



NIHB Health Reporter

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REPRESENTATIVES OF THE National Indian Health Board toured the impressive facilities at the Shoshone-Bannock Tribal Complex — including the tribal computer center shown here — during their quarterly board meeting on the Fort Hall Reservation in Idaho August 7-10. See related story pg. 16.

Senate Markup Nullifies Controversial Norton Sound Ruling

WASHINGTON, D.C.—On March 4, 1979, the U.S. Comptroller General handed down a decision that threatened to totally disrupt the Indian Health Services (IHS) contracting system and cost Indian tribes millions of dollars needed for health care services.

More than 18 months later, it appears that efforts by the National Indian Health Board (NIHB) and other Indian organizations to nullify that decision succeeded when the Senate Appropriations Committee markup of the FY 1981 IHS budget here September 23 included language granting IHS specific carryover authority for FY 1980 and FY 1981 contracts.

The Comptroller General's "Norton Sound" ruling (so-called because it resulted from a request for a contract clarification by the Norton Sound Health Corporation) prohibited IHS from writing contracts with tribes and Indian organizations that cut across fiscal years and allowed the contractor to carry over funds from one fiscal year to the next. The only exception to this ruling was for IHS contracts written under P.L. 93-638 authority, since Congress has

specifically stated that these funds can be carried across fiscal years.

The ruling, although technically sound, appears to contradict standard operating procedures for the federal government. According to NIHB General Counsel Daniel Press, "it has always been assumed that once a federal agency enters into a contract with a non-federal entity, the money is obligated and can be carried over to the next fiscal year regardless of whether Congress has specifically granted authority for the carryover. If this wasn't the case, the federal government would collapse."

Appearing before Congress earlier this year, NIHB testified that if the Norton Sound ruling was implemented it would "create administrative nightmares both for the Indian Health Service and for the tribes and Indian organizations affected."

"The Indian Health Service, tribes, and Indian organizations," NIHB's testimony continued, "have enough of a challenge trying to provide adequate health care to

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Health News Across the Nation

The following is a regular feature in the NIHB Health Reporter. In this section, we attempt to present readers with short, concise briefs on issues and activities around the country that are related to Indian health care, including such topics as conference and workshop dates, legislative notices, news on local events, etc. Further information on items mentioned in these short reports can be obtained from the NIHB Public Information Office.

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WASHINGTON, D.C.—Approximately four hundred Indian youths attended the National Indian Youth Leadership Conference here August 4-10. Among the different government speakers addressing the group was White House chief of staff Jack Watson, who told the young conference participants that the Carter Administration has established a new government-wide, inter-agency Indian task force to see that government "efforts and programs are streamlined and applied more effectively." Conference participants also took part in lectures and workshops designed to help them explore various careers and occupations.

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SPOKANE, WASH.—The National Congress of American Indians will hold its 37th annual convention here October 26-31. Eleven NCAI committees have been established to address key issues affecting American Indians and Alaska Natives. NIHB Executive Director Jake L. Whitecrow will serve as chairman of the NCAI Health Committee. For more information, contact the National Congress of American Indians; 202 E. St., N.E.; Washington, D.C. Phone: (202) 546-1168.

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OKLAHOMA CITY, OKLA.—The Association of American Indian Physicians will sponsor two Pre-Admission Workshops for American Indian undergraduate students who are preparing for health professions careers. Indian students who are planning to study medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy may apply. The two-day workshops review the applications process for health professions schools, financial aid, personal interviews, and selection of schools.

The first workshop will be held here November 8-9, and the second will be in Albuquerque, N.M., November 15-16. AAIP will provide participating students with round-trip travel and per diem. Requirements for selection are: one-quarter degree Indian blood by quantum with certified documentation and status as an undergraduate student preparing for entrance into a health professions school. For further information, contact: Association of American Indian Physicians; 6801 S. Western, Suite 206; Oklahoma City, Okla. 73139. Phone: (405) 631-0447.

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ANCHORAGE, ALASKA—The Alaska Native Health Board and the Alaska Federation of Natives will sponsor the Statewide Alaska Native Health Conference here October 21-22. The conference will feature 17 workshops on such topics as alcoholism, nutrition, health contracting, patient travel, and health legislation. In addition, there will be a health fair, with various tests, screenings, films, and booths on health related matters. Special attention will be given to community health aides that work throughout the state. For more information on conference activities, contact: Elaine Hultengren; 1689 C Street, Suite 230; Anchorage, Alaska 99501. Phone: (907) 276-8989.

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ACOMITA, N.M.—With the recent completion of a 50-unit housing project for hospital personnel, the Acoma-Canoncito-Laguna (ACL) hospital officially opened its doors for in-patient service August 4. The hospital opened in 1978 with a 40-bed in-patient capacity, but due to personnel and housing shortages, the in-patient operation was delayed. According to Larry Sanchez, executive director of the ACL Indian Hospital Board, the new housing unit and projected recreational facilities will hopefully alleviate past personnel problems for the hospital.

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CULVER CITY, CALIF.—The Institute for Career and Vocational Training will begin publication of a new, monthly magazine entitled *Indian Youth*. The first issue is scheduled to be printed in early October, according to the magazine's editor, Mark Trahan. The magazine will be distributed free of charge, Trahan said, with a goal of "reaching as many Indian youth as possible." For subscriptions of further information, contact Trahan at: The Institute of Career and Vocational Training; 5805 Uplander Way; Culver City, Calif. 90230. Phone: (213) 204-2080.

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BERKELEY, CALIF.—The University of California, Berkeley, is recruiting students for its Master of Public Health Program for American Indians and Alaska Natives. The program offers training in such areas of specialization as hospital administration, health administration and planning, environmental health, epidemiology, and health education. In addition, a program has been developed in the field of Native American Alcoholism and Substance Abuse. For more information, contact: Elaine Walbroek, Director; MPH Program for American Indians/Alaska Natives; School of Public Health; Earl Warren Hall; University of California; Berkeley, Calif. 94720. Phone: (415) 642-3228.

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SCOTTSDALE, ARIZ.—The National Institute on Drug Abuse (NIDA) will fund the American Indian Drug Program Conference here October 8-10. The primary purpose of the conference, which will be attended by representatives from

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MEL SAMPSON (at podium), chairman of the Northwest Portland Area Indian Health Board, addresses general session of the Northwest Indian Health Conference in Portland, Ore., August 4-7. More than 300 persons attended the conference, which addresses issues such as contract health services, preventative health, nutrition, and emergency medical services.

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NIDA-funded Indian drug abuse programs, will be to identify some of the problems, barriers, and concerns among Indian drug program managers in working with state agencies. Participants at the conference will also examine ways to improve the treatment of drug abuse. For more information, contact: Albert Pooley; American Indian Resource Organization, Inc.; 1955 East Broadway, Suite 3; Tempe, Ariz. 85282. Phone: (602) 967-3860.

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MT. PLEASANT, MICH.—A conference to provide training to Indian health and human services workers in the state of Michigan will be held here October 8-10. Sponsored by the Michigan Urban Indian Health Council, the Inter-Tribal Council of Michigan, and other health organizations, the "Circle of Life" conference will feature a number of seminars designed to assist participants in sharing resources, knowledge, and major issues related to Indian health and human services.

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ALBUQUERQUE, N.M.—The Association of American Indian Physicians bestowed its highest award upon Dr. Everett Rhoades at its annual meeting here August 2. Dr. Rhoades received the Association's Award of Excellence in recognition of his years of working to improve the health status of American Indians and Alaska Natives, and to increase the number of Indians in the health professions. Dr. Rhoades, a member of the Kiowa Tribe of Oklahoma, is Chief of Infectious Diseases at the University of Oklahoma Health Sciences Center.

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DILLINGHAM, ALASKA—The Bristol Bay Area Health Corporation is seeking applicants for several key positions at the Indian Health Service hospital here. The hospital, which provides services to the total population of 27 villages located in Bristol Bay, is the first IHS facility to be completely

— Bulletin —

WASHINGTON, D.C.—President Jimmy Carter was expected to sign the Mental Health Systems Act (S. 1177), which recently passed the House and Senate.

If signed, the legislation will provide tribes and Indian organizations a much greater opportunity to operate their own mental health programs. The bill will expand eligibility for funding from the National Institute on Mental Health to include mental health programs offering limited services, rather than restricting funds to only those entities capable of providing patients with a full range of comprehensive mental health services.

The bill will also allow tribes to contract directly with the federal government for mental health programs, rather than having to contract through state agencies for the services.

On a separate issue, the legislation contains an important amendment affecting the pay structure of many physicians working in the Indian Health Service. The amendment provides that physicians of the Public Health Service Commissioned Corps are eligible for special pay at a rate equal to that of physicians in the armed services.

The National Indian Health Board, as well as other Indian organizations and tribes, have actively supported passage of the Mental Health Systems Act and its provisions for American Indians and Alaska Natives. A detailed report on the legislation will appear in the next issue of the NIHB Health Reporter.

operated by the tribal groups which it serves. The four positions are: director of health services; human services administrative manager; regional field coordinator for human services; and health data specialist. Persons interested in obtaining more information about these positions should contact Steven Leninson; Bristol Bay Area Health Corporation; P.O. Box 10235; Billingsham, Alaska 99576. Phone: (907) 842-5266.

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DETROIT, MICH.—The American Public Health Association (APHA) will hold its annual conference here October 22-23. One of the featured activities of the conference will be a round table discussion on the implementation of the Indian Health Care Improvement Act and other issues related to Indian health care. The discussion will be co-chaired by Fashid Bashur and NIHB Executive Director Jake Whitecrow.

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WASHINGTON, D.C.—The Department of Housing and Urban Development (HUD) announced plans August 14 to improve the delivery and administration of Indian programs through the restructuring of field offices. The principal change is the creation of five field offices that will work only on Indian programs. All Indian programs, except those in Alaska, will be administered from the five new offices in

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Research Shows Increased Drug Use Among Native American Youth

Drug abuse is known to be a severe problem throughout the country; its effects are especially detrimental to the health and well-being of young people. In the following article, Joe Velarde, Dr. Fred Beauvals, and Dr. E. R. Oetting of Colorado State University discuss some of the results and implications of their research on drug abuse among Native Americans. Among other things, the writers conclude that drug abuse is at least as prevalent among Native American adolescents as it is among youth in the general population.

We invite responses to the following discussion. Comments may be sent to the NIH Public Information Office or to: Fred Beauvals, Ph.D.; Department of Psychology; Colorado State University; Fort Collins, Colo. 80523.

Until recently drug abuse has received very little attention as a problem among Indian people. In fact, before 1972 there was no real research about the extent of the problem or the reasons for it. In recent years some work has been done, although it has generally been restricted to one or two tribes and the quality of the research leaves much to be desired.

We began work in 1974 developing appropriate survey instruments to assess the nature and extent of drug abuse among young Indian people. To date we have surveyed over 6,000 Indian youngsters from about 25 different locations across the country. Most of these young people were in the 7th through 12th grades.

In general, the data show that Native American adolescents use at least as many drugs as other youth, and in some cases they use considerably more. The table below shows how many have tried different drugs.

The amount of drugs used and the way they are used depends to some extent on the tribe or school. In some places the problems are more severe than in others. We never report the specific data about local drug use to anyone but that particular tribe or school, but there are some situations that seem to increase the chances of drug use being a more serious problem.

. . . it is very clear that peer influence is quite strong with respect to drug use. If a youngster has a lot of friends who use drugs and the friends encourage use, he or she is more likely to use drugs.

An important factor is whether there are alternative activities for young people. When there is a lot for them to do, drug use seems to be lower. When there is little or nothing to do, they are much more likely to turn to drugs. If a tribe is isolated, far away from a major city, there may be a little less drug use but the full range of drugs seems to be available to children wherever they are.

The type of drug use in a community does not seem to be affected by other obvious community characteristics. For example, whether a tribe is very traditional does not seem to affect drug use: there is about the same amount of drug use in tribes with a lot of ceremonies, where an Indian language

is used and where traditional social structures are still intact, as there is in tribes with few of these characteristics.

A very tough anti-drug police approach does not seem to help much either. It may lead to a little less experimenting with drugs but the children who do get involved seem to use drugs more heavily than they would have with a less harsh approach. We think that very severe punishment for minor drug use, like using a little marijuana, drives the drug use deeper underground. The children who are involved are then likely to encourage each other to use drugs more heavily.

Native American Drug Use (Age 12-17)

1977

	<u>Lifetime Prevalence</u>	
	<u>Native Americans</u>	<u>Other Youth</u>
Marijuana	46%	28%
Inhalants	22%	9%
Stimulants	15%	5%
Tranquilizers	9%	4%
Hallucinogens	13%	5%
Cocaine	8%	4%
Sedatives	10%	3%
Heroin	4%	1%
Alcohol	78%	53%

The table shows the average use by all students in high school. Because of that, it underestimates the real extent of the problem. Drug use increased with age from the 7th to the 12th grade. Young people have more time to get involved with drugs and experiment with them more. By the time they are seniors in high school, a lot of adolescents have been involved in this kind of experimentation.

Alcohol is, of course, the most frequently used drug. Right now about 87 percent of high school juniors and seniors have tried alcohol. Many of these youngsters are not just having an occasional drink. Sixteen percent have been drunk three or more times in the last two months and 27 percent have been drunk enough at some time to have experienced a blackout and not remember what they did. The alcohol problem is familiar to all of us. We know about the number of adults who have a problem with drinking. A lot of young people are well on the way to joining them.

Marijuana is the second most common drug. Seventy percent of high school seniors have tried it, and 15 percent use it several times a week. Sniffing something to get high is next. Seventeen percent of high school seniors have tried sniffing, mostly gasoline or glue.

Use of these drugs is not only high, but it is increasing rapidly. Within the next three years we estimate that 85 percent of high school seniors will have tried marijuana and

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more than a third will have used inhalants. While the majority of this use will be light, it is still significant that this very large number of young people will have been exposed to drugs.

Use of other drugs, such as heroin, cocaine, hallucinogens, amphetamines and so forth is not nearly as high as the use of alcohol, marijuana and inhalants. However, these drug are available and do have the potential for widespread abuse.

About four percent of the youngsters in high school are heavily involved in polydrug use. They drink, smoke marijuana, and use other drugs too. Most use amphetamines or uppers and have tried hallucinogens. Many are using quaaludes and PCP (angel dust). A few also take barbiturates. These can be very dangerous drugs, but even worse than the effects that the drugs can have is the fact that these young people are living a drug-oriented life style. Drugs have become a very central and important part of their lives and are almost bound to interfere with their work as well as their social and personal growth.

There are a number of factors that appear to be associated with drug use. First, it is very clear that peer influence is quite strong with respect to drug use. If a youngster has a lot of friends who use drugs and the friends encourage use, he or she is more likely to use drugs. By contrast, when their friends would work hard to stop them from using drugs, they are much less likely to start or continue drug use.

The next important factor is parental influence. Where relatives are clearly against drug use and where parents show a greater attitude of caring toward their children, there is less drug use.

A third important area is school adjustment. We found that youngsters who liked school and who seemed to be getting along well with teachers tended to use fewer drugs. We cannot tell at this point whether poor schools actually cause drug use or not but it is clear that youngsters who are using drugs are also having difficulty in school. It can only be hoped that the school will not react negatively to these youngsters and further alienate them, but would respond as a resource and a source of encouragement toward non-use of drugs.

We cannot tell at this point whether poor schools actually cause drug abuse or not . . . It can only be hoped that the school will not react negatively to these youngsters and further alienate them. . .

The work to date has been strictly correlations. That is, we can find patterns that seem associated with drug use but it is difficult to specify exactly what causes this problem. The area of school adjustment is an example of this. Does poor adjustment lead to drug use or does drug use lead to poor school adjustment? To find the answer to this type of question we will need to do longitudinal research. We will have to survey the same children at two different points in time to see what changes occur. We will be doing this work over the next several years.

The patterns of drug use mentioned here are based on aggregate data from many sites. There are distinct differences from tribe to tribe and school to school which must be recognized if this type of research is to be useful. Different patterns of use require different prevention and

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Indian people without having to jump through the hoops that would be required in order to comply with the Comptroller General's unconstructive ruling in the Norton Sound case."

NIHB also testified in favor of the language approved in the Senate markup, and adopted earlier by the House Appropriations Committee, which states that funds provided to IHS in FY 1980 and FY 1981 "may be used for one year contracts and grants which are to be performed in two fiscal years, so long as the total obligation is recorded in the year for which the funds are appropriated."

An example of the impact of the Norton Sound ruling can be seen with the Cherokee Nation of Oklahoma. If the decision were implemented, the Cherokee tribal health department would have been required to turn back more than \$70,000 at the end of FY 1980 (September 30, 1980). With the Norton Sound ruling nullified, the tribe can carry over those funds into FY 1981 (which begins October 1, 1980).

Referring to the equity fund, the Senate Committee stated in its report that "the fund is only intended to soften the impact of *Rincon*'s implementation during fiscal year 1981 . . . IHS (is expected) to develop rational criteria for funding distribution and apply them to the 1982 budget."

In creating the equity health care fund, the Senate Committee followed action taken earlier by the House in recommending that the fund be offset with a reduction of \$3.6 million in hospital and health clinic programs, and the elimination of budget increases of \$798,000 for dental programs, \$1.8 million for contract care, and \$2.2 million for tribal management.

According to a representative from the Cherokee health department, negotiations are now underway with IHS to use those carryover funds to expand present services and possibly contract for a physician for the tribe.

Overall, it is estimated that tribes and Indian organizations would have lost approximately \$9 million if the Norton Sound decision were allowed to stand.

Addressing other IHS administrative areas, the committee expressed its concern over problems caused by IHS staff shortages. The committee recommended that IHS initiate a demonstration project to determine the feasibility of lifting position ceilings and managing solely through fiscal controls. This demonstration project, which was advocated by NIHB in its testimony, will be limited to two IHS areas for a period of two years.

In action similar to that taken by the House Appropriations Committee, the Senate established a new equity health care fund of \$7.9 million in response to the Federal district court's decision in *Rincon Band of Mission Indians v. Califano*, in which the court determined that IHS funds were unconstitutionally denied California Indians. The Court's decision also required IHS to develop criteria for a more equitable distribution of its funds nationwide.

In an important difference from the House, the Senate Committee recommended an increase of \$2 million for maintenance and repair of IHS health facilities. The Committee added that this increase be offset with a \$2 million reduction in Indian health manpower programs.

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Notes From the Executive Director:

The many activities of Native American people in regard to their participation in Self-Determination are reflected in numerous activities. Since P.L. 93-638 (The Indian Self-Determination and Educational Assistant Act) came into existence, Tribes and groups of Tribes, as well as Alaska Native villages, are exercising their rights to contract programs and projects that fit into their plans. These projects are implemented to fulfill local needs to the fullest extent possible.

The efforts being expended have come under much scrutiny by the news media in many areas of our Nation. Each time they find a reason to be critical of what is being done by a program, they jump all over it like "stink on a skunk". I see nothing wrong with criticism as long as it is constructive. The problem is, most criticism that hits the newspapers and other media is so destructive that it tears down all the good things that are involved with a program. That type of criticism tears families and friendships apart. It creates so much division that sometimes it takes years to recover.

Each of us, whatever it is we do, must come under some form of criticism. I suppose it is just human nature. However, I would like to propose that we be critical of our operations to such a point that we try to determine how we can improve on a project rather than tear it apart. I would like to propose that instead of downgrading a program for what it is doing wrong, offer your advice and services to help it do a better job.

This is what the National Indian Health Board is trying to do. NIHB has many obligations. We are responsible to the Indian Health Service to help them do a better job. We provide advice and counsel to their personnel through our resolutions process and personal contacts. We are responsible to our people in that we must do everything possible to improve the health care delivery system. We must hear their voices, which express their need and their desires, and then we must speak to these needs and desires.

You and I have our own personal obligations, but if we are in a position of leadership our responsibilities are greater. Therefore we are required to study and learn more so we can better express ourselves and do a better job in representing our people. Our tribal leaders daily "mail call" is so great that it is almost impossible for them to read and comprehend it all. Then after that, they have to attend to their enormous Tribal responsibilities. Someone once asked "why

does a person aspire to be President". Sometimes I wonder, "why does a person aspire to be a Chief, a Chairman, a Governor, or Councilman", because there is so much work to be done.

It takes a person with a special feeling for people to aspire to these positions and then be willing to take all the "guff" that goes with it. I am proud that we do have men and women willing to serve. I am proud that we have Native Americans willing to "take the plunge" and do their best.

Tribal leadership is going to be involved in many decisions these next few months. National conferences will be held, workshops will be conducted, and problems are going to be presented and hundreds of our people will be required to be involved in the decision-making process.

I urge each of you to make every effort to attend these programs and be active participants. Time is of the essence so don't waste it when you attend one of these conferences. It costs lots of money for each of us to get there, so make a special effort to utilize every minute of the conference.

When a workshop cannot start on time because of the participants not being there, it stumbles in meeting its responsibilities to the whole meeting. When you and I aren't there on time, are we fulfilling our responsibilities to our people back home who couldn't attend because of work or lack of money to get to this meeting? Just because they aren't in attendance at the meeting does not reflect their lack of interest.

So we will be looking forward to seeing and working with you on health issues at these conferences. ■

J.W.

NATIONAL INDIAN HEALTH BOARD

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Chicago, Denver, Oklahoma City, San Francisco, and Seattle. The Alaska programs will continue under the Anchorage Area Office.

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DALLAS, TEXAS—The National Indian Education Association will hold its 12th annual convention here October 19-22. Theme for the convention is "Indian Education in the 80's — From Survival to Quality." Further information on the convention can be obtained from the National Indian Education Association; 1115 Second Ave. South; Minneapolis, Minn. 55403. Phone: (612) 333-5341. ■

Need for Cooperation, Unity Cited at NIHB Special Meeting

DENVER, CO.—The lack of mutual support, coordination, and unification among national Indian organizations, Indian health boards, and tribes prompted the National Indian Health Board (NIHB) to hold a special meeting here August 20-23 in a concentrated effort to address these problems.

According to NIHB Executive Director Jake Whitecrow, the purpose of the meeting was also to focus on what other national organizations, tribes and health boards are doing in the area of health and how support for these efforts could be strengthened. Whitecrow stressed the "sharing of knowledge and health information with each other and the unification of effort among tribes and Indian organizations."

Attending the meeting were representatives and executive directors from national Indian organizations such as Americans for Indian Opportunity, the National Indian Council on Aging, the National Urban Indian Council, and the Indians Into Medicine program.

Also represented were executive directors from the Alaska Native Health Board, the California Rural Indian Health Board, and the Phoenix Area Indian Health Board.

Tribal health officials represented the Navajo tribe, the Ute Mountain Ute tribe, the Yankton-Sioux tribe, the Chippewa tribe of Minnesota, and representatives from Fort Yates, Montana, and Standing Rock, North Dakota.

The problems concerning the national Indian organizations that were addressed at the meeting included: a general lack of unified work and support for one another; duplication of efforts and programs; and a lack of communication and program coordination.

Marianna Rey, staff member of the Americans for Indian Opportunity (AIO), stressed her organization's concern with the lack of coordination among other national Indian groups and expressed the wish to see future sharing of ideas and programs.

The AIO, according to Rey, was founded 10 years ago to serve as a liaison between tribes, urban groups, and federal

agencies. The organization has been conducting a two-year survey of environmental health impacts resulting from energy development on Indian lands, says Rey. She stated that AIO realized that "you can't put environmental impact planning in a federal vacuum."

The findings of the study, according to Rey, will be printed and beginning this October seminars pertaining to their findings will be held regionally throughout the country. "We are not experts, but we think we can raise some questions about environmental health and natural resource development," she said.

Al Elgin, Executive Director of the National Indian Council on Aging (NICOA), addressed the meeting with an update of his organization's functions, purpose and goals. According to Elgin, the 39-member council is an advocacy organization that utilizes and gains access into federally funded programs for the Indian elderly. They have in the past helped bring about new legislation pertaining to the Indian elderly, specifically Title VI of the Older Americans Act.

The overall purpose of NICOA is to establish improved, comprehensive services to the Indian and Alaskan native elderly. Specific objectives are based on recommendations formulated at the 1976 and 1978 National Indian Conferences on Aging, said Elgin.

But he stressed that his organization still has problems with "getting their message across in an accurate manner." He stated there is concern with the feasibility of their program objectives. "Sometimes there are problems with local, regional and national objectives and how we all can coordinate," he said.

Area Health Boards

Concerns were also voiced by area health board directors attending the meeting. Similarities surfaced in

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PHIL NORRGARD (middle), of the Fond Du Lac Reservation in Minnesota, related his tribe's problems and concerns to Dr. David Cates (left), director of the Alaska Native Health Board and Perry Raglin (right), executive director of the California Rural Indian Health Board.

areas such as board management, communication, contracting, funding and overall credibility.

Representing the Alaska Native Health Board, Dr. David Cates said the problems facing Alaska's 74,000 Native population are unique. "We have severe communication problems, with most villages only having one or two telephones and no television," Cates said.

Another problem is the difficulty with evacuation services. "Most of the time when a person is ill and in need of hospital or emergency care, they are flown by airplane to the nearest hospital or medical facility. But sometimes when the weather is bad, a plane cannot takeoff or land," he said. Sometimes radio messages to doctors can't get through, and when that happens the community health aids take over, according to Cates. "These people are trained like military medics and sometimes are the only medical person in a village."

The major health problem in Alaska, according to Cates, is alcoholism, which he says is evident among even the very young. "We have seen children as young as seven or eight years of age with drinking problems."

Other problems cited by Cates were legal difficulties with IHS, contracting, and health board management.

Acknowledging and supporting Alaska's problems was Jim Porter, executive director of the Phoenix Area Indian Health Board, Porter said his board has communication problems, but is steadily improving its communication processes. "We are trying to establish better feedback and communication among the tribes, and provide them technical assistance and education."

Specific concerns for the California Rural Indian Health Board (CRIHB) is funding, said executive director Perry Raglin. CRIHB's Indian controlled health clinics are located in rural areas throughout the state and receive funding from state and federal agencies, third-party reimbursement, and membership, says Raglin.

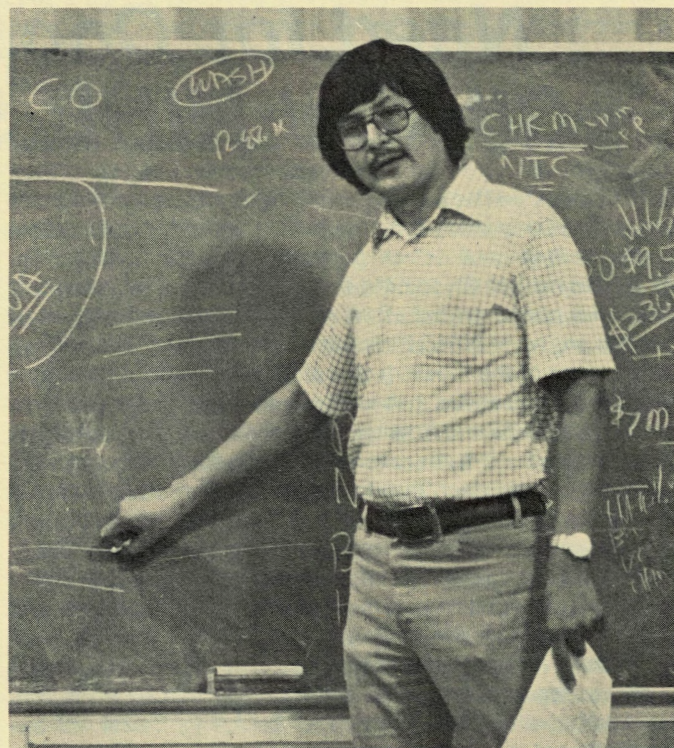
CRIHB's 15 health clinics provide medical, dental, outreach and other health related services to Indians in rural California including reservations, rancherias, and rural Indian communities. CRIHB also provides services in program planning, property and financial management, Raglin explained. "We see our future objectives in the areas of improvement and expansion of programs and services that are culturally sensitive to the community," he said.

. . . not enough legal information

Tribal health concerns voiced at the meeting included competition for funding, the lack of shared federal and tribal legal information, and day-to-day coordinating of health programs.

Phil Norrgard of the Fond Du Lac reservation in Minnesota said the tribes locally and nationally are highly competitive for funds and suggested that a "money-bank" be established specifically for tribal contract proposals.

Representing the country's largest reservation, Ron Wood, director of the Navajo Nation's Division of Health Improvement Services, said that IHS does not provide tribal health programs with enough legal information, specifically pertaining to Indian self-determination laws and regulations. Wood also said that environmental health hazards affecting his tribe have not been properly addressed by the federal government.



RON WOOD, Director of the Navajo Nation's Division of Health Improvement Services, describes his tribe's complex health care system to meeting attendees. Wood also stated the need for an "alternative information flow" to increase his tribe's awareness of other programs and alternatives.

The final presentation of the meeting was given by Dr. Lois Steele, director of the Indians Into Medicine (INMED) program at the University of North Dakota School of Medicine. Dr. Steele said INMED works to design health professions scholarship programs and strongly encourages Indian youth and adults to enter the health professions. The program is reservation based, representing 22 reservations in the five-state area of North Dakota, South Dakota, Nebraska, Montana and Wyoming. An all-Indian advisory board appointed by the tribal council from each reservation serves in the direction and success of the program.

According to Steele, the INMED program approaches its goal from many directions. By working with Indian communities (with an INMED staff liaison), a pool of Indian students who show an aptitude towards a medical career are identified, beginning from the elementary school level through the college level. Steele said the junior and senior high school and college student recruitment program also draws from this pool.

Other concerns voiced by Steele were the need for more financial and emotional support from families and health educators, especially for women. "Young women are not being encouraged to enter the health professions, especially in reservation schools where women are weak in the science or math areas," Steele said.

The final day of the meeting offered films from several area health boards throughout the country, with Whitecrow continuing to stress the need for "improving the communication process across the country that would allow for unified action in Indian health care." ■

Indian Mental Health Issues Examined at White Cloud Workshop

By Ann Goddard, Publications Coordinator
White Cloud Center

PORTLAND, ORE.—White Cloud Center, the National Center for American Indian/Alaska Native Mental Health Research and Development, held its third annual research workshop here June 11-12 with approximately 40 people attending, including both researchers and service deliverers from all over the United States and Canada. The purpose of the workshop was to generate ideas on what research should be done on American Indian families and other topics.

An honored guest of the meeting was Barbara Whitecloud, widow of the late Dr. Thomas St. Germaine-Whitecloud II for whom the Center was named. Mrs. Whitecloud spoke about her husband's commitment to improving the health and mental health of American Indians.

Marlene Echohawk, of Oklahoma State University in Stillwater, Okla., showed a film she produced on Indian children. The 30-minute, narrated movie depicts Indian children (mostly Plains and Eastern tribes) at school, at play, and at home, showing contemporary values and lifestyles among Indian people. The film will be available for distribution from the White Cloud Center in the near future. Video tapes (3/4") are also available.

One of the topics of discussion among the participants centered on the coping and adaptation behavior of American Indians and how it should be studied. The priorities determined by the group for research in this area included: (a) development of knowledge sharing using the White Cloud publications and bibliography, conferences, other newsletters, etc.; (b) determine how people view stress on individuals and the community by taking polls, using indirect measures, and using objective views of stress; (c) seek greater understanding of social support systems, including description of such systems, correlations between their use and outcomes illustrating functional and dysfunctional behavior, and developmental studies; (d) research on locus of control (a perception of the individual's on where control over one's life lies) including a literature review, studies of survival of students in university life, and correlations between childrearing practices and perceptions of locus of control in later life; (e) understand the dependency of Indians on the federal government and how it is reflected in their mental health; (f) research the impact of loss of roles resulting from the dependency on the federal government and other political/social changes; and (g) develop the processes of program evaluation and research evaluation, including process and outcome evaluations.

Another focus of discussion was the role of families in the development of individuals throughout their lives. One of the conclusions reached by the group was that too often research among Indians has focused on their problems, and not often enough on their strengths and on those people who have become successful.

Using this positive approach, several research topics were outlined: (a) What traditional cultural experiences are particularly significant in a person's development? (b) How can prenatal care be improved? (For instance the fetal

alcohol syndrome and nutrition appear to be important in the individual's later development); (c) How do childrearing practices differ among Indians and between Indians and non-Indians and of what significance are these differences? (d) How do cognitive styles, which are different among Indians, affect childrearing practices and early education? (e) What social support systems may be called upon to help children placed in boarding schools? (f) What are appropriate role models for Indian adolescents? and (g) What is the significance of the presence or absence of ceremony and ritual among urban Indian adults?

The participants desired to see positive, descriptive analyses of Native culture and what it can contribute to non-Indian cultures in the areas of childrearing, religious outlooks, ritual and ceremony, living with the elderly, and living in harmony with the environment. Also needed are descriptive studies of successful, mentally healthy Native people, and comparative studies of people maintaining the old ways and those who have adopted new ways.

The third major topic of discussion was epidemiology, the study of the prevalence and incidence of, in this case, behaviors. The participants were particularly interested in researching how Native Americans handle anger. For the topic of epidemiology, participants again wished to focus on the competent moments in people's lives.

The workshop not only identified a number of areas of research on which the participants will work in the future, but familiarized each person with the variety of programs across the continent which are dealing with American Indian mental health. Another workshop will be held next year during the week preceding the Rose Festival in Portland, the first week in June. Focus next year will be not only on research topics but also on information useful to service providers. ■

Senate

Continued from Pg. 5

Other major provisions of the Senate Committee markups included:

- a provision to lift travel ceilings for patient care. Administrative travel would still be subject to imposed ceilings
- a decrease of \$1.8 million for contract care in general, and an increase of \$2 million to provide increased services to Arizona Indians, and \$1 million for the Pawnee service unit in Oklahoma
- a decrease of \$1.5 million in the community health representative program
- an increase of \$900,000 for urban health projects
- funding for construction of hospitals in Chinle, Ariz., and Tahlequah, Okla.; for planning and design of hospitals at Crownpoint, N.M., Kanakanak, Alaska, and Browning, Mont.; and health clinics at Anadarko, Okla., Tsaile, Ariz., and Huerfano, Ariz.; and personnel quarters at Lodge Grass, Mont.

Overall, the Senate Committee recommended an IHS FY 1981 budget of \$592,332,000 for health services and \$84,469,000 for health facilities. The budget must now be reviewed by a House-Senate conference committee to resolve differences between the two appropriations bills. ■

INDIAN COMMUNITIES across the country are taking a more active interest in the potential health hazards related to energy development on their reservations.

Pictured here are members of the Church Rock Action Committee meeting with officials from United Nuclear Corporation following last year's spill of radioactive waste into the Rio Puerco river. More than 100 Navajo families recently filed suit for damages resulting from that spill.

(Photo by Paul Natonabah)



Uranium Millworkers for Ill Effects of

As the vast energy resources on different Indian reservations continue to be explored and developed, tribal leaders are expressing their concerns about potential health dangers related to these activities, especially uranium mining and mill operations. Although health studies on the subject are unfortunately few and inconclusive, many believe that workers involved in these activities in the past are now suffering from unusually high rates of disease, particularly cancer.

In the following article, Marjane Ambler discusses the efforts of uranium millworkers to gain compensation for damages they believe to be caused from excessive exposure to radioactive materials. To date, their fight has been a difficult one and it may still be several years before disabled millworkers receive any kind of compensation.

Ms. Ambler is presently investigating Indian energy policies and their effect on tribal self-sufficiency. We wish to thank the Alicia Patterson Foundation for permission to print this article. Comments on Ms. Ambler's discussion should be sent to the NIH Public Information Office.

SHIPROCK, N.M.—Grace Begay can't leave her husband Steven, 64, alone. She follows him around the house, afraid that he'll black out again with no one there to help him. As he sits patiently describing his symptoms in Navajo through an interpreter, he holds his arms crossed to still the otherwise constant tremor in his hands. He has seen eight doctors in the past 17 years, none of whom can figure out what's wrong with him.

For 10 years Wallace Martin, also a Navajo, has known there is something wrong with his lung. When he tries to walk faster, he has trouble breathing. Doctors kept telling him

there was nothing wrong with him until finally they saw the evidence of silicosis in his lung. "That uranium got me," he explained.

Henry C'Bearing, an Arapahoe Indian in Ethete, Wyo., also has trouble breathing sometimes. He claims he has felt "lazy" and lethargic for several years.

Most of Bob Haddenham's hair has grown back, and he no longer blacks out in the middle of sentences, but his bitterness has not abated. A resident of Riverton, Wyo., he believes the Eisenhower Administration used him and his co-workers as guinea pigs to test the effects of radiation, and he has devoted his limited energy in recent years to completing a file that his wife can use to seek compensation after he dies.

While these men and others who worked in uranium mills 15 to 20 years ago now suffer hundreds of miles apart, they have much in common. At least partially disabled, they share many of the same symptoms — unexplained blackouts, skin sloughing off, constant fatigue, asthma, chronic bronchitis and susceptibility to colds.

When they blame their afflictions on the uranium mill work they are written off as kooks or just looked at skeptically by peers and professionals. Until now, they have hesitated even to try for compensation because most of their symptoms showed up years after they stopped working at the mills.

Doctors, confronted with a confusing array of symptoms, tell these workers that they're diabetic or epileptic or not sick at all. If they are Indian, their health problems are assumed by some people to stem from excessive use of alcohol.

Lawyers won't take compensation cases without statements from doctors saying the ailments are

occupational in origin. Because working conditions in the mills were so much better than in the dogholes where the miners worked, most research has focused on the mines. Almost no health studies have been conducted on millworkers, so even sympathetic doctors don't have the necessary evidence to support claims that the health problems are work-related.

Someone finally is listening to these millworkers, however, and saying that their special problems should at least be investigated further. Dr. Leon Gottlieb, a pulmonary specialist formerly with the Shiprock Public Hospital in New Mexico, backed by Joseph Wagoner, a Public Health Service researcher in Washington, D.C., has convinced Stewart Udall, former Secretary of the Interior, to represent two Navajo millworkers. William Tsosie and Elvin D. Smith now have joined the 65 uranium miners who are suing the federal government and uranium companies for compensation.

Like the miners, these men helped to produce uranium for the nation's nuclear defense program in the 1950s and '60s. After the miners removed uranium ore from the ground, the material was sent to nearby mills to be crushed, ground, treated chemically and extracted from the resulting solutions. The final product, yellowcake (concentrated

uranium dioxide), was then dried and packaged for shipping to enrichment plants in the East.

furor that, according to a memo from Duncan A. Holaday, an industrial hygienist with the U.S. Public Health Service, it was "unadvisable" to survey the other uranium mills at that time. The article described mainly the toxic chemicals in the air, but as a result of the story, several workers from Naturita and other mills wrote to the Colorado health department inspector describing symptoms that indicated silicosis (scar tissue in the lungs) or radiation poisoning.

When other mills were subsequently surveyed, operators were assured the information would not be released in the newspapers. The reports are now stored in the files of the National Institute for Occupational Safety and Health (NIOSH). But "great care was taken not to identify the mills," according to NIOSH officials. Consequently, the reports are of little use in litigation today.

Holaday, who conducted many of the inspections, has since retired. He doesn't think that millworkers contracted diseases other than silicosis from their work. The dust in the mills, which under certain conditions could cause lung cancer and other diseases, was not that difficult to control, Holaday said recently. "Most of the mills did a beautiful job after we ran a few courses for their people on ventilation," he explained.

Seek Compensation Radiation Exposure

uranium dioxide), was then dried and packaged for shipping to enrichment plants in the East.

Then, as now, most of the mills were located in New Mexico, Colorado, Utah, Arizona and Wyoming. Several mills were operating on land bought or leased from Indians like the facilities at Mexican Hat, Utah; Shiprock, N.M.; and Monument Valley and Tuba City, Ariz. Many mills, including those on Indian land, closed down in the '60s after the nation had stockpiled enough uranium for its defense program and before there was much demand for fuel for nuclear power plants.

The number of millworkers who became disabled during that era doesn't approach the number of miners, 600 of whom have been screened by the Shiprock Hospital alone. But Udall and community-health representatives on the Navajo Reservation are convinced there are many more than have surfaced so far. While some have been disabled for years, others have only recently become cancer victims because of the long latency period typical of the disease.

When Udall began investigating the potential for a millworkers' suit, he found that in the late 1940s, when people first became alarmed about the exposure of uranium workers to radiation, they were concerned about both mines and mills. It was only later, when it became evident both money and investigating manpower were scarce, that the effort focused exclusively on the miners.

The mill investigation got off to a bad start. A front page story in The Denver Post of July 8, 1949, on an inspection of the Naturita uranium mill was headlined "A-Plant Fumes Lethal in Hour, Say Officials." The article created such a

However, some of the older mills — Naturita, Rifle and Uravan — which had been operating since the 1920s were notoriously dirty, he remembered. "What they needed most was a new plant."

"Most of the mill operators were trying, but they weren't really competent. They put in fancy ventilators that just got all the dust circulating because they hadn't bothered to clean up first. One place we offered to put in a ventilator for free if we could just keep the dust that they lost out of their stacks each day," Holaday said.

The mill at Shiprock on the Navajo Reservation was "a real mess," he noted. A few years after it closed in 1968, a Navajo cleanup crew found at least \$100,000 worth of yellowcake between two layers of roofing, according to Harold Tso, director of the Navajo Environmental Protection Commission. Apparently the dust had settled in the old roof, and no one had bothered to clean it out before a new roof was built over it.

Men who worked at various mills tell of stirring yellowcake with rakes in open, steam-heated floor pans. They were given cloth respirators to cover their noses and mouths, but sometimes even these primitive safety devices weren't cleaned, and men would use them still caked with residue from the previous day. Since the millworkers often weren't told that uranium could be dangerous, some men wouldn't bother to wear the respirators at all. In the early years, workers would eat their food in areas thick with the hazardous dust. Men who worked at the Susquehanna-Western plant near Riverton say that the drinking fountain sometimes wouldn't work, and when they took it apart, they

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would discover that it was clogged with yellowcake. One worker said he would take the mandatory shower at work, but the water was so contaminated that he would take another shower when he got home. The second shower still left a yellow residue in the bottom of the tub.

As early as 1959 the uranium mill operators and the U.S. Atomic Energy Commission were predicting compensation suits, and the Atomic Energy Commission (AEC) reportedly was cautioning mill operators to avoid actions which might provide evidence.

According to a memo prepared by Lew Hazen, a consulting engineer for Susquehanna, Dr. G. V. Beard of the AEC told mill operators not to give employees copies of the radiation tests. Speaking at a meeting of the AEC and mill operators in Grand Junction, Colo., in April, 1959, Beard reportedly said that once you admit an employee has been contaminated with radiation, then you "get into another category and it would cost everybody an awful lot of money to comply with regulations. Under no circumstances would the AEC tolerate or permit any licensee to admit that any employee had a 'body burden' of uranium."

Hazen's interpretation of Beard's remarks imply that he would just as soon not know if someone were exposed to excess radiation. However, Holaday doesn't believe this is true. While he cannot remember attending this particular meeting, he was familiar with Beard and says Beard was just reminding the operators of the importance of meeting the standards. "Mr. Walker (D.I. Walker of the Division of Inspection, AEC, Idaho Operations Office) said that if a mill could show that concentrations in certain parts of the plant must be higher than MPC (maximum permissible concentrations) he had authority to give, and would give, permission to operate under these higher conditions."

About 10 years later, some of the mills were closing down. A few millworkers were tested to see if radioactive elements had been deposited in their lungs, but nothing was found. Wagoner and Dr. Victor Archer of NIOSH studied 104 former millworkers who died prior to 1968 and found three more cases of cancer of the lymphatic and hematopoietic tissue than would have been expected. Archer said the results were considered suggestive but not necessarily conclusive, however, because the study group was small.

NIOSH started a larger study of millworker deaths, but the project was dropped for several years because of higher priorities, principally the uranium miners. By then, attention was focused on radon daughters as the principal radiation problem among uranium workers, and these radionuclei were thought to exist only in the mines.

Now, more than eight years after Wagoner and Archer warned of health problems peculiar to millworkers, the government is resuming its studies into the hazards of this occupation. The Nuclear Regulation Commission (NRC) has just funded McDonald E. Wrenn of the University of Utah Medical School to study lung tissue from millworkers who have died. NRC claims the study is routine, confirmatory biological research which, it points out, was proposed by Wrenn — not the NRC. Wrenn, however, says that the radiochemical techniques he will be using are much more sensitive than previous methods and may find evidence of contamination that earlier studies of the lungs of live workers might have missed.

Coincidentally, Dr. Richard Waxweiler of NIOSH is continuing the agency's study of millworker deaths that was dropped several years ago.

Wagoner thinks it is about time. The fact that the U.S. government has not conducted more research is evidence

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REPRESENTATIVES FROM THE Navajo Nation testified last fall before the House Subcommittee on Energy and the Environment on last year's uranium mill tailings accident at Church Rock, N.M. Pictured left to right are Harold Tso, director of the Navajo Environmental Protection Commission; Dr. Thomas Gesell, tribal consultant and health physicist; tribal vice chairman Frank E. Paul; and Helen George of the Church Rock Action Committee. (Photo by Paul Natonabah)



SIGNS ALONG THE Rio Puerco River on the Navajo Reservation warn residents of the potential dangers of contaminated water resulting from a large spill of radioactive waste last year at Church Rock, N.M. Health hazards from uranium mining and mill operations are becoming a growing concern to tribes around the country.

(Photo by Paul Natonabah)

Uranium

Continued from Pg. 12

that it has been negligent in its responsibility to protect people from radiation, he thinks. In light of the biological evidence already accumulated, he contends that additional studies are also needed to examine all health effects in millworkers.

Such studies are crucial to attempts to get compensation for the millworkers. While the health effects of radiation have been widely studied, the research has not found diseases peculiar to this cause. In other words, radiation victims get lung cancer, leukemia, bone cancer, skin cancer, but so do people who are not exposed to excesses of radiation. Radiation victims also age faster and their natural immunities to other diseases are broken down.

As the AEC told Congress in 1960: "It is impossible for a workmen's compensation program to provide compensation for all cases of occupationally connected diseases or disabilities without also providing compensation for nonoccupationally connected cases of disease or disability in several major classes of diseases."

Consequently the burden of proof is on the employee to show the connection.

While these new research efforts and Udall's suit are hopeful signs to some of the disabled millworkers, they realize the benefits — if any — are several years away. Their numbers are smaller and generally speaking, their problems less severe than those of the miners. So for now, they must wait their turn for medical and legal attention.

Udall and his associates have all they can do to represent the miners and fallout victims. The Indian Health Service in Shiprock has been strained beyond its limits just to screen all the miners who have shown up.

"The horror of this is that it isn't over," Udall said. "We can't just say we've picked up the wreckage and it's over. I just got a call yesterday saying another Navajo miner has died. The work is going to go on and on . . . We just must be patient." ■

Applicants Sought for Alcoholism Treatment Grants

BALTIMORE, MD.—The Health Care Financing Administration, in conjunction with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), will administer a grant program for the purpose of demonstrating the feasibility and effectiveness of providing alcoholism treatment services in Medicare and Medicaid programs using less expensive free-standing residential and outpatient settings than traditional covered settings.

Demonstrations will be funded up to a maximum of four full years. The anticipated funding for these demonstrations includes up to \$1 million for the administrative costs in FY '81.

Approximately five umbrella grantees will be selected to participate in this demonstration. They will represent different geographical sites. At least one site will have a substantial American Indian population. Each grantee must include the following providers: free-standing inpatient centers, halfway houses, and free-standing outpatient centers.

Applications must be developed in cooperation with the State Medicaid Agency and show compliance with State certification, licensing requirements and areawide clearances. Selected grantees must be prepared to comply with required uniform billing, accounting and data gathering procedures, and participate in a related training program. A uniform benefit schedule of covered services will be implemented.

The design of the application must conform with the program goals and objectives contained in the guidelines for this program. Since this is intended to be a coordinated demonstration utilizing five sites, it will be necessary for each grantee to follow prescribed demonstration research design and evaluation methods.

Grant funds will cover administrative costs only; allowed service costs will be covered by Medicare and Medicaid as appropriate. Detailed guidelines with an application kit will be available to interested parties after the publication of this solicitation in the Federal Register. These may be obtained by calling (301) 594-3332 or writing: Project Grants Branch, Office of Management and Budget; Health Care Financing Administration; Section E-1, 1710 Gwynn Oak Avenue; Baltimore, Maryland 21207. ■

at AAIP annual meeting

Indian Doctors Attempt to Bridge Gap Between Traditional and Modern Medicine

ALBUQUERQUE, N.M.—Off in the Dakotas, a medicine man prays for the sick inside a wooden sweat lodge. As the hot vapors rise and fill the room, the medicine man works to heal the sick and restore harmony between his patient and the environment.

Meanwhile, inside a city hospital a trio of cardiovascular surgeons peering through specially-designed eye glasses work on tiny blood vessels traced across a patient's heart surface. A coronary bypass operation that is meant to decrease severe chest pain and prolong life is in progress.

Two healing systems, one "traditional" in Indian culture and the other "modern" in Western culture, still co-exist — each with its own distinctive tools for healing.

In an effort to broaden understanding and to "bridge the gap" between the two, the Association of American Indian Physicians (AAIP) held its tenth annual meeting here August 1-2 with an objective of examining some possible interrelationships between traditional Indian healing and "modern" scientific medicine.

The two-day seminar featured interchanges between traditional medicine healers, Indian physicians and medical students, a Canadian herbalist, Western physicians and guests. Presentation on the tribal concept of health, disease and healing were given by representatives from the Hopi, Sioux, Navajo and Lummi tribes. Indian Health Services (IHS) representatives Edgar Monetathchi, Jr. and Dr. Frank Clarke presented an IHS Indian physician's perception of

healing and comparisons between traditional Indian medicine and Western medicine — Western medicine with its emphasis on scientism, and traditional medicine with its emphasis on religious, spiritual, philosophical, and counselor-healer services.

According to AAIP Executive Director Bill Wilson, the basic format of the meeting started over a year ago, and the decision to publicize information and practices of traditional Indian medicine was a difficult one.

"Over a period of several years, we have had visits with various traditional healers and they all seemed to share common problems on how they could work with their patients in conjunction with the Indian Health Service," said Wilson. "So, based on those different conversations, AAIP decided to have a conference. Our feeling was that Western physicians don't have enough knowledge of traditional Indian medicine and that this would be a way to share information on both sides."

As an independent organization, AAIP provides counsel to IHS while working towards the organization's major objectives — to raise the level of health services and care given to American Indians and Alaska natives, and to increase the number of Indians working in the health professions.

An example of AAIP's educational emphasis, according to Wilson, will be to present IHS with video tapes taken from

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DR. GEORGE IGNACE (left), President of the Association of American Indian Physicians, discusses commonalities and differences between traditional Indian medicine and possible recommendations from the meeting's participants to the Indian Health Service with Dr. Robert Bergman (right), Director of Post Graduate Education at the University of New Mexico School of Medicine.

the annual meeting so that incoming doctors not already sensitized to traditional medicine and healers can begin to learn about traditional healing philosophies and practices.

The AAIP meeting began with a presentation by Monetathchi, a specialist in traditional Indian medicine, who spoke about significant differences between Western physicians and traditional healers. He stated that Western physicians relate only to the body and the mind, and they rely on empirical scientific data.

In comparison, the traditional medicine man speaks with the "spirit" first and then concentrates on the body and mind of the patient, says Monetathchi. "Medicine people will not take the person's responsibility of the illness away. If help is wanted, the medicine person will help the sick heal themselves. And by the very fact of asking to be healed, the door is open for healing."

Monetathchi further stated that in traditional medicine everything is considered alive and living — everything has a "consciousness" and should be treated with respect. "Human beings should be treated the same way," says Monetathchi, "rather than being rushed in and out by a Western physician who is usually overworked. Medicine people can't be rushed — each person that comes is important."

Also featured at the meeting were four tribal medicine men who displayed strikingly similar features in their healing practices and philosophy. Most of the healers acknowledge patience, practice and intense memorization processes as part of their training.

Presenting his concept of health, disease and healing was Archie Fire Lane Deer, a member of the Rosebud Sioux tribe. Lane Deer expressed his dismay at not having access to IHS hospitals throughout the country and cited the need for monetary support from IHS.

Navajo medicine man Fred Stevens revealed the active practice he and others are experiencing in New Mexico and Arizona. According to Stevens, there are many Navajo healing ceremonies. They can vary from two to nine days and are very complicated, he said.

Stevens stated that the ceremonies are handed down from generation to generation and each one is specific to a certain type of illness or may employ a hand-trembler or other diagnostician in order to decide which medicine man (singer) to send for. The ceremonies, said Stevens, may also incorporate all the arts — prose, poetry, music, painting and often, dance. The ceremonies, some of which are called Beauty Way, Wind Way, Evil Way and Big Star Way, are part of a vast treasure of religious tradition that depicts a world in which everything is alive, has a consciousness and can be subject to disharmony with the environment.

Hopi medicine man, Soloho, remembered that long ago he was warned by his family not to practice healing. According to the 85-year-old medicine man, he waited until he was middle aged to begin practicing traditional medicine. He uses many herbs for his healing ceremonies and believes that herbs can be used as effective cures for all kinds of sicknesses.

Final presentations of the day were given by an Indian physician, Dr. Fred Clarke, a member of the Walapai tribe; Dr. Robert Bergman, a psychiatrist at the University of New Mexico School of Medicine; and Dr. Leonard Duhl, professor of Public Health at the University of California at Berkeley.



AAIP EXECUTIVE DIRECTOR BILL WILSON (left) discusses ways in which traditional healers may be utilized by the Indian Health Service (IHS) with Archie Fire Lane Deer, a Rosebud Sioux medicine man.

Clarke, chairman of the National Council of Clinical Directors, revealed the struggle between the past and present interpretations of what an Indian doctor is. "Sometimes the burden of being one of the older Indian physicians can be overwhelming," Clarke said. "We are still trying to bridge the gap and are caught between two healing systems."

Clarke said that as an Indian physician he has had many unusual experiences, such as having sacred corn sprinkled on the ground as he walked. "I have also been shocked when people would accept me as a medicine man rather than a Western physician."

Bergman related his experiences with Navajo medicine men and a pilot program that was established for the purpose of training future medicine people in Rough Rock, Ariz. Through this experience and others, Bergman revealed that his attitude towards his patients changed.

"One thing a trained physician can learn from traditional medicine practices is that it isn't us that heals, but something beyond ourselves. That presence, or attitude, is the heart of the healing process," he said.

"Healing is not accomplished by techniques, but by an attitude. When talking about the principles of healing and being human, healing is one of the oldest ways human beings can be connected to each other," Bergman added.

In a final summation, Bergman discussed the traditional healing principles as he perceived them and why he believes they work.

"Traditional healers are bringing people back to mankind. Sick people are often lonely and alienated — they (medicine people) convey the notion that they know what the patient is up against by understanding the illness and the

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NIHB Supports Stronger Tribal Involvement in Nutrition, Mental Health Programs

FORT HALL, IDAHO—When Congress passed the Indian Self-Determination and Education Assistance Act (P.L. 93-638) almost five years ago, it gave Indian tribes an important new opportunity to administer and control programs that provide health services to American Indians and Alaska Natives.

One of the prime examples of tribes taking advantage of that opportunity can be seen on the Fort Hall Indian Reservation, where the Shoshone-Bannock tribes operate a number of key health-related programs. These tribally run services include, among others, a tribal health department, an elderly nutrition program, maternal and child health services, an emergency medical services program, a youth home, and an alcohol and drug abuse project.

With programs such as these, the Shoshone-Bannock tribes have demonstrated a commitment to Indian Self-Determination through strong tribal management and control of their health services as well as numerous other enterprises on the reservation.

This background seemed to set the tone for the summer quarterly meeting of the National Indian Health Board (NIHB) here August 7-10 as the board heard presentations emphasizing the role of tribal involvement in the areas of nutrition, mental health, health education, and health management.

An increasing number of tribes around the country are opting to run their own food stamp and commodity distribution programs — as provided for under the Food Stamp Act of 1977 — rather than leave the operation of those programs to state agencies, according to Robert Price, Chairman of the National Indian Food and Nutrition Resource Center (NIFNRC).

One of the major reasons that more tribes are seeking to control federally funded food programs, asserts Price, is due

Price explained that the assistance provided by the NIFNRC staff is especially helpful to tribes in developing the complex proposals for reservation food programs. "The field workers have been able to break down communication barriers in federal offices to obtain information necessary to assist tribes with their applications," Price said.

Each of the four NIFNRC field workers covers a specific geographic section of the country and spends at least 50 percent of their time working in the field. As tribes become more aware of the assistance offered by NIFNRC and more familiar with legislation permitting them to manage their own food programs, there will be an increasing number of applications for tribally-run food and nutrition programs, Price said.

While several tribes have succeeded in taking over the administration of food stamp and commodity distribution programs in most parts of the country, Price indicated that legal problems in the states of Oklahoma and Alaska have hindered efforts to establish such control in those two states. Price added that NIFNRC is presently engaged in a to the expanded technical assistance provided by NIFNRC's four field workers. "We have had several tribes establish food programs, and several others coming on board in the next quarter, that could not have done so without the assistance of the field workers," Price told NIHB.

NIFNRC was established in October of last year to serve as a national advocacy center for the nutritional needs of American Indians and Alaska Natives, and to assist those tribes wishing to administer federal food programs on reservations. The center is funded by the Community Services Administration (CSA), and operates under the organizational umbrella of NIHB, with its own board of directors and staff.

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SEVERAL NIHB REPRESENTATIVES and alternates were introduced to crowd attending the Shoshone-Bannock Festival at the Fort Hall Reservation. Pictured left to right are Juan Joe Cipriano and Muriel Ortigas, Tucson area; Tony Secatero, Albuquerque; Constance Waters, Portland; Lawrence Snake, Oklahoma City; Daniel Foote, Billings; Donald LaPointe, Bemidji; Timm Williams, California; Ethel Lund, Alaska; and Elwood Saganey, Navajo Nation.

"comprehensive effort to determine the best way to address these problems and allow the tribes there to administer their programs."

NIFNRC is also actively involved in providing tribes with assistance in establishing child nutrition programs and feeding services for the elderly, Price said. The center will continue to monitor federal legislation and regulations on matters related to food and nutrition programs, and expand its efforts to make this information available to tribes and Indian organizations, he said.

Mental Health

Addressing a potentially important new option for tribal involvement in mental health programs was Jack Bartelson, Region X division director for mental health programs. Bartelson brought board members up to date on the status of the Mental Health Systems Act (S. 1177) and its provisions for Indian people. (EDITOR'S NOTE: As we were going to press, President Carter was expected to sign the Mental Health Systems Act, which recently passed the House and Senate and contains the provisions discussed here.)

Two years ago, Bartelson explained, the President's Commission on Mental Health determined that the "existing mental health legislation was too restrictive and denied services to certain populations." Consequently, the Commission found "there is a need for major reform to bring the mental health program in line with what seemed to be more important priorities."

Under present law, an agency is required to provide a full range of comprehensive mental health services to qualify for program funding through the National Institute on Mental Health (NIMH). Services must also be organized for a "federal catchment" area with a population of 75,000 or more. Such requirements effectively eliminate participation in these mental health programs by certain populations, one of which is Native American living on reservations and other isolated areas, Bartelson said.

Passage of the Mental Health Systems Act would significantly alter the present funding process, Bartelson stated. Eligibility would be expanded to those programs offering only limited services (such as screening and outpatient counseling), which would allow tribes to start basic mental health services geared to the needs of their communities and then build up those programs over time, Bartelson explained.

Another important provision of the proposed law would allow tribes to contract directly with the federal government for mental health programs, rather than having to submit their funding proposals to state mental health agencies for approval.

Additionally, Bartelson said, tribes, urban Indian projects, and other organizations providing health services to Indians would be eligible for the bill's special funding programs to serve severely disturbed children and adolescents, the chronically mentally ill, and the elderly.

Health Education

NIHB members also received an update on the activities of the Association of American Indian Physicians (AAIP) from that organization's executive director, William Wilson.



LITTLE ANTHONY SECATERO listens to one of several presentations made during NIHB quarterly meeting at Fort Hall, Idaho, August 4-7. Anthony's dad, Tony, is NIHB Albuquerque alternate and chairman of the Albuquerque Area Indian Health Board.

In seeking to increase the number of Indian health professionals practicing in the country, AAIP is working on recruitment and retention programs for Indian students, Wilson said. AAIP serves as a clearinghouse for health careers information and provides training sessions for Indian students interested in pursuing careers as health professionals.

Two of those training sessions will be held this fall when AAIP will sponsor its pre-admission workshops for American Indian undergraduate students who are preparing for health professions careers. The workshops — which review the entire admissions process for health professions schools from initial application to final interview — will be held in Oklahoma City, Okla., Nov. 8-9, and Albuquerque, N.M., Nov. 15-16, Wilson said.

AAIP also sponsors a summer Live-In Program for Indian students interested in health professional careers, Wilson said, which "gives Indian students a chance to see first hand how Indian physicians live and work."

At the association's recent annual meeting, physicians met with traditional Indian medicine men to examine ways traditional healing methods can be used in today's Indian health facilities. Recommendations from the meeting on this delicate issue will be forwarded to the Indian Health Service (IHS), Wilson said.

Reporting on an NIHB initiative to increase tribal involvement in health management, NIHB Health Planner Sandi Golden told the board about her efforts in coordinating a series of three-day IHS budget training session that will provide tribes and Indian organizations with the technical information needed to participate in budget analysis and development at service unit and area office

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TAKING A BREAK from a busy meeting to discuss activities at the Shoshone-Bannock Festival are (l-r) Tucson area representative Juan Joe Cipriano; Tucson alternate Muriel Ortigas, and Alaska representative Ethel Lund.

NIHB

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levels. Golden stated that the purpose of this process is to enable tribes and Indian organizations to participate directly in the development of the IHS budget for the 1983 fiscal year.

The training sessions will focus primarily on the concept of Zero Base Budgeting (ZBB), a system of budget planning that works from the "ground up" and is designed to promote participation by bottom and mid-level management in the analysis and development of budgets, Golden explained. This budget system is used throughout the federal government as well as many state governments, she added.

Because of deadlines involved in the federal budgeting process, the IHS budgets for FY 1981 and FY 1982 have been completed. The earliest that tribes will be able to impact the IHS budget will be for FY 1983, Golden said. For this reason, tribes must gear up for this involvement as soon as possible and NIHB will have to complete most of the budget training sessions this fall, she said.

Resolutions

In other business, the National Indian Health Board adopted the following five resolutions:

- supporting IHS efforts in requesting additional appropriations of \$1.8 million to cover cost increases for Indian alcohol programs transferring to IHS from the National Institute on Alcoholism and Alcohol Abuse (NIAAA)
- supporting the establishment of a comprehensive health education, prevention, and treatment plan within IHS to alleviate health hazards affecting Indian people as a result of nuclear resource development
- requesting the Senate Armed Services Committee to investigate the possibility of U.S. service men and women being held as prisoners of war in Korea, Vietnam, and other countries
- supporting the continued funding of the Association of American Indian Physicians, and

— recommending that efforts to close several Bureau of Indian Affairs (BIA) schools be halted and the schools be kept operational.

next meeting — Alaska

The board adjourned the meeting with a decision to reconvene for its next regular quarterly meeting in Anchorage, Alaska, October 20-23, at the Sheraton Anchorage Hotel. ■

Red Cliff Seminar Address Concerns of Indian Youth

BAYFIELD, WISC.—Indian youths from this northernmost part of Wisconsin took part in a unique seminar that allowed them to examine concerns of their own choosing. The seminar was held at the Red Cliff reservation near here August 21-22.

The purpose of the seminar was to provide area youth with an opportunity to learn about and discuss problems in the following areas: fetal alcohol syndrome; family planning, cultural awareness, educational opportunities, and self-awareness. A particular emphasis was placed on increasing community awareness of problems associated with alcohol and drug abuse. Programs for the seminar included films, small group discussions, speakers, and self-awareness activities.

NIHB Health Planner Sandi Golden was guest speaker for the seminar and participated in several of the group sessions.

The seminar was sponsored by the Red Cliff Youth Service Team, which was established last January to provide specific programs for the reservation's youth. Among other services, the Red Cliff Youth Service Team offers youth counselling, crisis intervention and prevention, special education, home school, and special youth activities. ■



EDUCATIONAL OPPORTUNITIES WORKSHOP was one of several activities at youth seminar on the Red Cliff Reservation near Bayfield, Wisc., August 21-22. Other workshops included fetal alcohol syndrome, family planning, and alcohol and drug abuse.

Indian Doctors

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powers that could heal them. The healing role, no matter who is facilitating it, is a sacred one," Bergman said.

The following recommendations of the meeting will be presented to the Indian Health Service, according to Wilson:

- a closer dialogue between IHS and traditional Indian healers or an organization representing Indian healers should be established for the purpose of determining how they can work together.

- traditional Indian medical practitioners want Western medical professionals to recognize them as equals, particularly in regard to remuneration for services performed and protocols to be observed for each individual healer.

- IHS should designate certain areas in Indian Health care facilities to be used by traditional Indian healers for their patients.

- IHS should finance training of traditional Indian healers. ■



JOE WASHINGTON, a medicine man from the Lummi Tribe, related his concept of health, disease and healing as did medicine people from the Sioux, Navajo and Hopi tribes during AAIP annual meeting.

Research

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treatment strategies. In our work we always return individual reports to the schools and communities who have cooperated in the data collection. In addition, we provide technical assistance to those tribes who would like further data interpretation or would like the data analyzed to answer specific local questions. Many communities have benefited in the past by having this type of data. It has been used to plan programs and in applying for prevention or treatment funds. ■



RENO-SPARKS COLONY Chairman Lance Astor (left), IHS Area Director Dr. George Blue Spruce (second left), his Special Assistant Bob Marsland (second right) and physician's assistant Gary Bowen (right) look over the new clinic's plans in an area that will be the pharmacy. (Photo courtesy of the Native Nevadan)

Reno-Sparks Colony Opens New Tribal Health Clinic

RENO, NEV.—A sparkling new health clinic serving 700 Reno-Sparks Colony members and an additional 1,700 area urban Indians will open its doors October 1, according to Tribal Chairman Lance Astor.

Considered a significant grass-roots effort on the part of the tribe, the clinic was funded through a Department of Housing and Urban Development (HUD) Community Block Grant and a \$24,000 contribution by the tribe. The tribe will receive an operating grant from the Indian Health Service (IHS) in addition to the three IHS contracts it currently has to provide services.

The clinic building (approximately 3000 square feet) will include a pharmacy, two examining rooms, laboratory, office for counseling services, a screening room and removable walls to allow for future expansion.

Staffing of the clinic will include an administrator, a physician's assistant, office staff, a combination driver and maintenance person, VISTA health volunteers, community health representatives and community health workers.

According to physician's assistant Gary Bowen, the health clinic is designed for preventive and chronic care treatment. Bowen said he expects to see patients for diabetes, hypertension, colds, ear infections, pap smears and respiratory problems. He also predicted that approximately 18 patients will be seen on an average day.

Touring the facility in late August, IHS Phoenix Area Director Dr. George Blue Spruce and his special assistant Bob Marsland credited the tribe's "tenacity and initiative" in establishing the clinic.

Marsland noted that the local CHR's had considerable input in the design of the facility. "That's a real success story for the CHR program to come from being health liaisons to participating fully in the design of a facility for the delivery of health care," Marsland said. ■

Arizona Project Seeks Data on Infant Feeding Practices

TUCSON, ARIZ.—A national search to find information pertaining to infant feeding practices by southwestern Indian tribes is underway, according to Dr. Burt Burkhalter, project coordinator at the University of Arizona school of Medicine.

The search, funded out of a Ford Foundation grant, will collect and summarize data on breast-feeding and other infant feeding practices, says Burkhalter.

"The idea for the project really grew out of the National Indian Health Board nutrition policy conference held in Flagstaff and Colorado Springs last year, which identified breast-feeding as an important policy issue for American Indians and Alaska Natives," Burkhalter added the project is also related to a request for proposals from the Ford Foundation to develop a program that will improve the health, nutrition, and development of all infants from low income-groups, including American Indians and Alaska Natives.

According to Burkhalter, national Indian organizations, the Indian Health Service, state nutrition programs, libraries, tribes and academic institutions will be contacted for information on the current practices and trends in infant feeding (especially breast-feeding), the consequences of these practices, causes of trends, organized efforts by the tribes or agencies to alter current practices and what useful actions the Ford Foundation could take in these matters.

The project requests that data on these subjects be sent to Dr. Gail Harrison at the University of Arizona School of Medicine; Department of Family and Community Medicine; Health Sciences Center, Tucson, Ariz. 85724.

NIHB Updates Mailing List with Computer

In an effort to provide better service to our readers and to accommodate the increasing number of requests for the *NIHB Health Reporter*, we have computerized our mailing list for the newsletter. If there was a problem in the way this issue was addressed, please contact the NIHB Public Information Office and we will make the appropriate correction.

The National Indian Health Board provides this newsletter at no charge to readers throughout the country and welcomes new requests from those interested in receiving this publication. Readers are invited to comment on any of the stories that appear in these pages, and we encourage them to submit ideas for articles they would like to see in the *Health Reporter*.

In addition, NIHB has completed publication of the conference proceedings from the Third National Indian/Alaska Native Health Conference. Copies of this report will be made available upon request.

The NIHB Health Reporter is published monthly by the National Indian Health Board. NIHB is pleased to provide this newsletter to our readers throughout the country and welcomes the further distribution of the information contained therein. We do kindly request, however, that NIHB receive credit for articles reprinted from the NIHB Health Reporter.

Please submit all articles, correspondence and mailing requests to John P. O'Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200, Denver, Colo. 80231.

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