools as a stop-gap measure for continuing the training of Indians as physicians until a medical school can be established.

Establishing comprehensive precollege and premedical school health programs for Indians is suggested to locate and provide to Indian students preparatory training for the health professions.

Expanding scholarship programs is suggested for ensuring that the financing necessary for the training of American Indian students is available.

Along with finding that a number of conditions clearly favor an American Indian medical school, the study report examines several difficult questions requiring consideration to determine the feasibility of this unique concept.

In the development of the study, several requirements were established by the FSG as critical for making the school acceptable from the Indian viewpoint. Upon consideration, these requirements were found to pose no substantial problems to the school's feasibility.

Several other factors were considered and most of these were also found to present no great cause for worry.

One such point taken into account was the school's ability to obtain a study body of sufficient size capable of being trained as physicians.

A sufficient pool of qualified Indian applicants with the necessary level of interest appears to be available, concludes the report.

In evaluating feasible site location, a set of four different criteria was applied to specific locations. These included location of the desired site in an area: with a high concentration of American Indians; with approved residencies in all of the undergraduate clinical clerkships; near accredited IHS facilities and with a substantial number of hospital beds.

Using these criteria, the report finds that it appears that an American Indian medical school could be located in Phoenix, Ariz.; Minneapolis/St. Paul, Minn. or Oklahoma City, Okla.

Perhaps more formidable are those factors requiring financial backing by the federal government and/or affiliation with an accredited university.

One such factor considered was the school's governance and administration. The primary obstacle, concluded the report, is in finding an accredited university interested in a formal affiliation with an American Indian medical school that will, at the same time, allow the Indian community to control the school's governance and administration. To ensure interest by a qualified university, suggests the contractor, it will probably be necessary for the federal government to provide strong backing, along with financial inducements to that university.

The ability to recruit and retain a faculty of sufficient size and quality is of major importance to the success of an American Indian medical school.

These requirements do not appear to be insurmountable, concludes the report, as long as the school is able to locate in a major urban center, and a clear expression of continued federal support has been made.

The general requirements for medical school facilities are discussed in terms of minimum needs and project cost. Medical schools require a unique set of facilities and even with the comparatively small size estimated for the American Indian school, major construction requiring between \$6 and \$15 million will be needed, a problem, according to the report, likely to be resolved only through federal funding.

About \$18 million is estimated to be needed in operating funds over the initial five-year period, and again, this is likely to necessitate significant federal funding, finds the report.

One of the critical issues associated with an assessment of medical school feasibility is a review of the available sources of funding. The school must demonstrate, at the outset, sufficient funding to cover at least a five-year period.

LCME is particularly hesitant about having the federal government fund a new medical school and stressed to the contractor that a federally-funded school would not be accredited unless funding is guaranteed over a period of years.

Three additional sources could be considered for financing the developmental and ongoing costs of an American Indian medical school including: state, county or city government funding from the jurisdictions where the school is located; private support from foundations or corporations; and self-generated income.

However, state and local appropriations and support from private foundations and corporations are likely to be limited. Also, because the school is new, the sources for research and teaching funds will be limited and difficult to obtain.

Federal Funding Critical

So, it appears that the financing of the American Indian medical school will depend most strictly on the availability of funding from the federal government. The vehicle for such support, suggests the report, could be either special appropriations or, "a less desirable option," a reallocation of existing program funding for American Indian education.

Aside from the established need for and feasibility of an American Indian medical school, the strongest argument of all may be the federal government's unique trust responsibility to American Indians.

The report points out that through treaty obligations

Continued on Pg. 10

NIHB Hears Representational Disputes but Will Be Worked Out by Areas

ASHEVILLE, N.C.—Three of the twelve service areas represented on the National Indian Health Board are experiencing disputes about just who should be representing them.

This became one of the issues discussed when the National Indian Health Board met jointly with the IHS Council of Area Directors for part of their quarterly meeting here July 26-29.

Those areas having conflicts or involved in reorganization are Bemidji, Albuquerque and Oklahoma. In the Bemidji area, as reported by NIHB Executive Director John Belindo, the Wisconsin, Minnesota and Michigan tribes feel that the Tri-State Indian Health Board no longer represents their needs. That board lost its funding in 1974 and has since been unable to procure funds from IHS to sponsor another organizational meeting.

Belindo met with tribal representatives in June in Duluth, Minn. at which time it was agreed that the inter-tribal councils of each of the three states would meet to choose a member and alternate. Thereafter, the inter-tribal councils will meet jointly to choose a representative and alternate to NIHB from among the first group.

In New Mexico, explained Belindo, the New Mexico Intertribal Health Authority, which represents 19 pueblos, has asked for its own representation on NIHB. George Platero, who chairs the Albuquerque Area Health Advisory Board and serves as the present NIHB representative said, "I don't see what problems we have in Albuquerque as far as the board is concerned." He feels the Intertribal Health Authority should participate on his board and said he has asked them to do so.

Continued on Pg. 6

Indian Preference Could Cause Tribes Problems

ASHEVILLE, N.C.—Although absolute Indian preference has been the official policy of the Indian Health Service since the end of April, one of the lawyers who helped secure that policy expects "a lot of foot dragging" in its implementation.

John Echohawk, Native American Rights Fund (NARF) attorney who helped litigate the recent "Tyndall case", told members of the National Indian Health Board here July 26, that he is "still looking for a commitment from IHS to comply with the spirit and enforcement of the law."

As provided in new policies and procedures, mailed to tribal groups in May, IHS is to practice absolute Indian preference "in filling all vacancies no matter how created." The new policies are the result of a class action lawsuit brought by Don Louis Tyndall, Sr. against IHS and DHEW, among others for failure to comply with the law under Title 25 of the U.S. Code which directed the defendants to give he and all qualified Indians preference in appointment over non-Indians to any vacant position within IHS.

Ruling in Tyndall's favor, explained Echohawk, Federal District Court Judge Barrington Parker ordered IHS to revise its prior Indian preference circular to comply with the law and to apply the same definition of Indian for purposes of Indian employment preference used by the Bureau of Indian Affairs.

The following persons are included under that definition: 1) Members of any recognized Indian tribe now under federal jurisdiction; 2) Descendants of such members who were, on June 1, 1934, residing within the present boundaries of any Indian reservation; 3) All others of one-half or more Indian blood; 4) Eskimos and other aboriginal people of Alaska; and 5) Members of a federally-recognized tribe whose rolls were closed by an act of Congress providing they are one-fourth or more Indian blood.

Although Indian preference had existed since 1934 when it was included as part of the Indian Reorganization Act,

prior to the Tyndall decision its enforcement was "pretty limited" according to Echohawk.

In 1972, the case of Freeman V. Morton challenged the limited application of preference laws. The court ruling which found Indian preference absolute and to be applied in any vacancy was "fought tooth and nail" by the BIA, but was affirmed by an appeals court in 1974, he stated.

A later Supreme Court decision found Indian preference to be constitutional yet, explained Echohawk, IHS did not comply arguing that it had not been named a party in these suits.

As a result of Judge Parker's decision, IHS will now exercise absolute Indian preference or risk being found in contempt of court. Unfortunately, as brought out at the NIHB meeting, the ruling may not be without its snags. As suggested by board chairman Howard Tommie, a problem may arise if an Indian from another area qualifies for a certain position but the local tribe prefers that someone else be hired.

He also raised the question of whether Indian preference applies to 93-638 contracts. (Although Echohawk was uncertain, later discussion with the other lawyer who handled Tyndall's case revealed that one of the provisions of 638 requires that with any contract to or for the benefit of Indian people, Indians are to receive preference in the administration, training and management of those projects.)

Raising another employment issue, Echohawk informed the gathering that at the time of his presentation a congressional subcommittee (the Subcommittee on Compensation and Employee Benefits of the House Committee on Post Office and Civil Service) was discussing a bill to allow non-Indian employees of IHS and the BIA to retire early with benefits. The subcommittee is to hold additional hearings on the proposed legislation, H.R. 4153, in September.

Johnson Still Urging Tribes to Develop Health Plans

ASHEVILLE, N.C.—Asked what strategy he would recommend to tribes for improving the health of their members, IHS Director Dr. Emery Johnson, recommended that over the next year tribes develop health benefit packages, then develop and “price out” reservation specific health plans.

Dr. Johnson, a strong proponent of tribal specific health plans comprising a composite plan to cover the last four years of P.L. 94-437, gave his response to a question posed by Buffalo Tiger, Chairman of the Miccosukee Tribe of Florida.

“We have the administration’s commitment to Indian health programs and the time has come for them to pay off on it,” said Johnson before a joint session of National Indian Health Board members and the IHS Council of Area Directors July 26. He gave a legislative progress report and addressed further tribal concerns.

One of the latter is the dilemma which tribes may face in developing the health plans Dr. Johnson recommends, that of knowing which service population figures to use. In determining program budgets, the government asks that tribes use the 1970 population figures for their areas, although even IHS records show these to be vastly outdated in many cases.

Asked by Gorvard Good Plume, Pine Ridge health board representative about this situation, Dr. Johnson replied, “IHS can’t solve the census figure problem . . . tribes must help define a more accurate method of census-taking.”

He predicted that the Indian Health Care Improvement Act (P.L. 94-437) would be ready for implementation by October. Indicating his pleasure with the appropriations for the act and the IHS budget, still on President Carter’s desk at the time of the meeting, Dr. Johnson noted that the \$60 million provided in congressional add-ons alone is “equivalent to the total budget of IHS 10 years ago.”

Several facilities will begin operations under funding received for the IHS budget, including tribal facilities to be opened within the next year at Ramah, Canoncito, Acoma and Laguna, N.M., reported Dr. Johnson.

Making its “first incursion back into California,” Dr. Johnson said that the Ft. McArthur facility there will be

transferred from the army to IHS for use as an ambulatory support center. If successful, he predicted, this first project may stimulate additional direct service projects by IHS in the state.

In Oklahoma, he reported, IHS will contract with the Creek Nation to enable the Creeks to reopen the hospital at Okemah and operate it as a private community facility.

Also included in the IHS budget, P.L. 93-638 projects funded this year by recurring money will be continued again next year. Dr. Johnson commented that IHS is “still going through some of the turmoil of implementation of 638 but is beginning to come to a consensus on its basic problems.”

Asked by Leonard Hare, Jr., Four State Health Board chairman and NIHB board member about the status of funding for a mental health facility to be established in the Dakotas, Dr. Johnson said that although the total amount was reduced, funding for that facility, provided under Title II, will be available.

Under Title III, Health Facilities, he reported, planning money for new facilities at several locations including Shiprock, N.M.; Pine Ridge and Rosebud, S.D. and Chinle, Ariz. was appropriated, although none was provided for construction.

A new issue has arisen related to facilities construction reported Dr. Johnson, this being congressional concern about the utilization of hospital beds. A recent study recommended reduction of the number of U.S. hospital beds and the General Accounting Office believes that IHS has built more beds than justified, said Dr. Johnson.

Congress has since declared a moratorium on beginning construction on new hospitals until a method for determining the appropriate number of beds is devised, he added. Therefore, IHS is currently conducting a review of its facilities constructed within the last five years and expects to complete it in October.

Dr. Johnson also informed the group that the sanitation facilities construction program, also under Title III, received full-funding. He stressed the importance of housing organization at the tribal level, including development of site plans and of a mechanism for coordination of federal housing activities.

DR. ERWIN S. RABEAU, Director of the IHS Office of Research and Development, has been actively involved in developing guidelines for tribal specific health plans. He reassured those in attendance that tribes will not be bound by the final suggested format. At right are area directors, Dr. Marlene Haffner and C. S. Stitt, Jr., D.D.S.





LISTENING IN as IHS Chief Dr. Emery Johnson addresses tribal concerns are (l-r): Mel Sampson, NIHB vice chairman; Dr. Erwin Rabeau, IHS Office of Research and Development director and Jim Smith, IHS Billings Area Director.

NIHB, Hears

Continued from Pg. 4

On the other hand, Albuquerque Area IHS Director Jay Harwood, admitted that there are two distinct groups to be dealt with and said "I recognize both of them and work with them on a par basis."

But he said he recognizes Platero as the area's present representative and added "I don't think at this point we're in any position to say how the representation asked by the All Indian Pueblo Council can come about."

In Oklahoma, the Five Civilized Tribes officially withdrew earlier this year from the advisory board, which now represents the 34 other tribes in the area.

Area Director John Davis said he recognizes "an indefinable cultural line between east and west in Oklahoma." He proposes dividing the money presently used to finance the area board among the nine service unit boards and selecting a representative from among the chairmen of that group.

Davis reported here that "since I'm being asked to support two boards, I have called a meeting of all the Oklahoma tribes" and promised that "we will be coming to grips with this very soon."

The representational question turned out to be one of the few prompting discussion between the NIHB and CAD members and in one of their own sessions later in the week, NIHB members expressed their desire for closer communication between themselves and the CAD. Suggested vice chairman Mel Sampson, "we need a sincere skull session with the Council of Area Directors."

Most of the remainder of the four day meeting centered around presentations on a wide range of subjects related to Indian health (see also three separate articles).

Tribal Specific Health Plan Guidelines Discussed

Dealing with the area of health planning, draft guidelines for tribal specific health plans were presented for discussion by Dr. Erwin S. Rabeau of IHS' Office of Research and Development.

He explained that, hopefully, such plans will provide the basis for the plan to be presented by the Secretary of HEW at year end 1979 to justify the continuation of P.L. 94-437. "This ties in very neatly with P.L. 93-638," commented Rabeau.

The proposal to have each tribal group develop its own specific health plan was included in the Implementation Plan for P.L. 94-437. The draft guidelines, mailed to Indian groups and tribes in July, are the result of a tribal specific planning meeting of Indian representatives and IHS staff held in June in Reno, Nev., said Dr. Rabeau.

Tribes will not be bound by the suggested format once it is finalized, he emphasized.

Service Populations 'A Thorny Issue'

In discussion with NIHB board members and other participants, he admitted that the definition of service population is a "thorny issue" because many tribes have found the 1970 census figures to be outdated. Yet, instructed Rabeau, unless tribes have another verifiable method of population count they are still to use the 1970 population figures in development of their plans.

Through the suggested format, maintained Rabeau, tribes are given a chance to emphasize their legislative and historical situation.

Continued on Pg. 7

Continued from Pg. 6

The comment and response period on the proposed guidelines ends September 1 with final guidelines to be distributed October 1. Thereafter Indian groups will have until August 1, 1979 to submit their specific health plans to IHS headquarters.

Commenting at the completion of Dr. Rabeau's presentation, Jim Smith, Billings Area IHS Director, reminded those present, "the thing to keep in mind is that if the tribe's don't pick up the ball, IHS will do it for us."

Relating another health planning development, Irene Wallace, NIHB representative from the Tucson area, reported on the Papago Tribe's involvement with P.L. 93-641, the National Health Planning and Resources Development Act.

She told the group that the act which is to provide health planning and development of health resources for the entire nation, has been extended, unchanged, for another year.

The primary mechanism for carrying out the act is Health Systems Agencies (HSA's), established in every part of the country, each usually encompassing an area with a half million to a million people. Each HSA is to develop a health needs and services plan for its area.

The Papago Tribe has tried to understand the law and work with it at its level, explained Wallace. Papago Tribal Chairman Cecil Williams and the United Southeastern Tribes originally lobbied against the legislation because, in addition to their planning function, in the case of Indian tribes, HSA's also have review and comment authority over all applications submitted to HEW for funding grants under certain health acts.

HSA's Doing Planning for Tribes, Warns Wallace

Wallace urged other tribes to become familiar with the law and with their local HSA's because "whether states have authority over tribes or not, they are doing the planning for them."

The Papagos are not encountering any problems with their HSA and have received its agreement that the tribe's

own health plan will be "accepted as equal," said Wallace.

It was largely through the efforts of the Papago Tribe that Indian people first became aware of another issue which may ultimately affect them, as well as all other Americans, that of National Health Insurance.

Belindo reported on the progress of the National Health Insurance Core Group, formed following the First National Indian/Alaska Native Health Conference last summer.

Indian Position on NHI Now 'Well Known'

Because of that group's work and the appointment of one of its members, Cecil Williams, as a representative to HEW Secretary Califano's Advisory Committee on National Health Insurance, said Belindo, "it is well known that an Indian position on NHI now exists."

The core group met in Phoenix, Ariz. June 16-17 and will continue to meet based on future developments with NHI. Belindo said the group's future activities will include monitoring and analyzing NHI activities, disseminating information to Indian tribes and providing them with technical assistance, recommending alterations and refinements to the Indian position and providing statutory language to change the Indian position into specific legislation.

Status of AIANMS Study

The board heard from Dr. William E. Bennett and Helen C. McCarron, both of the Division of Medicine, Bureau of Health Manpower of the Health Resources Administration, on Title VI of P.L. 94-437, a Feasibility Study to Determine the Need for an American Indian School of Medicine.

At the time of the meeting here, McCarron reported that the Feasibility Study Group, composed of representatives of several Indian organizations, a representative of traditional Indian medicine, an Indian medical student and several health educators had met with the contractor throughout the course of the study. Two sessions were also held with 50 representatives of Indian organizations and tribes, she added.

Continued on Pg. 8



REPRESENTING the Cherokee Senior Citizens at NIHB's quarterly meeting were Birdie Sixkiller (left) and Helen Jacobs.

From the Executive Director

The concept of this publication came into being in the context of providing communication activities within the NIHB Central Office to provide all health boards, Indian Health Service organizations, tribal organizations and the general public with news information on recent health developments, health-related issues, and other topics and concerns of vital interest to Indian people.

Our plan is to inform Indian country of the goals, objectives and program activities of the National Indian Health Board. Yet it is hoped that the *NIHB Health Reporter* will be a collective report, for the most part. We encourage our readers to suggest ideas for publication including, e.g., advising us of unique programs making a contribution toward the improvement of Indian health of which they may be aware; to submit news of their local boards; and other health developments and events in their own areas.

In an effort to continually improve the *Reporter* and make it more responsive to the health information needs of Indian people, we invite your critical and incisive reviews of any article published therein.

I am confident that the collective rewards that emerge from this publication will truly reflect the health concerns of Native Americans and Alaska Natives, now and in years to come. J.B.

NIHB, Hears

Continued from Pg. 7

A final meeting was scheduled for August 5 in Kansas City, at which time recommendations to accompany the final report would be developed. (See separate story on completion of feasibility study.)

McCarron gave an overview of the contractor's draft report including projected planning and operational costs until such a school is "fully-operational" of some \$20.2 million and another \$10-15 million in construction costs.

Panel to Evaluate NIAAA Projects to be Set Up

Dr. Donald A. Swetter, Acting Director of the IHS Office of Professional Standards and Evaluation requested that NIHB designate a representative to a panel which will evaluate alcoholism projects to be transferred to IHS.

Currently funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA), 148 projects are slated under Title II of the Indian Health Care Improvement for transfer to IHS from FY1978-FY 1980.

Thirty-four of the projects are to be transferred the first year, with the first of these scheduled for June 1, 1978. As explained by Dr. Swetter, these programs are subject to prior review by a panel composed of representatives of major Indian groups and four experts on Indian alcoholism. Executive Director John Belindo was selected to represent NIHB.

Up until now, maintained Swetter, there has been no constructive evaluation of these programs. Many are located in tribal areas but are not subject to tribal control. One means of correcting this situation, he suggested, would be for tribes to include the programs when developing their health plans.

Although P.L. 94-437 provides for the transfer of these programs to IHS, it fails to include administrative funds, pointed out Dr. Swetter.

Establishment of Congressional Committees Top Priority

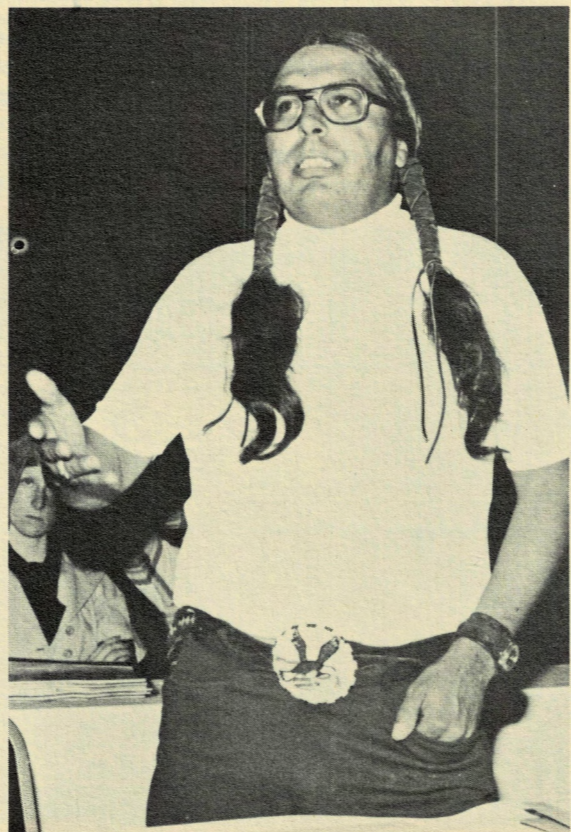
The number one priority of Indian people for the remainder of this congressional session should be pushing for one of the recommendations of the American Indian Policy Review Commission, establishment of full committees in both the house and senate. This was the action urged by Chuck Trimble, Executive Director of the National Congress of American Indians (NCAI) as he spoke to the audience here.

Trimble also spoke of the cooperative effort among Indian groups and organizations to counteract the current anti-Indian backlash across the country and the Carter administration's Indian policy, or rather lack of one, to date.

The Interstate Congress for Equal Rights and Responsibilities and the National Association of Counties, the two organizations heading the anti-Indian movement now have chapters in 26 states, reported Trimble. They are waging a state-by-state fight at the legislative level and these combined efforts are contributing to the abrogation of treaty rights, he warned.

Indian groups and organizations have begun publishing materials in an effort to counter the untruthful publications put out by these anti-Indian organizations, said Trimble.

Continued on Pg. 12



FT. BELKNAP Tribal Council and Health Board member, Donovan Archambault, makes a point.

Economics and Mental Health Related, Finds Testimony

ASHEVILLE, N.C.—Native Americans from around the country have been making their unique mental health concerns known recently.

The President's Commission on Mental Health has received the active participation of Indian people, largely through the efforts of one of its 20 members, LaDonna Harris (also President of Americans for Indian Opportunity).

Phyllis Cross, special assistant to Harris, reported at the NIH Quarterly Meeting here July 27 on the commission's activities to date.

Public hearings have been held in Philadelphia, Nashville, Tucson and San Francisco. Several Indian persons have presented testimony including, among others, Dr. H. C. Townsley, head of the Indian Health Service's Mental Health Program and NIH board members George Platero of the Albuquerque area, Perry Sundust of the Phoenix area and Ethel Gonzales from Alaska.

Concerned that the interests of "middle America" were being overlooked, Harris has held mini-hearings of her own, so far in New Mexico, Oklahoma and the Dakotas. Hearings to solicit further Indian input are scheduled for Zuni and Laguna, N.M.

In testimony and discussions with Indian people so far, said Cross, the commission has found a strong relationship between economics and mental health. There appears to be a direct correlation between mental health and the high unemployment rate faced by Indian people and, said Cross, "there is a strong indication that improving a reservation's economy can improve the mental health of its inhabitants." Related to this, Indian participants have indicated their concern about the lack of turnover of money at the reservation level, she added.

The commission has heard of numerous mental health problems faced by Indian people, one of the most prevalent being substance abuse including alcoholism. Such problems are beginning at increasingly-younger ages. Cross told the gathering of hearing testimony of "kids coming into school

drunk at age eight and nine and glue sniffing at seven or eight."

A number of factors present in their everyday lives contribute to poor mental health among Indian people or tend to worsen the situation. Such concerns said Cross, include racism and prejudice, the treatment afforded Indian children and the foster care systems in which they are often placed, the increasing dependence of Indian people on institutions, fragmented services, and what Cross termed "the lack of response of the traditional white middle class model." These personnel, she explained, "don't want to treat people unlike themselves and don't understand Indian concepts."

And curing mental health problems is not easy. As Cross explained of the testimony she has heard, "Indian people are reluctant to admit they have a mental health problem because the stigma of being labelled mentally ill stays with you the rest of your life."

A shortage of staff to work with mental health problems also exists.

In order to deal with mental health problems, Indian participants stated their support for strengthening and hiring more staff for those programs which have been successful, and stressed the need to look at the strengths of traditional Indian medicine.

Cross encouraged other Indian persons knowledgeable about mental health problems or treatment to become involved with the commission, either through one of its task forces or by providing testimony. At present, Ed Bates, a Yankton Sioux is serving on the commission's task panel on rural mental health and Sam Deloria will sit on the desk panel on special populations including minorities, women and the physically-handicapped.

The commission is to make its initial report in September and a final report to President Carter next April. Cross expressed her hope that that document, which will include a separate Indian report, will have special impact on congressional legislation and funding.



IMPROVING everyday life for Indian people will lead to betterment of their mental health, according to Phyllis Cross, special assistant to LaDonna Harris, member of the President's Commission on Mental Health.

Title IV of '437' Swings into Action

WHITE EARTH, MINN.—The White Earth Health Center recently received a check from the Minnesota Medicaid Agency for pharmacy services and is now processing a number of dental bills. So doing, the health center becomes the first IHS facility to bill and collect from a state Medicaid program under Title IV of the Indian Health Care Improvement Act.

Meanwhile, the Oklahoma Area Office has earned the distinction of being the first area to bill for Medicare under P.L. 94-437.

Previously, IHS could collect from these programs but was required to return the money to the U.S. Treasurer. With the enactment of P.L. 94-437, IHS is now able to put these funds to use for improvement of its facilities. A special fund is set up to route the money back to the areas for distribution to IHS facilities, whether IHS or tribally-managed.

Area Health Board Update

Navajo Area Plagued by High Medical Turnover

WINDOW ROCK, ARIZ.—An extremely high turnover rate faced by various medical programs on the Navajo reservation was among the major concerns voiced during the Navajo Area Health Board meeting held here June 29-30.

Indian Health Service area director Dr. Marlene Haffner reported that now is the annual turnover time among physicians, dentists, nurses, engineers and sanitarians and noted "considerable problems recruiting into these vacancies, especially in the physician and dental areas."

The reservation's Emergency Medical Services (EMS) program is experiencing approximately 85 per cent turnover rates according to David Jones, director of that program. He reported that the enormous turnover rate keeps each service unit Emergency Medical Technician crew understaffed.

Also plagued by a high turnover, with a rate topping 60 per cent last year, is the Navajo Community Health Representative Program. And, reported Program Director David Antle, projections based upon the first months of Fiscal Year 1977 indicate that this high rate will continue and perhaps increase.

Highlights of other departments concerning themselves with health were detailed by Dr. Haffner in her report to the board. Among others, these included the formation in July 1976 of the Navajo Nation Nutrition Council and beginning dialogue with the Bureau of Indian Affairs to address the issue of nursing home care for the elderly and chronically ill.

Currently, nursing homes on or near the reservation are inadequately staffed or lack medical care while off-reservation homes lack Navajo staff and Navajo patients are not provided interpreter services.

Portland Area Board Adopts Feasibility Study Conclusions

PORT ANGELES, WASH.—Members of the Northwest Portland Area Indian Health Board held their quarterly meeting here July 19-21, meeting for the first time in joint session with their area's service unit directors.

The joint meeting included a legislative update on Public Laws 93-638 and 94-437 and discussion of mutual health concerns and the final report of the recently completed Northwest Indian Hospital Feasibility Study.

Dave Lambert, executive director for the board, described the session as "very fruitful" and said that both groups expressed their desire to hold joint meetings in the future.

The following day, board members heard a presentation of alternatives for meeting Northwest Indian inpatient needs based upon the study which addressed the feasibility of an Indian hospital in the Pacific Northwest.

Presented in the following order of priority these included:

- 1) The Portland Area Indian Health Service be funded to its fullest capacity based on actual population figures;
- 2) Staffing at IHS clinics be brought up to above the 65% level;
- 3) Vacant hospital beds be utilized wherever possible before new ones built via contract or joint use agreements;
- 4) Where new Indian hospitals must be built to provide needed beds, they should be small inpatient facilities placed in areas of demonstrated need designed specifically for the Indian population.

The area board supported these conclusions in the indicated order and stressed the need for area tribes to involve themselves with the 1980 census.

They further urged that the current population figures, revealed by the feasibility study, be pushed in securing funds for Northwest Indian health services. The feasibility study found that the figure of 47,000 people which IHS reports serving in the area over the past three years contrasts sharply with the 28,000 population figure recorded by the 1970 census.

On their final meeting day, board members heard staff reports and passed resolutions in support of various tribal health programs.

Upgrading

Continued from Pg. 3

and legislation, the federal government has established for itself a unique trust responsibility toward American Indians.

Beginning in 1911, the Bureau of Indian Affairs earmarked appropriations specifically for health services to Indians. Subsequent legislative enactments, beginning with the Snyder Act of 1921, are significantly related to the present status of Indian health care.

The reports of Cresap, McCormick and Paget and the BHM were submitted to HEW for review on August 12. The Secretary is now to submit the final report to Congress September 30.

The BHM report draws heavily from that prepared by the contractor with a few differences, including a section on the uniqueness of Indian culture not contained in the contractor's report. It also declines to name possible sites for location of an Indian medical school.

The Indian recommendations prepared by the FSG included as an addendum to that report are as follows:

"The Feasibility Study Group is convinced of the need for and feasibility of a medical school for American Indians. This conviction is predicated on three facts: First, the current medical education system is inadequate and cannot develop American Indian medical professionals. Second, the current status of health care of American Indians is below the status of health care of the total population. Third, to turn around the low percentage of American Indians in the medical professions, a separate and innovative educational institution should be developed to provide a quality and relevant education leading to an M.D. degree. This is the only way there will be any effective change. This development must be in concert with a general upgrading of Indian education at all levels.

Major Changes

Continued from Pg. 1

Consequently, poverty, poor housing, lack of modern plumbing, and overcrowding are often cited by social workers as proof of parental neglect and are used as grounds for beginning custody proceedings against Indian parents, according to the NIHB testimony.

Under the provisions of the Child Welfare Act, basically, no Indian child placement would have any legal force or effect unless the appropriate tribal entity was given time to intervene in the proceedings. In cases where a tribal court exercising jurisdiction over child welfare matters exists, no Indian child placement would be valid or given any legal force, unless ordered by that court.

In the past, states NIHB's testimony, "the family-welfare crisis" in American Indian communities has been attributable not only to abusive practices by child-welfare and court officials but also to the absence of adequate preventive and rehabilitative services for families in trouble.

The policies and programs of the Bureau of Indian Affairs and state welfare departments are, for the most part, directed at crisis intervention. A family is rarely assisted until an acute crisis has arisen. Then, suggested NIHB's testimony, welfare agencies rapidly mobilize to provide the only remedy that seems practical to them — termination of parental rights.

A major feature of the bill is aimed at preventing the breakup of Indian families. Removal of an Indian child from his parents or guardian would be considered illegal unless the parents or guardian were given a chance to intervene on their own behalf.

In making such custody determinations, poverty, including inadequate or crowded housing, misconduct, and alcohol abuse on the part of the parents would not necessarily be viewed as evidence that emotional or physical impairment would come to the child. And perhaps most importantly, the standard to be applied in any proceeding would be the standard of the Indian community in which the parents or guardian of the child reside.

Most Indian children currently in foster care are placed with non-Indian families. As stated in NIHB's testimony, "The children are placed in those homes which can in no way approximate the type of native homeliving experience they need. The children are torn away from their family life, their community, and their culture. The removal of the children not only adversely affects them but also their families and in fact is one of the greatest instances of harm done to Indian life."

Yet, asserts NIHB's testimony, in the past non-Indian parents have been given priorities in adoption and foster care consideration while there has been a far from adequate effort on the part of agencies to place Indian children in Indian homes. Indian people have problems in applying as adopting and foster parents and in effect are often discriminated against in protection cases and in court hearings.

S. 1214 deals with this situation as well, as it would require non-tribal governmental agencies and institutions to grant preference to Indian individuals and entities in Indian child placement.

While attempting to correct the shortcomings of the existing child welfare placement systems, the Child Welfare Act also aims to provide mechanism for Indian communities to strengthen their own family life. The act authorizes some

\$70.6 million over the next three years and funding for subsequent years for the establishment and operation of on- and off-reservation "family development programs."

The objective of such programs as stated in the act would be "to prevent the breakup of Indian families and, in particular, to insure that the permanent removal of an Indian child from the custody of his natural parent or parents, or the custody of any blood relative in whose care he has been left by his natural parent or parents, by a tribal court or non-tribal government agency shall be effected only as a last resort."

Also included in the authorizations is a special home improvement program to correct substandard housing conditions among Indian foster and adoptive parents; Indian persons who seek Indian foster or adoptive children and Indian families facing disintegration, where improved housing would contribute significantly to family stability.

An additional provision of the act would work to correct past mistakes of welfare and social agencies and to restore custody of Indian children to their rightful parents or guardians. It authorizes the Secretary of Interior to initiate a study on all child placements which occurred during the 16 years prior to the act. From this study, if a child placement is found invalid or illegal, the Secretary is empowered on request of the child's parents or guardian to institute a habeas corpus action or other legal proceeding on their behalf.

And finally, to help protect the rights of Indian parents and children in the future, the legislation would authorize the Secretary of Interior to operate or assist Indian tribes or organizations in operating family defense programs which would provide representation by an attorney, or in tribal court, a lay advocate for any Indian child who is the subject of child placement proceeding.

An additional \$60 million is authorized for fiscal years 1979-1981 along with necessary additional sums for subsequent years, to finance the Indian child placements study, the Indian family defense programs and for collection and maintenance of Indian child placement records in a central location.

Having heard testimony on the bill, the Senate Select Committee on Indian Affairs is now working to amend the legislation in accordance with witness suggestions.

At this point, the bill has no sponsor in the House of Representatives, although the committee has received strong indications of support from at least two congressmen, according to a member of its staff.

Both the Department of Health, Education and Welfare and the Bureau of Indian Affairs oppose the legislation on the basis that the Carter administration has its own proposal for foster and adoptive care generally. They maintain that the Indian proposal should be incorporated into the Carter measure.

Chances for the bill's passage this session of congress are questionable, according to Senate Select Committee staff, as the senate is now taking a month's recess and may adjourn for the year in October. Still, if the bill receives a sponsor in the house and is introduced right away it does have a chance of passage before that time.

Accordingly, Indian tribes, organizations and individuals interested in the enactment of S. 1214, the Indian Child Welfare Act of 1977, are urged to write to their congressional delegations indicating the importance of this legislation.