S. HRG. 106–239

ALCOHOL AND SUBSTANCE ABUSE PROGRAM CONSOLIDATION ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

ON

S. 1507

TO AUTHORIZE THE INTEGRATION AND CONSOLIDATION OF ALCOHOL AND SUBSTANCE PROGRAMS AND SERVICES PROVIDE BY INDIAN TRIBAL GOVERNMENTS

OCTOBER 13, 1999
WASHINGTON, DC

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CONTENTS

	Page
S. 1507, text of	3
Statements:	
Campbell, Hon. Ben Nighthorse, U.S. Senator from Colorado, chairman, Committee on Indian Affairs	1
Daw, Raymond, executive director, Na'nizhoozhi Center, Inc., [NCI] New Mexico	26
Greene, Robert L., esquire, member, Committee on Treatment Benefits, National Council on Alcoholism and Drug Dependence, New York, NY	28
Gover, Kevin, assistant secretary for Indian Affairs, Department of the Interior, Washington, DC	14
Inouye, Hon. Daniel K., U.S. Senator from Hawaii, vice chairman, Committee on Indian Affairs	14
Joseph-Fox, Yvette, executive director, National Indian Health Board [NIHB], Denver, CO	23
Lincoln, Michel, deputy director, Indian Health Service, Department of Health and Human Services, Rockville, MD	15
Vanderwagen, Dr. Craig, director, Division of Clinical and Preventive Services, Office of Public Health, Department of Health and Human Services, Rockville, MD	15

APPENDIX

Prepared statements:	
Daw, Raymond	37
Gover, Kevin (with letter)	40
Lincoln, Michel E.	35
Joseph-Fox, Yvette (with attachments)	44

NATIVE AMERICAN ALCOHOL AND SUBSTANCE ABUSE PROGRAM CONSOLIDATION ACT OF 1999

WEDNESDAY, OCTOBER 13, 1999

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:32 a.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell and Inouye.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. We will now take up the Native American Alcohol and Substance Abuse Program Consolidation Act of 1999, S. 1507. This is a bill I introduced on August 5, 1999, to authorize Indian tribes to integrate and consolidate the dozens of alcohol and substance abuse programs offered by the Federal Government for the benefit of Native Americans.

I am sure we don't have to go through the tragic list of alcohol- and drug-related statistics in Native communities, but let me say that alcohol and drugs continue to be an albatross around the necks of Native people, and, together with them, we must craft better solutions to the problem.

I know that many people who have been near the reservations recognize, as I do, that the problem with alcohol among our Indian people is very often not—it wasn't started by Indian people.

I happen to be enrolled in Montana, which is a dry reservation, meaning you can't have any alcohol on that reservation. Any alcohol there is bootlegged on, as it is on some reservations. But you can't go on any road off that reservation without going by some dive not started by Indian people and not run by Indian people, but certainly used to prey on Indian people as they come and go on and off the reservation.

I've often said that folks that really want to correct the alcoholism problem we have facing Indian people, the best thing to do is help us buy out those places and burn them down.

But, in any event, this is an effort. S. 1507 is an effort to consolidate the many programs that are now in place, and I believe that the bill has great merit.

It will put the tribes and tribal organizations in the driver's seat, just as the very successful employment and training law known as the "477 model" already does.

Under the 477 model, tribes and organizations can draw resources and programs from across the Federal Government into one program. The benefits of the 477 model are increased efficiency and an economy of scale that tribes and organizations can attain.

Once tribes had to file plans and reports and audits and other requirements with every agency they worked with. The 477 model is a major advancement by allowing for a single plan and a single administrative framework and a single audit.

With S. 1507, we will authorize tribes to access and to make better use of alcohol and substance abuse treatment and prevention programs from HHS, from HUD, from the Department of Education, the Department of the Interior, the Department of Justice, Department of Transportation, and the National Institute of Health.

I am very hopeful that in the weeks ahead we can make whatever refinements we need to make to this important bill and have the committee favorably review and approve it.

[Text of S. 1507 follows:]

II

106TH CONGRESS
1ST SESSION

S. 1507

To authorize the integration and consolidation of alcohol and substance programs and services provided by Indian tribal governments, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 5, 1999

Mr. CAMPBELL introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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A BILL

To authorize the integration and consolidation of alcohol and substance programs and services provided by Indian tribal governments, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Native American Alco-
5 hol and Substance Abuse Program Consolidation Act of
6 1999".

7 **SEC. 2. STATEMENT OF PURPOSE.**

8 The purposes of this Act are (a) to enable Indian
9 tribes to consolidate and integrate alcohol and other sub-

1 stance abuse prevention, diagnosis and treatment pro-
2 grams to provide unified and more effective and efficient
3 services to Native Americans afflicted with alcohol and
4 other substance abuse problems; and (b) to recognize that
5 Indian tribes can best determine the goals and methods
6 for establishing and implementing prevention, diagnosis
7 and treatment programs for their communities, consistent
8 with the policy of self-determination.

9 **SEC. 3. DEFINITIONS.**

10 For the purposes of this Act, the following definitions
11 shall apply:

12 (1) FEDERAL AGENCY.—The term "Federal
13 agency" has the same meaning given the term in
14 section 551(1) of title 5, United States Code.

15 (2) INDIAN TRIBE.—The terms "Indian tribe"
16 and "tribe" shall have the meaning given the term
17 "Indian tribe" in section 4(e) of the Indian Self-De-
18 termination and Education Assistance Act.

19 (3) INDIAN.—The term "Indian" shall have the
20 meaning given such term in section 4(d) of the In-
21 dian Self-Determination and Education Assistance
22 Act.

23 (4) SECRETARY.—Except where otherwise pro-
24 vided, the term "Secretary" means the Secretary of
25 the Interior.

SEC. 4. INTEGRATION OF SERVICES AUTHORIZED.

The Secretary of the Interior, in cooperation with the appropriate Secretary of Labor, Secretary of Health and Human Services, Secretary of Education, Secretary of Housing and Urban Development, United States Attorney General, Secretary of Transportation, and Director of the National Institutes of Health shall, upon the receipt of a plan acceptable to the Secretary submitted by an Indian tribe, authorize the tribe to coordinate, in accordance with such plan, its federally funded alcohol and substance abuse in a manner that integrates the program services involved into a single, corridated, comprehensive program and reduces administrative costs by consolidating administrative functions.

SEC. 5. PROGRAMS AFFECTED.

The programs that may be integrated in any such plan referred to in section 4 shall include any program under which an Indian tribe is eligible for receipt of funds under a statutory or administrative formula for the purposes of prevention, diagnosis or treatment of alcohol and other substance abuse problems and disorders, or any program designed to enhance the ability to treat, diagnose or prevent alcohol and other substance abuse and related problems and disorders.

SEC. 6. PLAN REQUIREMENTS.

For a plan to be acceptable pursuant to section 4, it shall—

(1) Identify the programs to be integrated;

(2) be consistent with the purposes of this Act authorizing the services to be integrated into this project;

(3) describe a comprehensive strategy which identifies the full range of existing and potential diagnosis, treatment and prevention programs available on and near the tribe's service area;

(4) describe the way in which services are to be integrated and delivered and the results expected under the plan;

(5) identify the projected expenditures under the plan in a single budget;

(6) identify the agency or agencies in the tribe to be involved in the delivery of the services integrated under the plan;

(7) identify any statutory provisions, regulations, policies or procedures that the tribe believes need to be waived in order to implement its plan; and

(8) be approved by the governing body of the tribe.

1 **SEC. 7. PLAN REVIEW.**

2 Upon receipt of the plan from a tribal government,
3 the Secretary shall consult with the Secretary of each Fed-
4 eral agency providing funds to be used to implement the
5 plan, and with the tribe submitting the plan. The parties
6 consulting on the implementation of the plan submitted
7 shall identify any waivers of statutory requirements or of
8 Federal agency regulations, policies or procedures nec-
9 essary to enable the tribal government to implement its
10 plan. Notwithstanding any other provision of law, the Sec-
11 retary of the affected agency shall have the authority to
12 waive any statutory requirement, regulation, policy, or
13 procedure promulgated by the affected agency that has
14 been identified by the tribe or the Federal agency to be
15 waived, unless the Secretary of the affected department
16 determines that such a waiver is inconsistent with the pur-
17 poses of this Act or those provisions of the statute from
18 which the program involved derives its authority which are
19 specifically applicable to Indian programs.

20 **SEC. 8. PLAN APPROVAL.**

21 Within 90 days after the receipt of a tribe's plan by
22 the Secretary, the Secretary shall inform the tribe, in writ-
23 ing, of the Secretary's approval or disapproval of the plan,
24 including any request for a waiver that is made as part
25 of the plan submitted by the tribal government. If the plan
26 is disapproved, the tribal government shall be informed,

1 in writing, of the reasons for the disapproval and shall
2 be given an opportunity to amend its plan or to petition
3 the Secretary to reconsider such disapproval, including re-
4 considering the disapproval of any waiver requested by the
5 Indian tribe.

6 **SEC. 9. FEDERAL RESPONSIBILITIES.**

7 (a) RESPONSIBILITIES OF THE DEPARTMENT OF THE
8 INTERIOR.—Within 180 days following the date of enact-
9 ment of this Act, the Secretary of the Interior, the Sec-
10 retary of Labor, the Secretary of Health and Human Serv-
11 ices, the Secretary of Education, the Secretary of Housing
12 and Urban Development, the United States Attorney Gen-
13 eral, the Secretary of Transportation, and the Director of
14 the National Institutes of Health shall enter into an inter-
15 departmental memorandum of agreement providing for
16 the implementation of the plans authorized under this Act.
17 The lead agency under this Act shall be the Bureau of
18 Indian Affairs, Department of the Interior. The respon-
19 sibilities of the lead agency shall include—

20 (1) the use of a single report format related to
21 the plan for the individual project which shall be
22 used by a tribe to report on the activities undertaken
23 by the plan;

24 (2) the use of a single report format related to
25 the projected expenditures for the individual plan

1 which shall be used by a tribe to report on all plan
2 expenditures;
3 (3) the development of a single system of Fed-
4 eral oversight for the plan, which shall be imple-
5 mented by the lead agency;
6 (4) the provision of technical assistance to a
7 tribe appropriate to the plan, delivered under an ar-
8 rangement subject to the approval of the tribe par-
9 ticipating in the project, except that a tribe shall
10 have the authority to accept or reject the plan for
11 providing the technical assistance and the technical
12 assistance provider; and
13 (5) The convening by an appropriate official of
14 the lead agency (whose appointment is subject to the
15 confirmation of the Senate) and a representative of
16 the Indian tribes that carry out projects under this
17 Act, in consultation with each of the Indian tribes
18 that participate in projects under this Act, of a
19 meeting not less than 2 times during each fiscal year
20 for the purpose of providing an opportunity for all
21 Indian tribes that carry out projects under this Act
22 to discuss issues relating to the implementation of
23 this Act with officials of each agency specified in
24 subsection (a).

1 (b) REPORT REQUIREMENTS.—The single report for-
2 mat shall be developed by the Secretary, consistent with
3 the requirements of this Act. Such report format, together
4 with records maintained on the consolidated program at
5 the tribal level shall contain such information as will allow
6 a determination that the tribe has complied with the re-
7 quirements incorporated in its approved plan and will pro-
8 vide assurances to the Secretary that the tribe has com-
9 plied with all directly applicable statutory requirements
10 and with those directly applicable regulatory requirements
11 which have not been waived.

12 **SEC. 10. NO REDUCTION IN AMOUNTS.**

13 In no case shall the amount of Federal funds avail-
14 able to a participating tribe involved in any project be re-
15 duced as a result of the enactment of this Act.

16 **SEC. 11. INTERAGENCY FUND TRANSFERS AUTHORIZED.**

17 The Secretary of the Interior, the Secretary of Labor,
18 the Secretary of Health and Human Services, the Sec-
19 retary of Education, the Secretary of Housing and Urban
20 Development, the United States Attorney General, the
21 Secretary of Transportation, or the Director of the Na-
22 tional Institutes of Health, as appropriate, is authorized
23 to take such action as necessary to provide for interagency
24 transfer of funds otherwise available to a tribe in order
25 to further the purposes of this Act.

1 **SEC. 12. ADMINISTRATION OF FUNDS AND OVERAGE.**

2 (a) ADMINISTRATION OF FUNDS.—

3 (1) IN GENERAL.—Program funds shall be ad-
4 ministered in such a manner as to allow for a deter-
5 mination that funds from specific programs (or an
6 amount equal to the amount attracted from each
7 program) are spent on allowable activities authorized
8 under such program.

9 (2) SEPARATE RECORDS NOT REQUIRED.—
10 Nothing in this section shall be construed as requir-
11 ing the tribe to maintain separate records tracing
12 any services or activities conducted under its ap-
13 proved plan to the individual programs under which
14 funds were authorized, nor shall the tribe be re-
15 quired to allocate expenditures among individual
16 programs.

17 (b) OVERAGE.—All administrative costs may be com-
18 mingled and participating Indian tribes shall be entitled
19 to the full amount of such costs (under each program or
20 department's regulations), and no overage shall be count-
21 ed for Federal audit purposes, provided that the overage
22 is used for the purposes provided for under this Act.

23 **SEC. 13. FISCAL ACCOUNTABILITY.**

24 Nothing in this Act shall be construed to interfere
25 with the ability of the Secretary or the lead agency to ful-

1 fill the responsibilities for the safeguarding of Federal
2 funds pursuant to the Single Audit Act of 1984.

3 **SEC. 14. REPORT ON STATUTORY AND OTHER BARRIERS TO**
4 **INTEGRATION.**

5 (a) PRELIMINARY REPORT.—Not later than two
6 years after the date of enactment of this Act, the Sec-
7 retary shall submit a report to the Committee on Indian
8 Affairs of the Senate and the Committee on Resources of
9 the House of Representatives on the implemenation of the
10 program authorized under this Act.

11 (b) FINAL REPORT.—Not later than five years after
12 the date of the enactment of this Act, the Secretary shall
13 submit a report to the Committee on Indian Affairs of
14 the Senate and the Committee on Resources of the House
15 of Representatives on the results of the implementation
16 of the program authorized under this Act. The report shall
17 identify statutory barriers to the ability of tribes to inte-
18 grate more effectively their alcohol and substance services
19 in a manner consistent with the purposes of this Act.

20 **SEC. 15. ASSIGNMENT OF FEDERAL PERSONNEL TO STATE**
21 **INDIAN ALCOHOL AND DRUG TREATMENT**
22 **PROGRAMS.**

23 Any State with an alcohol and substance abuse pro-
24 gram targeted to Indian tribes shall be eligible to receive,
25 at no cost to the State, such Federal personnel assign-

1 ments as the Secretary, in accordance with the applicable
2 provisions of the Intergovernmental Personnel Act of
3 1970, may deem appropriate to help insure the success
4 of such program.

5 **SEC. 16. ALASKA REGIONAL CONSORTIA.**

6 (a) IN GENERAL.—Notwithstanding any other provi-
7 sion of law, subject to subsection (b), the Secretary shall
8 permit a regional consortium of Alaska Native villages or
9 regional or village corporations (as defined or established
10 under the Alaska Native Claims Settlement Act (43
11 U.S.C. § 1601, et seq.)) to carry out a project under a
12 plan that meets the requirements of this Act through a
13 resolution adopted by the governing body of that consor-
14 tium or corporation.

15 (b) WITHDRAWAL.—Nothing in subsection (a) is in-
16 tended to prohibit an Alaska Native village or regional cor-
17 poration from withdrawing from participation in any por-
18 tion of a program conducted pursuant to that subsection.

○

The CHAIRMAN. Senator Inouye, did you have any comments on this bill?

Senator INOUYE. Yes; just a few words.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator INOUYE. I commend the chairman for scheduling this hearing. It is on a subject matter of great importance to Indian country, because the most precious resource for Indian families obviously are the children, and all the statistics indicate that children are dying at rates that are absolutely shocking.

The mortality rate from alcoholism among Native youth aged 15 to 24 is 17 times higher than their non-Indian counterparts. This is alarming by any standard, and I think it tells us in no uncertain terms, where we must place our priorities.

So I look forward to the testimony this morning, with our assurance to Indian country that we will do what is physically possible, because it is our moral obligation.

The CHAIRMAN. With that, we will start with the administration's witnesses: Kevin Gover, assistant secretary for Indian Affairs, Department of the Interior; and Michel Lincoln, deputy director of the Indian Health Service.

If you gentleman would proceed in that order, I'd remind all the witnesses your complete testimony will be included in the record, and you may wish to abbreviate.

We will start with you, Assistant Secretary Gover.

STATEMENT OF KEVIN GOVER, ASSISTANT SECRETARY FOR INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, WASHINGTON, DC

Mr. GOVER. Thank you, Mr. Chairman. Thank you for calling this hearing today and thank you for introducing this bill.

This is the most difficult and most important problem that is faced in Indian communities today. Many of the issues that we deal with, both here in the Congress and in the administration, are, of course, extremely important, but they pale in comparison to the importance of addressing the problem of alcoholism and substance abuse on the reservations.

We want to commend the chairman for this bill. We think that it embodies a very important concept: First, that we consolidate the Federal Government's efforts to assist tribal communities in this regard; and, second, that these programs be designed by the tribes, themselves.

I have often said that the best ideas come from Indian country, itself, and that those of us here in Washington have only a limited ability to really help in this regard. All we can do is make resources available, but the ideas and the commitment to address the problem of alcoholism has to come from the community, itself.

What this bill proposes to do is give the tribes the tools that they need to address the problem when they choose to do so.

Having said that, Mr. Chairman, the administrative and budget issues surrounding the bill are fairly complex, and I think Mr. Lincoln will go into a little more detail on that matter, but what we in the administration would propose is that we spend the next 2

or 3 months working with each other, with the committee, and with tribal leaders who have taken a strong interest in this issue to refine in some detail the administrative process that would be required in order to consolidate all of these programs and begin block granting these funds out to the tribes.

Along with that, as reluctant as I am to give up turf under any circumstances, I do think that the appropriate agency to administer the program is the Indian Health Service, and so we would suggest that we work from that basis. IHS should really be the one to run this program. They are the experts. This is primarily a health issue. The great consequences of alcoholism are very much a factor in the work IHS has to do in terms of chronic liver disease, the diabetes issue, and many, many other problems that the Indian Health Service faces everyday.

So with that, Mr. Chairman, I just want to express my gratitude again that the committee wants to take this issue on, because it is so important, and express our great willingness to work with you to refine the ideas in this bill and come up with a program that really makes resources readily available to tribes that choose to take it on.

With that, Mr. Chairman, I have submitted a statement for the record and I would yield to Mr. Lincoln.

[Prepared statement of Mr. Gover appears in appendix.]

The CHAIRMAN. Thank you. I appreciate any suggestions you have to try to move this along.

I don't know of an Indian family, including mine and including yours, that hasn't been touched by either alcohol or drug abuse through a mother, a father, or a brother, or a cousin, or something. I've seen plenty of my relatives die from it, Kevin, and you have, too, and I think both of us recognize that the related problems of alcohol and drug abuse just permeate the whole Indian culture now, whether it is loss of productivity or the residual violence or fetal alcohol syndrome—all the other things that go along with it.

It is long overdue, I think, to move towards a better system of helping people recover.

Thank you for being here.

Mr. Lincoln, go ahead.

STATEMENT OF MICHEL LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CRAIG VANDERWAGEN, M.D., DIRECTOR, DIVISION OF CLINICAL AND PREVENTIVE SERVICES, OFFICE OF PUBLIC HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Mr. LINCOLN. Thank you, Mr. Chairman.

I was just reflecting on Assistant Secretary Gover's comments relative to the commitment that the administration has within the administration to coordinate not only among ourselves between the Bureau of Indian Affairs and the Indian Health Service, but our sister agencies.

In addition to that, working with your committee and your committee's staff and tribal governments and other entities that have shown commitment to improving the health of American Indian

and Alaska Native children and individuals that are involved in this, is noteworthy.

We are here representing the administration, bringing forward the commitment to the committee that we will work with you to see that the principles that are embodied in this piece of legislation are carried out on an effective basis.

Mr. Chairman, I am joined today by Dr. Craig Vanderwagen. Dr. Vanderwagen is the director of our division of clinical and preventive services here in the Washington office. It is significant that he is here, in the sense that he is one of the most knowledgeable individuals about not only what the problems are, the mortality and morbidity associated with Indian kids and Indian families that are impacted by alcohol and substance abuse, but also I think quite expert at working with groups, working with tribal groups, or working with various societies in this country in developing the answers, the intervention that needs to occur, from both a clinical or direct care perspective, but also from a preventive perspective. We must have preventive programs in place.

We know that this piece of legislation would allow and would cause greater collaboration among those of us who have responsibilities, and we know that it will also cause an integration of services. It's not just the Federal agencies working with each other in single document with tribes. That's important. We agree with that and we strongly support that. But the collaborations that really have to occur as a result of this is our working relationships with the tribes, first of all, and then our sister agencies, like the Substance Abuse/Mental Health Services Administration, which has a number of grants that go out to Indian country—about $50 million worth of grants. We've got to work with them also so that their resources are brought to bear on this horrendous problem that has been in Indian Country immediately and over a long term.

This is not an effort, I believe, when I read the legislation, for a quick fix. It is an intervention that the Congress would like to see that will sustain itself over the generations that are going to be necessary to make the kind of changes we need to be involved with that need to be made in Indian country regarding alcohol and substance abuse.

The administration is committed to preparing a report addressing the most effective and efficient means to implement the concept outlined in S. 1507 early in the next session of Congress. This is a discussion that has occurred with the Assistant Secretary for Indian Affairs, with the Office of Management and Budget, with our department in Health and Human Services and the resources that we have among us of working with tribal organizations, tribal governments.

That work will occur over the next 2 and 3 months, and we look forward to coming back to the committee with some very detailed recommendations on how to make this piece of legislation work.

I would like to mention just a couple of statistics.

We are a health organization. When you look at the death rates associated with alcohol cirrhosis and other alcohol diseases, those rates are almost always higher than the general population.

When I say that, you miss the scope, one misses the scope of the problem, as you've described.

The mortality due to alcoholism in the Aberdeen is 20 times the United States' all races number. In general, Indian Health Service is seven times the United States' all races.

The reason I point those out—and I didn't write them down in the testimony—was that this problem is great in every community, but in some of the communities it is greater, and we need to have targeted interventions working with those tribes in those communities in order to make a difference.

We believe that there are other related mortality/morbidity that needs to be reflected, and we've submitted that in our testimony. The relationship between alcoholism and suicide, between alcoholism and other mental health issues, between alcoholism and injuries, have all been demonstrated, especially those related to injuries, to have major impact on Indian people, and especially on young Indian people.

As you were describing the situation approaching your reservation, mine is no different. I am from Navajo, was born and raised there, and—as I know you have—as I make the drive to Gallup or make the drive to Farmington or Winslow or Flagstaff or Page, it is the same story that you see over and over and over, and you see our kids, you see our young people between the ages, really, of 15 or 16, when they can drive, and all the way into their 30's and 40's, you see the unacceptable deaths that occur on those highways.

I would like to point out, Mr. Chairman, that you will be considering in this committee the reauthorization of the Indian Health Care Improvement Act. That is a bill that kind of lays out the framework for the health programs and it lays out the expectation by the Congress as to what the priorities of the agency would be over a given period of time, the lifetime of the Health Care Improvement Act.

I would like to let you know that we've had an extensive consultation process that has involved the breadth of Indian Country in developing various proposals that I know the committee will consider as it looks at the broad basis of health issues.

There is a section, though, in this report or in this proposed legislation that will be developed that deals with alcoholism and substance abuse, and we want to make sure that whatever action the committee takes on S. 1507 is also factored into that piece of authorizing legislation. It is an important piece of legislation.

Mr. Chairman, within the statement that has been provided to the committee, we document again, because we think it is critical that the committee document the health need and the ravishing of Indian people of this program, quite extensively.

In addition to that, though, I'd like to again offer the committee a document that we use in helping guide our programs, but, more importantly, that locally the tribes and those local managers use in addressing health programs, and this is a document called, "The Regional Differences in Indian Health Care."

What it will show you is not only the comparisons between alcoholism mortality and the United States' all races; it will show you the diversity of the problems throughout the areas. So it will show you Aberdeen, it will show you Portland, it will show you Navajo and Albuquerque and all the areas that we work with and their mortality and morbidity statistics, and some work load statistics.

I offer that to the committee to ensure that the full breadth of this problem is part of the committee record.

In closing, Mr. Chairman, we believe that deaths associated with alcohol and substance abuse are preventable, and that must be a focus of our efforts. Even in a bill that wants to streamline and provide a single place, a single instrument for tribal governments to acquire Federal resources, the objective, though, should be the elimination of alcohol and substance abuse problems in Indian country, and prevention will be a key component of that.

We suggest that comprehensive, community-wide efforts, including medical treatment programs, are the most appropriate approach to prevention. This has been demonstrated by a variety of Indian Health Service and DHHS-funded programs to prevent alcohol and chemical substance abuse related issues.

The tribes and the Federal agency are seeking ways to work collaboratively to develop the comprehensive, coherent programs to achieve the dramatic changes in the health behaviors and social structures needed to redress these challenges.

We look forward to working with the committee. We support your bill. And over the next couple of months, we want to interact more directly with your staff.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you for your testimony.

[Prepared statement of Mr. Lincoln appears in appendix.]

The CHAIRMAN. I am sure you are familiar with a place called White Clay. It has been in the news a lot lately. It is my understanding that one liquor store there, alone, sells over $4 million of liquor to Indians, primarily Lakotas that come south off the reservation.

I tell you, to my way of thinking that is a systematic way of killing our kids, and it just really galls me that that is done under the guise of free enterprise and that we can't seem to recognize that the cirrhosis, fetal alcohol syndrome, all the stuff that is related to alcohol consumption that is happening to our Indian children, if you—in any other forum, if you were to say there are people intentionally preying on kids to give them something that is going to kill them or put them in a position to kill themselves, they would be liable, but in this forum we don't. It's called "free enterprise," and they are welcome to sell all the booze they want to those kids.

Thank you.

Secretary Gover, you are going to establish, as I understand it, an Office of Alcohol and Drug Abuse within the Bureau; is that correct?

Mr. GOVER. That's correct, Mr. Chairman. The office was actually established by the Congress earlier this decade, and for some reason it disappeared. One of my first priorities was to reestablish that office, and I just want to thank the Congress, and especially the Appropriations Committee, because you provided us with some funds to build up that program next year.

The CHAIRMAN. Yes.

Mr. GOVER. And so next year we will have a fully-capable and functioning office.

The CHAIRMAN. Well, if S. 1507 passes—and certainly I hope it will—will there be some duplication of effort, or are you going to

work some way you can coordinate with whoever the lead agency is on this streamlined method?

Mr. GOVER. We would absolutely coordinate, and I think all that we want to see my office do is to shine more attention on this issue until we've dealt with it and prowl the government, if you will, looking for opportunities to make more resources available. This bill does exactly the sort of thing that we wanted to see happen.

The CHAIRMAN. Well, it is kind of patterned after the 477 model, and I hope that there are benefits. There have been some benefits from 477 as you know. At least the tribes seem to think there are. And I do, too.

Mr. Lincoln, several of our witnesses today in their testimony are recommending that S. 1507 be administered by the IHS rather than the Bureau, and Secretary Gover thinks it may work out well that way, too. What about IHS? Do you also believe that that should be the lead agency?

Mr. LINCOLN. We do, to be quite frank with the committee, and it has to do with two things. One of them is the working relationship that we have with the tribes right now in the field of alcohol and substance abuse and mental health through the various Public Law 93–638 agreements that we have, the Indian self-determination contracts and compacts.

We have an appropriation in excess of $90 million—more toward $100 million—and over 90 percent of that appropriation is already included in existing contracts with tribal governments. And there are flexibilities that the tribes have as being part of or having a Public Law 93–638 contract that I know tribes would want to preserve, and they see this, I think, as adding to those resources they need to address this problem.

The second issue is one of health, to be quite frank with you. We were not opposed to the Bureau taking the role, but we wanted to point out that the complexity of this particular health problem is so great that it wasn't just a matter of coordinating or collaborating between agencies.

At the delivery point, the issue of dual diagnosis, the issue of how one uses mental health monies and social service monies —

The CHAIRMAN. You probably have more people that are qualified to deal with it than the Bureau does because you have doctors.

Mr. LINCOLN. Absolutely. And because we have those working relationships at the community level.

The CHAIRMAN. Yes.

Dr. VANDERWAGEN. May I make one other comment on that, Mr. Chairman?

The CHAIRMAN. Yes; identify yourself for the record, if you would.

Dr. VANDERWAGEN. Yes; this is Dr. Craig Vanderwagen with Indian Health Service.

I think the other issue that is emerging in the administration, as we've worked with the Interior Department and the Department of Justice, is the recognition of many of the crime issues as really being a public health set of issues, and that, by putting a public health entity in a lead relationship with those other entities, we continue to move forward with that approach to dealing with many of the crime and law and order issues that I think are of benefit to the communities to have that kind of public health approach to

the issue, rather than just looking at crime and punishment approaches to dealing with juveniles in detention and so on.

The CHAIRMAN. Yes.

Dr. VANDERWAGEN. And on that basis, too, we felt that it was—we would agree with that.

The CHAIRMAN. And that, of course, brings up another question, and that is what we really want to avoid, if we can move this bill forward, is that we don't want to give other agencies an excuse to reduce their funding by saying,

> Well, now it is in the bailiwick of the IHS, so it is their ball. We are no longer an agency that needs to deal with it, so we don't have to provide funding.

But we will, obviously, watch that very carefully.

This bill only proposes formula funds to be included in 1507, but I would assume the IHS would support grant programs, too, if we can refine the bill to incorporate grant programs. Is that correct, Mr. Lincoln?

Mr. LINCOLN. Yes, Mr. Chairman; I think that is a critical factor here.

I believe what we are talking about is an increase of resources that would be focused on this problem within the respective communities, and, to that extent, as the committee and as the Congress considers a grant program or considers additional appropriations through out other committees, I think that will make a big difference.

I need to say that Assistant Secretary Gover has been very open in discussions about ensuring that the Federal Government responds appropriately to this bill. He is to be congratulated for that.

And, vice versa, the Indian Health Service has made commitments to the BIA that we will be partners in this, and there needs to be a loci of control or effort that has to occur, and we believe the Indian agencies are where that should occur.

The CHAIRMAN. Well, Secretary Gover is a pretty good fellow.

Thank you.

Senator Inouye, did you have questions?

Senator INOUYE. I find this discussion on the lead agency to be very interesting, because I am reminded that not too long ago, just a few years ago, when the time came to cut down the cost of government, IHS was called upon to cut full-time equivalent positions at a disproportionately higher rate than the rest of the Department of Health and Human Services [DHHS].

The CHAIRMAN. That's right.

Senator INOUYE. And when we asked the question, "Why so?" they said, "Well, there are so many unfilled positions." And if you delve a little further, we find that naturally they are unfilled because IHS was not provided adequate resources and funds.

Now, if DHHS becomes the lead agency, because logic says it should be, do we have any assurance that Indian country will not be treated as poor step-children, as they have been for a long, long time?

Mr. LINCOLN. Senator Inouye, your statement and your observation relative to the reduction of positions with Indian Health Service is accurate. What we've seen over the last 5 years is a reduction of headquarters staff by in excess of 50 percent, from approximately 900 people to 400 that exist now.

We've seen the same level of reduction, about 50 percent, at all of our area offices.

But what we've seen at the service unit level, at the delivery point, is an increase in the number of staff that we have, and that reflects the priority, quite frankly, of the Administration and of the Indian Health Service, of which I am an active participant. It is the prioritization of health over administration.

This bill has that element, also.

I would like to say that the administration this year proposed a budget for fiscal year 2000 that marked a turn-around, in our opinion, in the Indian Health Service's opinion, in its initial funding request.

The administration requested $170.1 million as a proposed budget increase, and the commitment by the Department and by Secretary Shalala to submit for the second year in a row a significant budget increase for the fiscal year 2001 has been made and has been sent to the Office of Management and Budget.

Now, you and I both know there will be significant changes and negotiation occur between now and when the President's budget, but I can tell you unequivocally the last 2-year budget submittals by the Secretary of Health and Human Services have been large and I believe they have been reflective of her commitment and our Department's commitment to Indian health care.

Senator INOUYE. If the Congress should decide that the lead agency should be the Indian Health Service, is your Service prepared at this moment or capable, with sufficient talent and dedication, to carryout this mission?

Mr. LINCOLN. Senator Inouye, that is an extremely important question, and I believe it is one that needs to be answered within the context of us working with your committees, your staff, and develop over the next 2 months.

My understanding of our staff at the local area and at the areas and at headquarters leads me to believe that there will be need for modest increases in two areas, one of them to ensure that these plans that are described, these local plans that are described in the legislation come to fruition and are plans that we can implement. That's going to require some additional assistance.

And, as we move toward the administrative mechanism, that there be a single contractual instrument, we are probably going to need some assistance in administering those contracts or those compacts or those grants, whatever the committee decides is most important.

So there will be some additional needs, but we've not staffed that out. We need the opportunity to work with you to staff out that.

Senator INOUYE. Well, Secretary Gover has indicated that the most critical issue, most critical public health and social issue facing Indian country, is what we are discussing this morning. You are not telling me that your agency is afraid to tackle this, are you?

Mr. LINCOLN. No, Senator Inouye; as the testimony states, we do believe that the right place for the coordination of this effort is the Indian Health Service.

Senator INOUYE. Well, as far as I am concerned—and I believe the chairman believes, also—we have great faith in the Indian Health Service.

Mr. LINCOLN. Thank you.

Senator INOUYE. And I, personally, think that, if given the challenge, you will meet that challenge.

I would hate to have some agency look upon this problem and say, "Well, we have other priorities." We should have a lead agency that says, "This is the priority," and I think you can do it.

Thank you, sir.

The CHAIRMAN. One maybe last question, Mr. Lincoln.

If the IHS, under the bill, was designated as the lead agency, would that require a new office to manage these programs to be set up, or would it be done through the expansion of any current management that you have now?

Mr. LINCOLN. It would be an expansion through the current offices that we have. The Indian Health Service has been able to maintain a core set of health professionals, even through this dramatic downsizing that has occurred. There isn't any doubt in my mind, though, that that would have to be supplemented, to a limited extent, and I am just very glad to hear that the Bureau of Indian Affairs will be establishing an office that will be able also to work on these issues.

I am, quite frankly, counting very heavily upon our Department, the Health and Human Services, Department of the Interior, and the BIA to be full partners in this effort. I don't believe it can work any other way.

The CHAIRMAN. Okay. Thank you.

Yes, Doctor?

Dr. VANDERWAGEN. To add one or two things to that, we are consolidating alcohol with the mental health activities because of the frequency of the dual diagnosis—that is, kids who have both chemical abuse problems and mental health problems—and we think that consolidation, which really reflects what the tribes are doing at the ground level, will offer us some efficiencies.

And then, second, to echo Secretary Gover's comments about the tribes and the ideas that come from the community level, we believe that there is much energy that can be tapped and brought to bear on this problem within the tribal environment, and it is building on their strength that I think we are really going to be able to pull this off, because the communities, themselves, are the ones who determine what is going to happen, what the values are, and what is acceptable, and we are in a position to be facilitative and supportive to the degree that they want, but the heart of this is really at the community level, and that's where the strength is for this activity and that's where the commitment is to make this number one priority and make it happen.

The CHAIRMAN. Yes; perhaps one last thing, too.

The effects of alcohol and drug abuse are pretty expansive. Do you think—maybe Mr. Lincoln should answer this—that S. 1507 should be amended to include mental health resources, too?

Mr. LINCOLN. As we've reorganized, as Dr. Vanderwagen was describing, it became clear to us that there is such overlap that we should have a behavioral health effort.

I think that's the way it works also at the service delivery level, where the line is blurred when you have a patient that is dually

diagnosed. The word is blurred in terms of the way we use resources.

I believe it is in our existing Indian Self-Determination Act contracts. Where the tribes have the flexibility to use the money outside of their categories, this is occurring now.

I believe, although I've not seen any scientific evaluation, I believe there are benefits from that occurring.

Having said that, I keep referring back to this report that we've agreed can be done, and it would be one of those issues that, if the committee would allow us, we'd like to explore with a little more depth over the next couple of months.

The CHAIRMAN. Okay. I thank you.

I appreciate your appearance this morning. Thank you very much for being here.

With that, we will go to the next panel, which will be: Yvette Joseph-Fox, executive director of the National Indian Health Board; Raymond Daw, executive director—and I don't know if I am pronouncing this right, Na'nizhoozhi Center, Gallup, NM; and Robert Green from the Committee of Treatment Benefits, National Council on Alcoholism and Drug Dependence from New York.

First of all, Mr. Daw, can you tell me what that word means, the Na'nizhoozhi? How do you say that?

Mr. DAW. It is a four-syllable Navajo road, Mr. Chairman, Na'nizhoozhi. It is a Navajo word to describe a crossing.

The CHAIRMAN. Crossing?

Mr. DAW. Like at a creek or a stream.

The CHAIRMAN. Thank you.

Why don't we go ahead and start with Yvette Joseph.

Nice to see you here. We used to see a lot more of you at this committee before you went off to Denver and became a mama.

STATEMENT OF YVETTE JOSEPH-FOX, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD [NIHB], DENVER, CO

Ms. JOSEPH-FOX. Thank you, Senator Campbell.

This is really actually my first time ever testifying before the committee as a public witness. Formerly I worked here for the Senate and had offered statements, just as Mr. Moorehead and Mr. Jackson did earlier, so this is, indeed, an interesting day for me, especially to see both you and Senator Inouye, my idols in the U.S. Senate.

Chairman Ben Nighthorse Campbell, Vice Chairman Daniel Inouye, and distinguished members of the Senate Committee on Indian Affairs, I am honored to offer testimony on behalf of the National Indian Health Board in support of S. 1507.

As you well know, the National Indian Health Board serves all 558 tribal governments in advocating for the improvement of health care delivery. Our Board members represent each of the 12 Indian Health Service areas and are generally elected at large by the tribal governmental officials within their respective regional areas.

Today, I am very apologetic that our Board members could not be present to testify. I am here to offer the deepest appreciation of the chairman, Buford Roland, for the opportunity for NIHB to be present.

The National Indian Health Board has a duty to represent the sovereign right of all tribal governments to promote the highest levels of health care for American Indians and Alaska Natives, and to advise the Federal Government in the development of responsible health policy.

No discussion of the development of alcoholism and substance abuse prevention and treatment amongst American Indians and Alaska Natives during the past 15 years can avoid considering the role of the Federal Government and the agencies of the Government authorized to provide services to Indian people and to tribes.

Most of the money that has been available for the war on substance abuse has come from the Federal Government via appropriations authorized under a number of important public laws.

The National Indian Health Board supports the intent of S. 1507, as we support the desire of tribal governments to consolidate many of their programs into a flexible and responsive program at the local level. However, we strongly recommend that the primary agency responsible for Federal oversight of these consolidated programs be the Department of Health and Human Services' Indian Health Service program.

It is our recommendation that sections three, section four, section 9A, and section 11 be amended to indicate that the Indian Health Service shall serve as the lead agency for purposes of carrying out the administrative duties outlined within the bill and other existing authorities.

Our primary reason for suggesting that the IHS serve in the lead role stems from the basic fact that alcoholism is a disease affecting both the physical and behavioral health of American Indians and Alaska Natives, as well as their families.

It is widely recognized that alcohol is a major factor in 5 of the 10 leading causes of death for American Indians, and we know that comparisons of Indians to non-Indians shows that the age of first involvement with alcohol is younger, the frequency and amount of drinking is greater, and the negative consequences are more common.

Despite the negative statistics, we have also found that in American Indian and Alaska Native communities that they sometimes have the highest rates of abstinence of any ethnic group in the United States. These are positive indicators of the importance of dealing with alcoholism as a familiy disease.

These data are included in a briefing book that we had prepared for use by four national organizations in the development of what we call the "healing journey accord."

The healing journey accord is a commitment of the National Congress of American Indians, the National Indian Health Board, and the National Association of Native American Children of Alcoholics, as well as the new National Council on Urban Indian Health, whose members joined with the NIHB in putting forth this accord to set forth a framework by which all of our national organizations nationwide could begin to address the devastation of alcoholism.

I am pleased to offer this briefing book today to the committee for your use in preparation of the committee report to accompany S. 1507.

The CHAIRMAN. Without objection, we will include that in the record.

Ms. JOSEPH-FOX. It is an excellent document in terms of looking at the most recent innovations in treatment and local grassroots efforts over the past decade that are preventing this chronic disease.

I also wanted to bring to your attention a hearing record that came from July 30, 1992. It is titled, "The BIA and IHS Inspector General Reports on Indian Alcohol and Drug Abuse Programs." This particular hearing record has a very substantial set of recommendations from the inspector generals of both the Department of the Interior and the Department of Health and Human Services about the efforts of both Federal agencies in addressing the implementation of alcoholism and substance abuse efforts in Indian country.

While it is dated, it does answer the question of which Federal agency was best in carrying out its responsibilities for administering the alcoholism and substance abuse programs.

It had appeared from the hearing record that the Indian Health Service had accomplished greater activity than the Bureau in the Inspector General's review of the alcoholism and substance abuse program efforts.

There continue to be challenges, and yet remarkable accomplishments due to the enactment of the Public Law 99–570, and the overall funding focused on prevention and treatment has increased up to a level of 100 million. Despite the increases, funding levels are still inadequate, and to address the unmet financial need the Indian Health Service has successfully implemented a budget formulation process that recognizes the recommendations of tribal governments in the development of the forthcoming fiscal year.

Specifically, for fiscal year 2000, tribal governments are recommending a budget increase of $15.1 billion for IHS, and out of that, $290 million is recommended for alcoholism and substance abuse efforts.

I am noting this budget formulation process because it is an excellent approach. You know, we are 4 months away now from the release of the President's 2001 budget, and what we have been able to do consistently in the past 3 years is help justify substantial increases in the Indian Health Service budget to address some of the needs, Senator Inouye, that you raised with respect to the support for Indian health funding.

Based on that process and just the simple fact that alcoholism is a health disease, we would recommend support for S. 1507, but we would also recommend that the IHS become the lead agency for carrying out this initiative.

There are other comments included in my statement.

I know you mentioned earlier the reauthorization of the Indian Health Care Improvement Act. We know that the new amendments to that act addressing substance abuse are going to serve to strengthen the program, and it is our recommendation that hearings begin very soon to ensure that health care needs are clearly stated and presented for committee markup early in the spring of 2000.

In closing, the National Indian Health Board stands ready to assist the committee in securing enactment of this bill, as well as the reauthorization of the Indian Health Care Improvement Act.

Thank you.

The CHAIRMAN. Thank you for your testimony.

[Prepared statement of Ms. Joseph-Fox appears in appendix.]

The CHAIRMAN. Mr. Daw, why don't you proceed?

I understand the abbreviation of the name I can't pronounce very well is "NCI." Go ahead.

STATEMENT OF RAYMOND DAW, EXECUTIVE DIRECTOR, NA'NIZHOOZHI CENTER, INC. [NCI], GALLUP, NM

Mr. DAW. Good morning, Chairman Campbell, Vice Chairman Inouye, and members of the committee. My name is Raymond Daw. I am executive director of two private, non-profit organizations in Gallup, NM. I am a member of the Navajo Nation.

I and the agencies that I work with fully support the intent of the legislation to consolidate Native American substance abuse prevention and treatment.

In the process of preparing for this hearing, Mr. Chairman, I consulted with a number of leaders in my region—in particular, the vice president of the Navajo Nation, Taylor MacKenzie, and the executive director of the Pueblo of Acoma Housing Authority, Raymond Concho.

We are in agreement that the intent of this legislation is good. We are also in agreement that the lead agency for this effort should be the Indian Health Service, under the Department of Health and Human Services.

The vice president of the Navajo Nation, in fact, wished me to point out his strong support for the legislation and his desire to see Indian Health Service be in the lead.

The programs that I work with and how I come before this committee, basically, is that I am director of probably the largest Native American treatment facility in the United States. I operate a 150-bed substance abuse program.

We were created, as Senator Inouye may recall, in 1990 in response to the devastating effects of alcoholism upon Native American people in Gallup, NM. Senator Inouye, Senator Domenici, Congressman Richardson, and Senator McCain, put forth Federal legislation and authorized monies to create the Gallup Alcohol Crisis Center, which transformed into the Na'nizhoozhi Center, Inc.

The board of directors that I work for are individuals who represent four different governments in the region I work with—the Navajo Nation, the Pueblo of Zuni, the city of Gallup, and McKinley County, so, in essence, I work for four governments.

Within that context, we have made very significant progress in Gallup, NM, and McKinley County. In the discussion among the committee earlier there was a discussion about problems within border towns. I believe that Gallup, NM, as a border town to two neighboring Native American communities, the Zuni and Navajo people, have made the most progress of any in the last 7 years toward reducing the effects of alcoholism and drug dependency among Native American people.

We have reduced by over 50 percent in Gallup the incidence of public intoxication.

We have implemented, in the 150-bed program, a Native American residential treatment program that runs 2½ weeks, which has a treatment completion rate of nearly 95 percent.

We have been able to document, through our implementation of Native American culture, spirituality, and traditions, a success rate where 70 percent of our clients, 6 months after completing our 2½-week program, are still doing significantly well. At 6 months, 40 percent are still sober.

Those are some of the things that we do in the region that I work with.

The other program I am director of is Northwest New Mexico Fighting Back. Within that program I work, on the board of directors are members of the Navajo Nation, individuals from the Acoma Pueblo, Laguna Pueblo, and the Cherokee Nation. So, as a private, nonprofit agency, Northwest New Mexico Fighting Back has contributed to putting in place public policies, initiatives that have greatly improved the health status of residents of McKinley County.

In the far eastern portion of the Navajo Nation, through the work of Northwest New Mexico Fighting Back and five Navajo chapters, community people have been able to close three of four liquor establishments. I bring this comment to you, Mr. Chairman, as a response to concerns over White Clay and other border towns. It can be done.

Those are some of the efforts that we engage in through the two organizations I work with.

The reasons for our recommending Indian Health Service over the Bureau of Indian Affairs to be the lead agency is threefold.

The first reason has to do with the emphasis of Indian Health Service on Native American health and the mandate that IHS be the lead agency for health concerns.

The second reason for our recommendation, including the vice president of the Navajo Nation and the executive director of the Pueblo of Acoma Housing Authority, is that IHS has infrastructure already established, a fairly comprehensive infrastructure, to begin doing the consolidation work that is being required under this legislation.

The third reason is expertise. I know, through my work with Indian Health Service facilities and providers, that IHS does have the expertise to implement this legislation.

Those are the three reasons that we have to our proposal.

In conclusion, I do wish to thank the committee for inviting me to testify at this hearing. I wish you well and hope that your work and endeavor is blessed.

Thank you.

The CHAIRMAN. Thank you. I am very interested in your testimony. I will get back to you in 1 minute with a few questions.

[Prepared statement of Mr. Daw appears in appendix.]

The CHAIRMAN. Why don't you go ahead and proceed, Mr. Greene?

STATEMENT OF ROBERT L. GREENE, ESQUIRE, MEMBER, COMMITTEE ON TREATMENT BENEFITS, NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, NEW YORK, NY

Mr. GREENE. Thank you, Senator Campbell and Senator Inouye.

We are honored to have this opportunity to testify concerning S. 1507. We believe it is important legislation, and we do appreciate the opportunity to offer our thoughts and experience.

The National Council on Alcoholism and Drug Dependence is the oldest advocacy organization concerning substance abuse in the United States. It was founded in 1944 by the first woman who got sober in Alcoholics Anonymous, a woman named Marty Mann. Her purposes were to reduce the stigma of alcoholism and drug dependence, and also, by doing so, to get people into treatment.

We wish to thank your staff, Ms. McNeil and Ms. Martin, for their assistance in making it easy and comfortable for us to have the necessary information to testify intelligently on the bill here today.

As you know, and as you've mentioned this morning, alcoholism and drug addiction are chronic and often fatal diseases. Fortunately, these illnesses can be treated effectively and efficiently because of the great strides in research and practice over the last several decades.

Our written testimony cites a number of instances, studies, and gives you footnotes on information along those lines for the general population. It also describes the work of our Committee on Treatment Benefits, or COB, in working with Native American treatment programs around the country.

In connection with that, I particularly wish to make note of the contributions of Dr. Walter Hillabrant, president of Support Services, International, and Dr. Norman Hoffmann, who are conducting a major—and I believe the first—nationwide study of Native American women who receive alcoholism treatment. I believe it is the first study of its size and offers quite useful information to all of us on the needs of this population.

Dr. Hillabrant is here with us today, should you wish to ask him any questions, as are Sarah Kayson, the NCADD director for public policy, and Michael Varadian, who is also from the Committee on Treatment Benefits.

We welcome Senator Campbell's initiative, because we believe that it offers a way to increase the resources that will actually go to providing treatment to those who need it.

As it is currently structured, each different funding program has its own accounting, administration, and auditing requirements, as well as specific limitations on funding.

Most of the tribal programs that we are familiar with are small, under-funded, and under-staffed. They also tend not to have adequate computer and other kinds of administrative support, equipment, and services. It is common to hear them lament spending disproportionate amounts of time, effort, and funds just to deal with the reporting requirements that come from the funding agencies.

I know of one which received a grant which allowed them to hire about six people for providing treatment, but then, because of the

evaluation criteria that were with the grant, four of those people had to be assigned to just fulfilling the evaluation criteria.

This bill should make it possible to cut that sort of thing back, although it is probably impossible to eliminate it.

The CHAIRMAN. Bureaucracies being what they are.

Mr. GREENE. Yes, sir.

As to specific recommendations, it has been our experience that, as with any health issue, people who have experience in dealing with that particular illness are best equipped to evaluate and provide the appropriate services.

Addiction, with the unique needs of the people involved in it and the ways in which it relates to so many other health problems throughout the community, particularly needs oversight by an agency trained and equipped to deal with it.

We would, therefore, strongly recommend that the committee carefully consider assigning principal agency responsibility to an agency or department with experience in health care, and, specifically, with experience in the treatment of alcoholism and substance abuse.

The Indian Health Service is the principal provider of health services and alcoholism and substance abuse services for the American Indian and Alaska Native population. Its work in the field is very important. It spends about $100 million directly on alcohol and substance abuse services, and portions of all of the other areas of its budget also go to treatment of that, since the problem pervades the entire area of Indian health.

Most of its money for substance abuse is spent on contract to tribes, and most of the services are provided in a way very similar to what you are already suggesting. Therefore, they do have some experience in working in that particular way. They also run several regional youth treatment programs, or the tribes do on their behalf, and other facilities.

IHS also correctly views this problem as integrally related with many other aspects of the overall health problems of Native Americans and with the mental health system.

Just in relation to the comment about the integration of other behavioral health issues, it has been our experience, just anecdotally, that more and more people are presenting with not only substance abuse but other mental health problems, as well, and some of the more—well, certain tribal programs have already begun to integrate their mental health and their substance abuse treatment, the Cherokee Nation of Oklahoma being one.

This bill also offers you a golden opportunity to do something else very significant for the tribal treatment providers—that is, that you could develop, in setting up this unified system for the reporting and management of these funds, you could develop one which actually was easy to use, was uniform, and which contributed to the process of substance abuse treatment.

Currently, there are all sorts of conflicting and, frankly, muddling computer systems, reporting systems, etc. You could develop or require the development of a single, uniform system for all tribal programs to handle this, and you could foster the development of a management information system which would both capture the clinical needs and also develop the financial data that you need.

The National Council on Alcoholism and Drug Dependence and its Committee on Benefits, as I said, considers this an important bill, and, with our experience in substance abuse, etc., and the fact that we are a neutral organization, not witness a direct stake in the questions of how it gets administered, we may be able to provide some assistance in the process of developing the bill.

We stand ready to do so in any way that we are able, and we thank you very much for this opportunity to contribute to your deliberations. We hope it is helpful.

The CHAIRMAN. Thank you, Mr. Greene.

[Prepared statement of Mr. Greene appears in appendix.]

The CHAIRMAN. Mr. Daw, let me ask you a couple of questions.

You gave us a number in your testimony of 50 percent. What was that again? You reduced the—was it the number of these establishments by 50 percent or the use of alcohol by 50 percent?

Mr. DAW. The use of alcohol through public intoxication by 50 percent.

The CHAIRMAN. Does the Navajo Nation currently work with the city of Gallup or the county? What is the county down there? Is that Pima County? What is the county Gallup is in?

Mr. DAW. McKinley County, sir.

The CHAIRMAN. McKinley County, regarding the establishment of or to try to get zoning changes where these shanty town bars that are not owned by Indians wouldn't spring up near the reservation?

Mr. DAW. Right. I didn't include this in my comments, Mr. Chairman, but within the city of Gallup there are a disproportionate number of liquor licenses, as is the case with most border towns.

But, in working with the business community in the last seven years within the city of Gallup, we have seen the closure of 10 problem bars.

The CHAIRMAN. And others ones didn't spring up to replace them? You have seen a net reduction of 10?

Mr. DAW. A net reduction of 10 bars.

What happened, Mr. Chairman, is those liquor licenses were transferred to restaurants and stores. That's how those bars were closed.

The CHAIRMAN. And did that come about with the active encouragement of the tribe?

Mr. DAW. Yes, sir.

The CHAIRMAN. On the Navajo Reservation, are the chapters autonomous, in that if one chapter wanted to have a restaurant or allow the opening of a restaurant or bar, can they do that when other chapters cannot, or is that a decision done by the Navajo Tribal Council for the whole reservation?

Mr. DAW. Chapters could make a decision to enter into a business, profit-making business; however, as you are aware, the mechanisms to set up a business on any Indian land, particularly on Navajo, is really cumbersome, and that process usually impedes.

It has been my experience—and it's the reason why I work in the private, non-profit sector, is that it is a heck of a lot easier to set up a non-profit business than it is a for-profit business.

The CHAIRMAN. Yes.

Yvette, I mentioned a while ago perhaps the possible inclusion of a mental health section in this bill. What would your view of that be?

Ms. JOSEPH-FOX. I would agree earlier with the presentation made by Dr. Vanderwagen. In my own tribal experience, and before I ever came to Washington, I did work and I am certified as an alcoholism counselor. In fact, I was 21 years old when I was hired by my tribe to direct staff who were, like, 35 to 60. I had 12 staff working for me, and we ran a comprehensive alcoholism and drug treatment program.

Since my departure from the tribe, the tribe has actually consolidated both the alcoholism and the mental health program, because there are comprehensive needs that are necessary to be addressed to arrest alcoholism and its effect on the family.

I think it is very appropriate. They say sometimes in the alcoholism world that someone who is afflicted with alcoholism operates under sort of somo-psychotic behavior, and then the family members tend to be psycho-somatic. They operate almost in a psychosis because they are going crazy because of the alcoholism.

And so it is appropriate, if you are going to offer family treatment, to be oriented toward both alcoholism and mental health, but the first problem is getting the person who is alcoholic sober and abstinent, and then looking at their mental health subsequently down the road.

The CHAIRMAN. And emotional problems. You took over that job for your tribe when you were 21 years old?

Ms. JOSEPH-FOX. It was one of these things where I had experienced first-hand the grief that the alcoholism brings to the family, and I got my degree in psychology, and I stayed at Washington State University an additional year to get a certificate in alcoholism counseling, thinking I would go back and become a mental health counselor, and I ended up being recruited to direct the program, and did that for a period of 5 years, and saw the opportunity, when Senator Daschle, who was a Congressman, and Congressman Bereuter had decided to introduce a bill to prevent alcoholism, substance abuse in Indian country, particularly with a focus at children. That's when I fell in love with health policy and went to graduate school and met you and decided I wanted to come to Washington, as well.

So it has been my primary interest in my entire career, and I think what you are trying to attempt to do is merely improving a policy that has benefit for all of Indian country.

The CHAIRMAN. Well, you've done a marvelous job. I was rather amazed that you took a job like that with that kind of responsibility and pressure at 21 years old. I was going to say it could make you prematurely gray, but I probably ought to pass on that one.

Ms. JOSEPH-FOX. Well, one of the things I know that is important in terms of support for the Bureau of Indian Affairs is that we really do need to have a concentrated focus on case management, because I know I have been out with police officers, out on call, in suicide intervention circumstances and domestic violence circumstances where sometimes the only way to get a person sober is to either lay their job on the line or go through a court-ordered treatment program.

There is a real important necessity that someone be the primary responsible party, and usually it is the alcoholism program staff, and then everyone sort of works around that person to support them, to help them to get the appropriate treatment that they need.

I think that you need to have a comprehensive program between both the BIA and IHS, and, unfortunately, in the past what has happened is that the appropriations to carry out these wonderful pieces of policy have never been 100 percent funded.

The CHAIRMAN. Well, the reason I focused on the mental health aspect is because I know that there is peer pressure involved, too. When you can help someone clear up their alcohol problem, but if they go back into the same circle of friends that they had before and there is peer pressure on them to start drinking again, it is doggone difficult to resist. I know I've dealt with that myself years ago when I was young when there was so much drinking and I didn't.

I can remember going home sometimes and some of my own relatives would be drinking. If you were there, they would offer you a bottle. It was sort of a litmus test, and if you did they'd say something like, "Oh, you are a real Indian," as if you had to drink to be a real Indian. I mean, it was the craziest distorted idea of self that you can imagine, but they'd actually say comments like that. And if you wouldn't drink, they'd say some pretty strong comments, too.

Ms. JOSEPH-FOX. Yes.

The CHAIRMAN. Senator Inouye, did you have any questions of this panel?

Senator INOUYE. Mr. Chairman, if I may, I would like to just make a statement.

Once again, I would like to commend you for taking the initiative in drafting this measure.

We have hundreds upon hundreds of studies. I think that most Americans today and the Congress of the United States all have to believe that there are many, many causes of alcoholism, be it poverty or lack of self esteem or the stress of living, inadequate education. You can go on and on.

But I think the time has come when talking should end and action should follow, and I think now is the time.

I would like to commend the Indian Health Service. I have been in the Congress now for four decades, and I have sat through literally hundreds if not thousands of hearings, and it is almost a consistent pattern that whenever an important department head or person finishes his or her testimony, they stand up and walk out.

I realize that all of our department officials are very busy, but I would think that their presence here listening to the testimony of others would demonstrate importantly their commitment, and I want to commend you, Mr. Lincoln and Dr. Vanderwagen, for staying here to listen to testimony. I wish that more department heads and important officials would remain in the committee room to listen to what the folks are saying, so I want to thank you for remaining here. It demonstrates your commitment very much.

Mr. Chairman, I want to pledge to you that I will do whatever you want me to do to bring this about.

The CHAIRMAN. Thank you, Senator Inouye. You were here long before I got here doing the work of the Lord. Four decades is more perseverance than I will probably have at staying here, because less than two decades ago I was spending most of my time in Gallup in my other life as a jeweler. I used to participate in what was called Gallup Intertribal, and I used to spend summers down there and was very well aware, when we were at Gallup, even before it moved out to the new location 20 years ago——

Senator INOUYE. Can you yield for one?

The CHAIRMAN. Yes.

Senator INOUYE. You know, the challenge before us is an immense one. For the first 70 years of this century, Hollywood did a great job in establishing a stereotype of Indians.

The CHAIRMAN. Yes.

Senator INOUYE. That is the impression all young children had in all of the cowboy/Indian movies. It is only recently that Hollywood has begun to see the light.

So the challenge before us is an immense one: Clean up the stereotype, because you know and we know that alcoholism is not a genetic weakness; it is a disease that all of us can be confronted with.

So, Mr. Chairman, I am ready to work.

The CHAIRMAN. Thank you.

With that, I appreciate the witnesses being here. The record will stay open for a period of two weeks for any additional comments or questions from panelists or from the audience, in general.

This committee is adjourned. Thank you.

[Whereupon, at 10:49 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MICHEL E. LINCOLN, DEPUTY DIRECTOR, OFFICE OF THE DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Good morning Mr. Chairman, I am the Deputy Director of the Indian Health Service [IHS].

Accompanying me today is Dr. Craig Vanderwagen, Director of the Division of Clinical and Preventive Services, Office of Public Health in IHS. I am here today to present the views of the Department of Health and Human Services [DHHS] on S. 1507, a bill to authorize the integration and consolidation of alcohol and substance programs and services provided by Indian tribal governments, and for other purposes. The Department strongly supports the goals and intent of the legislation and would like to take this opportunity to provide a few constructive comments on the proposal. The Administration is committed to preparing a report addressing the most effective and efficient means to implement the concept outlined by S. 1507 early in the next session of Congress. The report will be prepared in consultation with tribal governments, affected Federal agencies and other interested parties. Further, the Administration believes that the bill should be amended to specify the DHHS as the lead agency responsible for implementation of the bill's provisions. I will discuss the rational for this recommendation in my statement.

The issue of alcohol and other substance abuse is significant to American Indian/Alaska Native [AI/AN] communities. The death rates associated with alcoholic cirrhosis and other direct alcohol diseases for AI/AN are well above general U.S. population. In addition, injuries are the leading cause of death for AI/AN's between the ages of 15 and 44 years. The majority of these deaths, whether intentional (such as suicide and homicide) or unintentional (such as motor vehicle crashes) are associated with alcohol and other chemical abuse.

The IHS and tribes have initiated a significant program of injury prevention and in fact the deaths related to injuries has declined. These programs have generally aimed at making the environment safer through targeted intervention such as seatbelt use and roadside safety enhancements. Notwithstanding, deaths due to injuries are still 2–3 times more likely in the AI/AN population. Suicide deaths in our service population are 1.5 times more frequent than in the general U.S. population and certain age groups in some communities may be 3 times more likely to die in this manner. Domestic violence associated with chemical abuse is especially lethal for AI/AN women. A recent University of New Mexico study revealed that American Indian women are the population most likely to die as the result of domestic violence when compared to other ethnic populations. This is a social and clinical issue of significant proportion.

The first official authorization for the IHS and Indian tribes to provide alcoholism treatment services was established in 1976 within the Indian Health Care Improvement Act, Public Law 94–437. The Anti-Drug Abuse Act of 1986, Public Law 99–570, and the Omnibus Drug Bill Amendments, Public Law 100–690, expanded this authority to include alcoholism and other substance abuse treatment and prevention

services for AI/AN youth, women, children, dual diagnosed youth and family members. All of the authorities were later combined under title VII of the Indian Health Care Improvement Act Amendments of 1992, which is the existing authority for the IHS/Tribal/Urban (I/T/U) programs.

The IHS receives close to $100 million in appropriations for its alcohol activities. Greater than 90 percent of these funds are provided directly to the tribes under Indian Self-Determination agreements for programs which they design and implement. The tribes and IHS have addressed this problem persistently and have some demonstrated success. The IHS has had significant and successful experience in developing and executing partnerships with tribal governments. In the last 5 years Self-Governance agreements in IHS has expanded from 14 tribes to well over 40 percent of the tribes we serve. This process of transferring the Federal functions related to health programs has taught both tribes and the IHS many lessons in planning and implementing comprehensive health and social programs. Indeed, the evidence suggests that tribes can address these issues in ways that the Federal partners cannot.

The IHS and tribes have established outcome measures through the Government Performance Results Act [GPRA] to evaluate the success of their health programs and have been lauded for the appropriateness of the indicators associated with the anticipated outcomes. The death rate due to alcoholism has in fact generally declined over the last 20 years. Alcohol related illnesses that have been targeted (such as FAS and FAE in some high risk communities) have been reduced. Inhalant abuse also appears to be on the decline. The youth regional treatment activities are demonstrating clear success in treatment.

While the death rate due to alcoholism has declined 17 percent since 1980, current data shows that this downward trend has stopped. Since 1990, the rate has been rising and is now 7 times greater than the United States. All Races rate. These deaths are preventable, but only through a comprehensive program of medical, behavioral, and preventive services. In fact, the evidence suggests that comprehensive community wide efforts (including medical treatment programs) are the most appropriate approach to prevention. This has been demonstrated in a variety of IHS and DHHS funded programs to prevent alcohol and chemical abuse related illness. The K'e project in Navajo is only the most recent example of success. This effort, funded by SAMHSA, operated by the Navajo Tribe, and in collaboration with IHS, utilized traditional tribal culture, more standard alcohol prevention efforts, and clinical care activities to demonstrate a reduction in chemical abuse among young people. The tribes and the Federal agencies are seeking ways to work collaboratively to develop the comprehensive and coherent programs to achieve the dramatic changes in the health behaviors and social structures needed to redress these challenges.

Within DHHS there is a significant partnership among the agencies with health and social programs targeting chemical abuse built around the highest quality professional approaches to treatment and prevention. The IHS has working relations with the Substance Abuse and Mental Health Services Administration [SAMHSA] for Mental Health Services [CMHS], Substance Abuse Treatment [CSAT], and Substance Abuse Prevention [CSAP]. These programs provide will over $15 million in funding through the competitive grant processes for service to AI/AN communities in a coordinated effort with IHS.

The Centers for Disease Control [CDC] also provides funding for prevention services in partnership with IHS in the area of tobacco use. The CDC has also provided support to a partnership between IHS and the Bureau of Indian Affairs to develop and disseminate an HIV comprehensive prevention for school aged children and adolescents. The National Institute for Alcoholism and Alcohol Abuse has provided support to research efforts examining the characteristics of chemical abuse in AI/AN populations. Last, the IHS partnership with the Headstart program has provided support and technical assistance to Indian Headstart prevention program efforts.

There have also been significant efforts among the Department of Justice [DOJ], the Department of Health and Human Services [DHHS], and the Department of the Interior [DOI], and other Federal departments to plan and implement coherent programs of prevention and treatment. A major vehicle for this effort has been the Domestic Policy Council Working Group on Native Americans chaired by Secretary Babbitt. This forum has developed innovative approaches to streamlining tribal access to government-wide programs through inter-agency efforts and methods. The concept of integrated service access has been a theme and focus for this group. Specific partnerships between DOJ, DOI, DHHS, and the tribes are now being implemented to address chemical abuse and other behavioral problem among Indian youth in detention. These principles should be formalized and validated more effectively in the Federal relations with tribes.

Accordingly, the IHS believes that the principles addressed by this bill reflect an appropriate public health and intra- and inter-government approach to the issue. We are concerned about how the distribution of funds authorized and appropriated under existing competitive or formula grant authority will be affected. For example, SAMHSA is concerned that given the broad scope of the bill, it might be construed (a) to make tribes eligible for funding under a program for whose funding they are not currently eligible, or (b) to guarantee tribes a share of funding from a discretionary grant program or other similar program under which they are eligible for funding but have to compete for funding. There are concerns that the technical assistance and other "in-kind" services and relationships between tribes and Federal agencies will decline significantly under this approach. The partnerships that are functioning could be lost. There are also concerns that the funding levels keep pace with identified need and that resource flexibility which works to the advantage of tribes not be lost.

Because of these and other potentially complex issues involved in applying the Public Law 102–477 model of program consolidation to federally funded alcohol and substance abuse programs serving the AI/AN population, we would recommend that a careful and comprehensive report be prepared to ascertain the implications of applying this model to existing programs. We need to ensure that the critical contributions of the multiple Federal, Tribal and other health, social and community service agencies along with judicial and law enforcement agencies are not compromised. A report to outline the issues at hand and recommendations to address those issues prior to implementation would be sound investment of time and resources. As I stated earlier in the testimony, the Administration will be consulting with the appropriate Tribal governments in the preparation of this report.

The Administration believes that the DHHS, with its demonstrated record of health improvements in public health, is a more logical choice to ensure that improved social and health status changes are the outcomes. Based on these considerations, the Administration recommends that DHHS be given the lead responsibility for the implementation of the provisions of this proposed bill. The DHHS would work closely with the Department of the Interior, other Federal agencies and tribal governments to achieve the bill's objectives.

Thank you for this opportunity to provide testimony on S. 1507. I will address any questions you may have at this time.

PREPARED STATEMENT OF RAYMOND DAW, EXECUTIVE DIRECTOR, NA'NIZHOOZHI CENTER, INC., NEW MEXICO

Thank you for inviting me to speak to the Senate Committee on Indian Affairs regarding this legislation. I am Raymond Daw, a member of the Navajo Nation and life-long resident of Navajo Country. I am the Executive Director of two very innovative and effective programs located in northwest New Mexico. The first is Na'nizhoozhi Center, Incorporated or NCI. NCI is a 150-bed substance abuse agency that provides protective custody, social detoxification, short-term shelter, DWI (for driving while intoxicated offenders) residential treatment, Native American culture-based residential treatment, and Native American culture-based outpatient treatment. The second agency I am Executive Director of is Northwest New Mexico Fighting Back, Incorporated, or Fighting Back. Fighting Back is a community-based substance abuse prevention and public information that builds community capacity to reduce the harm caused by alcohol and drugs.

Members of the NCI Board of directors are nominated by four governments, who have entered into an intergovernmental agreement, the Navajo Nation, the Pueblo of Zuni, city of Gallup, and McKinley County. These governments have formed a private agency, which is NCI, to consolidate and integrate substance abuse treatment for the chronic substance abuser in Gallup, NM.

The Fighting Back Board of Directors is no less diverse and focused in their efforts, this governing body is comprised of members of the Navajo, Acoma, Laguna, and Cherokee tribes. Board members are recruited from a large three-county area that encompasses almost the entire northwest quarter of New Mexico. This board has been attempting to establish a prevention model that is coordinated and well planned.

Both private sector programs I am affiliated with serve a population that is primarily Native American. NCI is a private, non-profit substance abuse program whose service population is 98 percent Native American, persons who mainly reside in northeastern Arizona and northwestern New Mexico. NCI has reduced public intoxication by over 50 percent in Gallup, NM. In the past 7 years, winter exposure deaths have been reduced by over 60 percent, as has alcohol-related emergency

room visits in the Gallup Indian Health Service facility. These changes have been the result of a singular effort to combat public intoxication and the face of Gallup, NM has changed for the better. Over 90 percent of our clients complete the residential treatment programs that we operate and 70 percent of these individuals continue to do better than prior to entering our residential programs. Our success comes from being able to collaborate effectively with law enforcement and medical providers in McKinley County. NCI has a very strong interest in improved collaboration among providers who benefit from Federal funds in areas outside of McKinley County. Because our purpose is to reduce public intoxication and chronic alcoholism.

Fighting Back has also contributed significantly to positive efforts in McKinley County, NM. This is a county that was once the worst county in the United States for alcohol-related mortality. This county no longer has claim to that notorious distinction. Our efforts in prevention and alcohol policy is being modeled that other communities across the country. From California to Wyoming to Michigan, we have entertained visitors wanting to learn about DWI law reform, efficient treatment of public inebriates, and development broad community-based planning. McKinley County has a Native American population of over 70 percent. Fighting Back has promoted the concept of building "Healthy Nations" with the Navajo, Laguna, Acoma, and Zuni Tribes in our region. Such that there is growing movement to create more opportunities for Native American youth interested in athletic activities and the establishing community youth programs in our very rural region through the formation of private, non-profit agencies in six isolated Native American communities we currently serve.

I see a great opportunity for Federal resources to be consolidated and a truly collaborative approach to beating the monsters, alcohol and drug dependency. While Native Americans in northwest New Mexico, particularly in McKinley County, have made great strides in the past 9 years, our work is far from over. NCI's admissions of intoxicated persons for protective custody is still over 17,000 per year.

All of the towns bordering our lands have become, increasingly concerned about the problems of alcoholism and drug-abuse. Farmington, NM approached the Navajo Nation this week for assistance in planning an effective prevention and treatment strategy on behalf of Farmington and San Juan County residents, many of whom are Native American. Winslow, AZ has approached the Navajo Nation for similar input and leadership. The problem is so devastating that no single rural government has the resources to create and effective prevention and treatment system alone. The Navajo Nation is beginning to make strides against bootlegging within its borders, but continues to seek solutions in the areas of prevention and treatment. A single and unified approach is needed if tribes are to begin turning the tide of substance abuse and related problems that is tearing at the fabric of Native American society and culture.

The 99th Congress passed Public Law 99–570 in the mid-1980's, which reads in part; *Coordination of Resources and Programs—Directs the Secretary of the Interior and the Secretary of Health and Human Services to develop and enter a memorandum of agreement to better coordinate the provision of alcohol and substance abuse treatment and prevention services for Indians and Alaska Natives.*

Allows the governing body of any Indian tribe to establish a tribal action plan to coordinate available resources and programs in an effort to combat alcohol and drug abuse among its members.

Additionally, Public Law 99–570 required for tribes to establish Tribal Coordinating Committees [TCC] who would coordinate development of and implementation of the Tribal Action Plan. Most tribes have Tribal Action Plans [TAP's], but have not been able to re-visit them and make changes as the needs of the tribe changed since the late 1980's.

Alcohol-related mortality and accidents continue to plague Native peoples at an alarming rate. Not all tribes, like the Navajo Nation, have gaming as a way to increase tribal resources. Non-gaming tribes, particularly, must begin to create plans that consolidate the resources currently available, regardless of the source. The Navajo people are a proud people with visions of economic and social stability. However, like most rural tribes, the Navajo Nation still has high unemployment rates to contend with as the population increases and the economic disparity among tribal members also increases. This legislation will begin to provide a means of consolidating tribal efforts toward improving the health status of tribal members adversely affected by alcoholism and drug abuse. I believe, this improves tribal efforts to become economically diverse and stable.

Alcoholism and drug abuse is a major destroyer of lives and families in Indian country, particularly among the Navajo people. Ever since 1953, when it became legal for Native Americans to consume and possess alcohol in the United States, the problem of substance abuse dependency has substantially increased. Tribal re-

sources are scarce and tribes rely upon the Federal Government for resources to begin addressing this scourge among Native peoples of this country. Tribe rely on Federal funds to help combat the significant problems associated with alcoholism and drug abuse.

In 1988, the Congress authorized Public Law 99–570, which required the implementation of TCC's and TAP's. I see that this legislation as the next step toward creation of a unified approach to reduce the harms associated with alcoholism and drug abuse. It is through the TCC's that tribes are to develop comprehensive strategies for prevention, intervention, and treatment of substance abuse. TCC's are either non-existent or not functioning in most of Indian country. However, the TCC model can be the forum through which tribes can create their plans on toward a broader approach against substance abuse.

As a private sector provider, with no allegiance to any Federal department, I give you my recommendations. Prior to embarking on my journey to testify at this hearing, I consulted with the vice president of the Navajo Nation, the Honorable Taylor McKenzie. Vice President McKenzie wishes for me to forward to you his recommendation that the Secretary of Health and Human Services be given authority to enact this legislation, instead of the Secretary of the interior. I wholeheartedly concur with Vice President McKenzie's recommendation for these reasons. The Indian Health Services, which is part of the Secretary of Health and Human Services, department, has trust responsibility to provide for the health care of Indian people. The Department of the Interior does not have that same mandate from Congress. This is an especially important recommendation, because substance abuse has been publicly acknowledged by many tribal leaders across the United States as being the number one health problem for many years. This health concern expressed by tribal leaders and health providers has not changed.

A second reason for this recommendation is that the Indian Health Service already has infrastructure developed to more efficiently consolidate substance abuse prevention and treatment activities at a national and local level. Indian Health Service has a Substance Abuse Branch that convenes regional and national meetings, workshops, and training on substance abuse. Within the each Indian Health Service Area are Alcoholism and Substance Abuse Branch Chiefs, who provide guidance and direct services to contract and grant programs operating with Federal funding. On the Navajo Nation, each IHS Service Unit, local hospital, has a Substance Abuse Coordinator to provide direct service and coordinate referrals to local substance abuse agencies and support groups.

The Bureau of Indian Affairs does have such comprehensive infrastructure for tribes to readily access. Particularly in the development of tribal plans to begin consolidation of tribal resources derived from Federal funds. It is desired by the sponsors of this legislation to reduce duplication and build upon already existing systems in Indian country. Giving this responsibility would be contrary to the intent of this legislation.

My third reason for this recommendation is experience and expertise. As I have noted above, IHS has teams of people experienced in management and provision of substance abuse prevention and treatment services within each tribe. Most tribes already provided I.H.S. with strategic plans that describe tribal health agency capabilities and resources.

So IHS has the necessary framework established to assist tribes to take the next step toward a truly comprehensive and consolidated approach toward improving upon the health status of tribal members.

When I discussed this legislation with several private sector Native American providers in my region that I interact with, the first response I received in all cases was, "Why the BIA? Why not IHS?" That is an appropriate question in Indian country for this committee to consider as this legislation is moved forward.

In closing, thank you for your committee's invitation to me and wish you well in your endeavors. Good-bye.

Statement of Kevin Gover, Assistant Secretary for Indian Affairs,
before the
Senate Committee on Indian Affairs
Hearing on
S. 1507, the "Native American Alcohol
and
Substance Abuse Program Consolidation Act of 1999"

October 13, 1999

Good morning, Mr. Chairman and Members of the Committee. I am here today to provide the Department of the Interior's position on S. 1507, a bill to consolidate alcohol and substance programs and services provided by Indian tribal governments. The Department strongly supports the goals and intent of S. 1507. The Administration believes that we need to provide you with a report that will be delivered to you early in the next session. The report will outline the most effective and efficient means to implement the concept outlined in this legislation. Further, the Administration believes that S. 1507 should be amended to assign the lead agency coordination responsibility to the Department of Health and Human Services.

BACKGROUND

Understanding the scope and underlying causes of the alcohol and substance abuse problem, as found in varying degrees within Indian Country, is a difficult task. Yet, proven indicators of alcohol and substance abuse, both behavioral and economic, can be readily observed in many American Indian communities. Examples of co-occurrence indicators come from tribal and federal law enforcement records. Law enforcement records document increasing levels of child abuse, gang activity, youth violence, domestic violence, DWI violations, and drug-related arrests among youth and adult tribal members. Too often Indian tribal members, whether they happen to be perpetrators or non-perpetrators, live in harsh economic conditions – conditions that have shown over time to compound the numbers of alcohol/substance abuse related violence observed in tribal communities. The economic adversity facing a majority of the nation's tribal members was noted in the BIA's 1997 Labor Force Report: almost 50 percent of the adult labor force was unemployed, and, of those employed, 30 percent were still living below the poverty guidelines established by Health and Human Services.

The Indian Health Service (IHS) has published studies suggesting an association between alcohol and drug abuse and the American Indian and Alaska Native suicide rates, which are nearly twice the rates for all races in the United States. Also, according to IHS, 17 times as many Indians and Alaska Natives die from alcoholism than the U.S. white race rate from ages 15 to 24. The Department of Justice Bureau of Justice Statistics has published data showing that Indian and Alaska Native offenders who were under the influence of alcohol and/or drugs committed 55 percent of the violent

crimes against other American Indians or Alaska Natives.

THE VISION

Shortly after I took office, I announced that one of my priorities for Indian Country was to help direct Bureau of Indian Affairs (BIA) resources to assist Tribes better in reducing alcohol and drug abuse in their communities. Toward that goal, the BIA has initiated interagency agreements and established other interagency liaisons. One promising interagency agreement with the Administration for Native Americans at HHS involves 48 small Tribes in a pilot study to employ a normed screening survey to assess the extent of alcohol problems among all adult members, household by household. After analyzing the assessment information, the Tribes will be designing abuse prevention programs.

As we embark on a new millennium, alcohol and substance abuse in Indian Country shows no sign of reversing itself on its own. The BIA is prepared to continue to use its available resources. I see the BIA continuing to exercise its role as stated in S. 1507 to improve the quality of life of tribal members by working with individual Tribes to reduce incidents of alcohol and substance abuse taking place in their respective communities.

CONCLUSION

Currently, we are meeting with representatives of the Corporation for National Service's AmeriCorps program to share resources and strategies to involve our nation's Indian and Alaska Native youth and elders in alcohol and substance abuse community projects.

We view S. 1507 as both a challenge and as an opportunity. S. 1507 provides an opportunity for HHS and BIA to work constructively with each Tribe, to share federal resources, and to help draft or negotiate a quality plan that identifies the Tribes integrated approach to implementing alcohol and substance programs and services.

I firmly believe that the concept of S. 1507 holds the promise to be as successful in reducing tribal administrative costs and reporting requirements for S.1507-eligible alcohol and substance abuse prevention programs, as is reflected within the Public Law 102-477 program.

Thank you, Mr. Chairman, for inviting me to address you and the Members of the Committee on this important legislation. I will be happy to answer any questions you may have.

United States Department of the Interior

OFFICE OF THE SECRETARY
Washington, D.C. 20240

OCT 13 1999

Honorable Ben Nighthorse Campbell
Chairman, Committee on Indian Affairs
United States Senate
Washington, D.C. 20510-6252

Dear Mr. Chairman:

This responds to your request for the views of the Department of the Interior on S. 1507, the Native American Alcohol and Substance Abuse Program Consolidation Act of 1999.

The Department supports S.1507 for the reasons set forth more specifically below.

Understanding the scope and underlying causes of the alcohol and substance abuse problem, as found in varying degrees within Indian Country, is a difficult task. Yet, proven indicators of alcohol and substance abuse, both behavioral and economic, can be readily observed in many American Indian communities. Examples of co-occurrence indicators come from tribal and federal law enforcement records. Law enforcement records document increasing levels of child abuse, gang activity, youth violence, domestic violence, DWI violations, and drug-related arrests among youth and adult tribal members. Too often Indian tribal members, whether they happen to be perpetrators or non-perpetrators, live in harsh economic conditions – conditions that have shown over time to compound the numbers of alcohol/substance abuse related violence observed in tribal communities. The economic adversity facing a majority of the nation's tribal members was noted in the BIA's 1997 Labor Force Report: almost 50 percent of the adult labor force was unemployed, and, of those employed, 30 percent were still living below the poverty guidelines established by Health and Human Services.

The Indian Health Service (IHS) has published studies suggesting an association between alcohol and drug abuse and the American Indian and Alaska Native suicide rates, which are nearly twice the rates for all races in the United States. Also, according to IHS, 17 times as many Indians and Alaska Natives die from alcoholism than the U.S. white race rate from ages 15 to 24. The Department of Justice Bureau of Justice Statistics has published data showing that Indian and Alaska Native offenders who were under the influence of alcohol and/or drugs committed 55 percent of the violent crimes against other American Indians or Alaska Natives.

One of my priorities for Indian Country was to help direct Bureau of Indian Affairs (BIA) resources to assist Tribes better in reducing alcohol and drug abuse in their communities. Toward that goal, the BIA has initiated interagency agreements and established other interagency liaisons. One promising interagency agreement with the Administration for Native Americans at HHS involves 48 small Tribes in a pilot study to employ a normed screening survey to assess the extent of alcohol

problems among all adult members, household by household. After analyzing the assessment information, the Tribes will be designing abuse prevention programs.

As we embark on a new millennium, alcohol and substance abuse in Indian Country shows no sign of reversing itself on its own. The BIA is prepared to continue to use its available resources. The BIA will continue to exercise its role as stated in S. 1507 to improve the quality of life of tribal members by working with individual Tribes to reduce incidents of alcohol and substance abuse taking place in their respective communities.

Currently, we are meeting with representatives of the Corporation for National Service's AmeriCorps program to share resources and strategies to involve our nation's Indian and Alaska Native youth and elders in alcohol and substance abuse community projects.

We view S. 1507 as both a challenge and as an opportunity. S. 1507 provides an opportunity for HHS and BIA to work constructively with each Tribe, to share federal resources, and to help draft or negotiate a quality plan that identifies the Tribes integrated approach to implementing alcohol and substance programs and services.

The Department believes the concept of S. 1507 holds the promise to be as successful in reducing tribal administrative costs and reporting requirements for S.1507-eligible alcohol and substance abuse prevention programs, as is reflected within the Public Law 102-477 program.

The Department strongly supports the goals and intent of S. 1507. However, the Administration believes that we need to provide the Committee with a report that will be delivered to you early in the next session. The report will outline the most effective and efficient means to implement the concept outlined in the legislation. Further, the Administration believes that S. 1507 should be amended to assign the lead agency coordination responsibility to the Department of Health and Human Services

The Office of Management and Budget has advised that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Kevin Gover
Assistant Secretary for Indian Affairs

cc: Honorable Daniel K. Inouye,
Ranking Minority Member

NATIONAL INDIAN HEALTH BOARD
1385 S. Colorado Blvd. • Suite A-707 • Denver, Colorado 80222-3304
Phone: (303) 759-3075 • Fax: (303) 759-3674
Website: www.nihb.org

Statement of Yvette Joseph-Fox, M.S.W.
Executive Director
National Indian Health Board
on
S.1507, the "Native American Alcohol and Substance Abuse Program Consolidation Act of 1999"
October 13, 1999

Chairman Ben Nighthorse Campbell, Vice-Chairman Daniel K. Inouye, and distinguished members of the United States Senate Committee on Indian Affairs, I am honored to offer testimony on behalf of the National Indian Health Board (NIHB) in support of S.1507, the "Native American Alcohol and Substance Abuse Program Consolidation Act of 1999".

The NIHB serves all 558 Tribal Governments in advocating for the improvement of health care delivery. Our Board Members represent each of the twelve Indian Health Service Areas, and are generally elected at-large by Tribal Governmental officials within their respective regional Areas. The NIHB has a duty to represent the sovereign right of all Tribal Governments to promote the highest levels of health for American Indians and Alaska Natives, and to advise the federal government in the development of responsible health policy.

No discussion of the development of alcohol and drug abuse prevention and treatment among American Indians and Alaska Natives during the past 15 years can avoid considering the role of the federal government and the agencies of the government authorized to provide services to Indian people and tribes. Most of the money that has been available for the "war on substance abuse" has come from the federal government via appropriations authorized under a number of important public laws.

Ever since the United States Government entered into treaties with the tribes, the Sovereign Tribal Nations have had to deal with federal efforts to live up to treaty and trust obligations. This includes living with and adapting to the structures and processes by which the federal government makes decisions, authorizes, appropriates and distributes monies, and oversees the agencies and programs charged with carrying out these obligations.

The National Indian Health Board supports the intent of Senate Bill 1507, as we support the desire of Tribal Governments to consolidate many of their programs into a flexible and responsive program at the local level. However, we

strongly recommend that the primary agency responsible for Federal oversight of these consolidated programs be the Department of Health and Human Services' Indian Health Service. Thus it is our recommendation that Section 3(4), Section 4, Section 9(a), and Section 11 be amended to indicate that the Indian Health Service shall serve as the lead agency for purposes of carrying out the administrative duties outlined within the bill and other existing authorities.

Our primary reason for suggesting that the IHS serve in the lead role stems from the basic fact that Alcoholism is a disease affecting the physical and behavioral health of American Indians and Alaska Natives (AI/AN) and their families. It is widely recognized that Alcohol is a major factor in 5 of the 10 leading causes of mortality for American Indians. Comparisons of Indians to non-Indians shows that the age of first involvement with alcohol is younger, the frequency and amount of drinking is greater and the negative consequences are more common. Despite the negative statistics, we have found that American Indians and Alaska Natives have the highest rate of abstinence of any ethnic group in the United States.

These data are included in a briefing book that we prepared for use by four national organizations at the National Summit on Native American Substance Abuse Prevention held four years ago in Albuquerque, New Mexico. The National Congress of American Indians, the National Association of Native American Children of Alcoholics, and the membership of the new National Council on Urban Indian Health, joined with the NIHB in putting forth a "Healing Journey Accord" which has allowed our national Indian organizations an opportunity to address Alcoholism and Substance Abuse comprehensively at the community and organizational level.

I am pleased to offer this briefing book today to the Committee for your use in preparation of the Committee Report to accompany S. 1507. It is an excellent document in terms of synthesizing the latest research, the Federal involvement in alcohol and substance abuse prevention and treatment, and local grassroots efforts over the past decade which are effectively preventing this chronic disease.

I would also like to bring your attention to a Hearing Record titled, **"BIA and IHS Inspector General Reports on Indian Alcohol and Drug Abuse Programs"**, which was prepared on July 30, 1992, during second session of the 102nd Congress. Even though the IG reports are outdated at this time, the question of which Federal Agency was best carrying out it's responsibilities for administering their alcohol and substance abuse programs was noted.

It appeared that the IHS had accomplished greater activity than the BIA in the Inspector General's review of Alcoholism and Substance Abuse prevention and treatment which examined agency efforts in implementing the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (P.L. 99-570). The

hearing record indicates that, "a significant area of non-compliance concerns the Bureau's lack of coordination among Federal agencies and tribal organizations. Although the director (BIA Director of the Office of Alcohol and Substance Abuse Prevention) appeared to be coordinating the Bureau's program activities at the national level in an entirely satisfactory manner, efforts at the field level where the services are ultimately delivered needed to be vastly improved."

There continue to be challenges and yet remarkable accomplishments due to enactment of P.L. 99-570 and the overall funding focused on prevention and treatment has increased up to a level of $100 million. Despite the increase, funding levels are still inadequate. To address the unmet financial need, the Indian Health Service has successfully implemented a budget formulation process in the past three years which upholds responsive Government-to-Government consultation between Tribal Governments and the IHS.

To ensure that comprehensive consultation reflects the grassroots needs of Tribal communities, the IHS provides an opportunity for each of the Tribal Governments in their twelve Areas to make recommendations on the IHS budget beginning in March and April of the budget cycle. By early June, the leadership of the National Indian Health Board, the Tribal Self-Governance Advisory Committee and the National Council of Urban Indian Health, met to determine a tribal needs based budget for the forthcoming fiscal year. Together, we recognize the need to increase the IHS budget to a level of $15.1 billion, which includes an increase of $290 million for Alcoholism and Substance Abuse Prevention and Treatment. Tribal Governments support this increase as a key health priority.

I've mentioned this process of budget consultation and formulation, because it points out the extra effort undertaken by the IHS to incorporate tribal support in development of the Fiscal Year 2001 IHS Budget. We are four months away from the release of the President's Budget Request, and yet Tribal Governments working with the NIHB, NCAI and Tribal Self-Governance Advisory Committee are quite prepared to advocate for increased funding for the IHS with consistent information available to the Administration and the Congress on our budget priorities. It is this model of budget consultation that we strongly encourage the Bureau of Indian Affairs to consider, as it is an excellent approach to increasing tribal support for increased IHS funding.

Tribal people at the grass-roots level, tribal leadership, mental health workers, IHS personnel, and staff from juvenile and adult treatment centers, all believe that the health and safety of Indian families continues to be at risk due to alcoholism and other drug use. Tribal leaders have expressed concern that should the BIA be made the lead agency responsible for implementation, progress already underway by tribal programs will suffer as a result. There are distinct differences between the Bureau and the Indian Health Service in their application of Self-Determination Contracting and Self-Governance Compacting,

and thus we opt to endorse the approach of the IHS in their implementation of contracting and compacting.

In addition, section. 9. (a) (1); (2); (4) and, (5) all relate to reporting activities, development of a plan and distribution of funding. Currently, the IHS does provide funding to operate community based alcoholism and substance abuse programs. Data is collected from the programs, IHS service units and clinics and is than transmitted to the Chemical Dependency Management Information System (CDMIS). This is an automated system, with computer edits, that is monitored by IHS Headquarters personnel. Based on the CDMIS, Tribal leaders are able to use the data to provide their tribal constituents a supportive atmosphere in accordance with rules that sustain an alcohol and substance abuse free community.

As you are well aware, the reauthorization of the Indian Health Care Improvement Act (P.L. 94-437) is about to be undertaken in the coming session of this Congress. New amendments to P.L. 94-437 will serve to strengthen the Alcoholism and Substance Abuse program. It is our recommendation that hearings begin very soon to ensure that health care needs are clearly stated and presented for Committee Markup early in the Spring of 2000.

In closing, the National Indian Health Board stands ready to assist the Committee in securing the enactment of S.1507. We believe that this bill, as amended with bill language which directs that the IHS serve as the lead federal agency, will enhance the Government-to-Government relationship between the United States and each Tribal Government. This bill will provide an opportunity for Tribal populations to share common visions in the promotion of safe, healthy, alcohol and drug-free Indian communities. The NIHB is convinced that the negative manifestations of chemical dependency upon tribal communities can be best addressed by Indian tribes through consolidation of alcohol and substance programs which benefit the entire Tribe as well as the individual client.

NATIONAL SUMMIT ON NATIVE AMERICAN
SUBSTANCE ABUSE PREVENTION:
THE HEALING JOURNEY ACCORD

October 16 - 18, 1995
Albuquerque, New Mexico

BRIEFING BOOK

Sponsored by:

National Association for Native American Children of Alcoholics
National Congress of American Indians
National Indian Health Board
American Indian Health Care Association

NATIONAL INDIAN HEALTH BOARD
1385 S. Colorado Blvd. • Suite A-708 • Denver, Colorado 80222
Phone: (303) 759-3075 • Fax: (303) 759-3674

October 5, 1995

Dear Meeting Participants:

I am pleased to submit to you the National Summit on Native American Substance Abuse Prevention Briefing Book. This document provides an overview of the problems and solutions needed to overcome the number one killer of American Indian and Alaska Native people in Indian Country. It addresses the latest research, the Federal involvement in alcohol and drug abuse prevention and treatment, and local grassroots efforts over the past decade which are successfully preventing this chronic disease.

The National Indian Health Board (NIHB) is pleased to join the National Association for Native American Children of Alcoholics (NANACOA), the National Congress of American Indians (NCAI) and the American Indian Health Care Association (AIHCA) in convening this historic and necessary Summit Meeting. Under the leadership of NANACOA and in the spirit of cooperation, our organizations have banded together to examine the issues contributing to alcoholism and substance. And TOGETHER with your assistance we will chart the course by which our Indian communities can take the steps to join us on The Healing Journey. In fact, it is expected that you will help to write **The Healing Journey Accord** during the Summit Meeting and will share this information with others in your communities after the gathering.

This Briefing Book makes an important compelling point to us and to all Indian people: We must stop the dying and the heartache associated with Alcoholism and Substance Abuse. With good hearts, clear minds and the information in hand, the sponsors of this Summit Meeting believe their is great hope for the future.

With the submission of the National Summit on Native American Substance Abuse Prevention Briefing Book, I commit the National Indian Health Board along with our colleagues at NANACOA, NCAI and the AIHCA to work toward reaching **The Healing Journey Accord.**

Sincerely,

Yvette Joseph-Fox, M.S.W.
Executive Director

CREDITS

The National Indian Health Board is grateful for the assistance of FieldWorks, Inc., in the development of this briefing book. The expert staff of FieldWorks, Inc., Dr. Arie Pilz, Dr. Gladys Levis-Pilz and Dr. Susan Carter, are based in Albuquerque, New Mexico and have assisted numerous tribes, schools and communities in their substance abuse prevention efforts.

Credit must also be given to Ms. Anna Latimer and Ms. Jo Ann Kauffman, who are both founding members of the National Association for Native American Children of Alcoholics, for their support and review of this document.

A PRAYER OF THANKS AND HOPE FOR NATIVE AMERICAN CHILDREN OF ALCOHOLICS

We choose to come together recognizing that the paths to healing and wholeness come from our faith in our Creator. Our hearts are grateful for the gifts of Mother Earth and our Creator: gifts such as the two-leggeds, the four-leggeds, the winged ones, the elements of air, water, fire, and stone. It is our responsibility to show respect to all of these gifts through active nurturance and care of Mother Earth, ourselves, our children, our children to come, and our belief in our Creator.

At this time, we acknowledge the gifts of those elders who have gone on before us. Their gifts to us are their dreams, visions, ceremonies, songs, and prayers. Their prayers are being answered now in our lives. We are returning to that part of the circle where balance among all parts of the Creation is respected and achieved.

We choose to continue their vision, to learn our traditional values and apply them in new ways so that we will recapture the spiritual energy of our elders and pass it on to those who will follow us. Our coming together is a Living Memorial to our elders. The time has come to acknowledge who we are. The time has come to put away the negative influence of drugs and alcohol and to bring along our richness as a people, in memory of our elders.

Prayer written at the founding of NANACOA

National Native American Summit on Substance Abuse Prevention: *The Healing Journey Accord*

October 16-18, 1995 Albuquerque, New Mexico

Briefing Book

Introduction

This Briefing Book was prepared as a background piece for participants in the National Native American Summit on Substance Abuse Prevention to be held October 16-18, 1995 in Albuquerque, New Mexico. This book should provide participants with some common language and a background of understanding on which to build discussions for future directions and strategies. This is not a comprehensive review. It is meant to provide an overview of the problems and promising efforts in the development of alcohol and substance abuse prevention and treatment programs in American Indian and Alaska Native communities especially focused on the past decade. The last major review of substance abuse prevention and treatment efforts in Indian country was accounted for in the 1985 IHS Program Review and Action Plan. Materials in three main areas were reviewed. There is a Section in the book devoted to each area. They include:

Section I. A Review of Research and Academic Writings About American Indian and Alaska Native Substance Abuse Issues: This section provides a context for understanding the problem as well as a brief summation of statistics and directions for future research.

Section II. Federal Involvement in Alcohol and Drug Abuse Prevention and Treatment among American Indians and Alaska Natives: 1985-1995: This section reviews the federal role over the past decade, including an analysis of the "promise and the problems" in legislative intiatives, funding, and opposing models between the federal service agencies and tribal communities.

Section III. Substance Abuse Prevention Programs for American Indians and Alaska Natives: This section presents a review of prevention and training strategies that were established during this past decade, as well as some brief descriptions of programs to illustrate the various approaches.

This Briefing Book bears witness not only to the problems related to substance abuse, but also to the hard work and dedication demonstrated by so many throughout Indian country to attack this problem. Elaine Johnson, Director of the Center for Substance Abuse Prevention, sums up the hopes for this Summit by stating her admiration for:

> ...the tireless efforts and the creativity of the groups who will comprise this historic summit. They have sought out new ways to express the message of prevention. Through education, advocacy, community organizing and a variety of other avenues, they are...advancing the development, acquisition and application of prevention reltaed knowledge.

Section I. A Brief Review of Research and Academic Writings About American Indian / Alaska Native Substance Abuse Issues

We need to concentrate every day on current needs. We need to remember that each day we fail to adequately address an important health issue, another Indian person is dying unnecessarily, another fetal alcohol syndrome child is being born, another avoidable amputation is being done, or another teen commits suicide. This is what Indian people are facing every day. Every day this situation should be considered absolutely unacceptable to all of us. (Dr. Gerald L. Hill, M.D., Klamath, 1993, p.6)

Introduction

The purpose of this section is to provide a brief overview of some of the recent research and other scholarly writings associated with the alcohol abuse problems faced by American Indian and Alaska Native people and communities. Although much of the academic literature is still being written by a group of dedicated non-Indian researchers, an effort was made to include information written from the American Indian and Alaska Native perspective whenever possible. *This is not a comprehensive review of the literature*, rather this section excerpts ideas, challenges, recommendations, and statistics to help summit participants structure their conference discussions and formulate action plans for the future which take into consideration recent research and academic thought.

Research Challenges in American Indian and Alaska Native Communities

The quality and quantity of research and academic writing about American Indian and Alaska Native substance abuse has improved dramatically in the past decade. Many researchers have made this focus part of their life's work (May, Trimble, Beauvais, Fleming, Manson and others). Important medical facts regarding the effects of substance abuse on the body, surveys of youth substance abuse that establish when, where, and how youth use, and evaluations of treatment and prevention programs, all help policy makers and tribal groups "see" the problem and plan interventions.

Many cultural/traditional and spiritual issues specific to American Indian and Alaska Native communities remain difficult for researchers to grasp and are missing or under-represented in the literature. Gregory Cajete (Santa Clara) observes how issues that are very important to American Indian and Alaska Native people may be absent from current research,

> It is the affective elements - the subjective experience and observations, the communal relationships, the artistic and mythical dimensions, the ritual and ceremony, the sacred ecology...These dimensions and their inherent meanings are not readily quantifiable, observable or easily verbalized, and as a result, have been given little credence in mainstream approaches to education and research. (1994, p. 21)

Trimble and Beauvais (1992) describe the difficulty encountered by some substance abuse researchers working within a traditional American Indian and Alaska Native community:

> ...if one were to ask a very native-oriented (i.e., traditional) Indian what causes alcohol and other drug abuse and were to give that person the usual psychosocial options to choose from, most likely he or she would be at a loss to respond. **For some tribal world views, the most appropriate response would be that the individual or family member had broken some type of taboo and that the resulting lack of harmony with the spiritual world must be rectified through traditional medicine.** (p. 184)

In his vision statement for the Indian Health Service, Michael Trujillo (1994), IHS director, expresses a related theme regarding the importance of traditional cultural values,

> The values of human dignity, honesty, compassion, coupled with shared values of many different tribes and cultures that have come to be spoken of as "Indian values" of listening, mutual respect, dignity, and harmony must always be at the forefront of what we do and how we do it...Healthy American Indian and Alaska Native communities are at the center of the circle of my vision for Indian health. (p. 1)

Another pattern apparent when reviewing the literature in this area is the overwhelmingly negative picture that can emerge. Highlighting the dismal statistics that often arise from studies of American Indian and Alaska Native communities is important and helps to keep this issue in the public eye, but this information, presented in a one-sided manner promotes a sense of helplessness rather than hope. McClellan Hall (Cherokee, Pawnee) decries the negative stereotypes of youth so common in the literature,

> Native youth are too often categorized as failures in this environment and were labeled with the school jargon related to helplessness (special education, high-risk youth, etc.). There is a deep disappointment in Indian communities with a variety of deficit models proposed for work with high risk youth and their parents. **We must avoid the negatives of labeling, the power of negative suggestion and self-fulfilling prophecy inherent in the "isms" approach (alcoholism, recidivism, absenteeism, etc.) -- we must refocus instead on the positive outcomes we want rather than emphasizing what is wrong.** (1995, personal correspondence)

Candace Fleming (Kickapoo, Oneida, Cherokee) is also concerned with the negative tone in much of the research. She states,

> ...Research on the American Indian undertaken by social scientists and humanities scholars... has overemphasized and given credibility to selected negative beliefs about American Indians. Although the goal of this research has been to find explanation and solutions to devastating problems, ...the continued focus of social scientists on the alarming rates of self-destructive behavior subtly serves to promote the public image of the Indian as "drunken" and "suicidal." **A balanced treatment of American Indians and Alaska Natives also needs to focus on the resiliency, strengths, and numerous significant contributions these people have made and continue to make to other societies of the world. (1992, p. 148)**

Recommendations for Future Research

Many of the authors writing in this area make recommendations for the conduct and direction of future research. Recommendations include the need to include American Indian and Alaska Native communities as active partners in the formation of the future research agenda and implementation of community-based research efforts, the need to refocus research and academic writing to explore the more subtle aspects of the problem that may lie in the cultural and spiritual realms, and the continuation of epidemiological studies that separate medical myths from reality, thus providing planners with accurate information. Phillip May (1995) points out that although there are many promising substance abuse interventions based on available research in American Indian and Alaska Native communities, the effectiveness of these programs has yet to be firmly established. Future research should also include rigorous evaluation of innovative programs in order to support requests for ongoing funding. May notes that, "The lack of systematic evaluation of these approaches calls for more involvement of researchers at all levels."

A selection of these recommendations follows:

- Clearly, we must become aware of the many factors that establish, nurture, or rupture the link between the individual and the community. Individual and collective trauma must both be addressed so that the sense of Indian and Native community is restored (Fleming, 1992, p. 169).

- The most difficult problems to assess may be the most important of all - problems in development. If alcohol and drugs are having as much admitted and direct influence on the lives of these children...how much subtle damage are these substances causing to the development of their physical, emotional, social, and spiritual growth (Beauvais, 1992, p. 37).
- American Indians and Alaska Natives through their own representatives must be included in the planning, implementation, and dissemination of substance abuse prevention research activities in their communities (Trimble, 1984, p. 29).

- In the light of the present state-of-the-art primary drug use and abuse, prevention research must consider the following:
  ...What forms of drug use are thought to be preventable? By what indigenous and tribally specific means?
  ...What are the nature and dynamics of natural support systems and traditional ways of changing and strengthening them to promote the prevention of substance abuse?
  ...What are the social, institutional and psychological forces which negatively affect substance use and abuse of Indians and the responses, behavioral and cognitive, typically used to cope effectively with attendant problems?
  ...What culturally appropriate information about the nature and consequences of substance use and abuse is available for distribution in Indian communities? (Trimble, 1984, p. 28)

Alcohol and other Drugs: Statistical Selections from the Research on American Indian and Alaska Native Communities

The statistics provided by the research cannot help but startle even the most casual reader. May and Moran summarize these findings in a recent paper in the following way, "As a group, American Indians experience many health problems that are related to alcohol misuse. *Comparison of Indians to non-Indians shows that the age of first involvement with alcohol is younger, the frequency and amount of drinking is greater and negative consequences are more common* " (1995, p. 288).

Even the small sample presented in the following subsections will serve to emphasize the importance of the work undertaken at this conference.

Data on the General Population

As a group, American Indians and Alaska Natives experience high rates of heart disease, cancer, diabetes, and injuries and death resulting from accidents.

For example, alcohol is a major factor in 5 of the 10 leading causes of mortality for American Indians.

More recently, Walker et al. found that among persons newly discharged from Veterans Administration hospitals, American Indian veterans had twice the rate (45%) of alcohol dependence as did non-Indian veterans.

(May and Moran, 1995, p. 288)

A study completed in the Portland area by the IHS showed that of 8,299 hospitalizations in FY 1987 through 1989, almost 30% of the hospitalizations were identified as being alcohol related. 40% of all male hospitalizations were at least partially alcohol-related, while 21% of female hospitalizations were at least partially alcohol-related.

This study details 50 different alcohol-attributable diagnoses including cancer, mental disorders, heart-related problems, respiratory diseases, maternal alcoholism, digestive diseases, unintentional injuries, suicide, homicide, diabetes and others.

(Mason-Hovet, 1994)

During the years 1986 through 1988 for the age group 25 to 34:

Indians died 2.8 times more frequently from motor vehicle crashes than did non-Indian men,

2.7 times more from suicide,

1.9 times more from homicide, and

6.8 times more frequently from alcoholism (alcohol dependence syndrome, alcoholic psychosis, chronic liver disease, and alcoholic cirrhosis).

(May and Moran, 1995, p. 289)

American Indian and Alaska Native Men and Women

Indian men have twice the rate of alcohol-involved death as Indian women.

Compared with non-Indians, Indian women aged 25 to 34 years die 1.4 to 12.0 times more frequently of alcohol-involved causes than do non-Indian women.

(May and Moran, 1995, p. 289)

Sixty-one percent of Maidu or Miwok women interviewed for a recent study thought their parents had a problem with alcohol; 46% reported at least one parent used alcohol daily.

Seventy-four percent of the women described their fathers' primary behavior while drinking as violent, and their mothers' as depressed.
Twenty percent of the women could not stop using alcohol during pregnancy even though they were aware of the dangers to their pregnancy.

(Hussong et al., 1994)

American Indian and Alaska Native Youth

The age at first involvement with alcohol is younger for Indian youths, the frequency and amount of drinking are greater, and the negative consequences are more common.

Oetting et al. have found that at all ages and grades a greater percentage of Indian youths are more heavily involved with alcohol than non-Indians.

Several studies indicate that this is both encouraged and expected among many peer groups as the "Indian thing to do."

By twelfth grade, 80% of Indian youth are current drinkers, but there is some variation from reservation to reservation.

Those youths most likely to abuse alcohol are those with close ties to alcohol- and drug-abusing peers. Also, those Indian youths who do not do well in school, who do not strongly identify with Indian culture, and who come from families who also abuse alcohol are more likely to abuse alcohol and drugs.

(May and Moran, 1995, p. 289)

Daily use of marijuana is found much more often among Indian youth. One in every 20 Indian seniors, on or off the reservation, used marijuana daily.

...Native American youth have the highest rate of sexually transmitted diseases found in any ethnic group. The use of alcohol and drugs undoubtedly has an influence on this problem...

Nearly one-third of reservation Indian 8th graders anticipate that they will use drugs in the future compared to 17% of non-reservation Indian 8th graders and only 10% of Anglo 8th graders.

...Indian children are developing accepting attitudes about drugs. The messages that drugs are harmful...are not getting through.

(Beauvais, 1992, pp. 32, 33 & 42)

Hopeful Signs

Native Americans have the highest rate of abstinence of any ethnic group in the United States.

(The Healing Journey Accord agenda, 1995)

The mortality rate from alcoholism for American Indians decreased from 54.5 per 100,000 population to 26.1 between 1978 and 1985 - a reduction of 52%

(Rhoades et al., 1988, p. 621)

For most Native American youths, alcohol use is not a serious problem. 59.8% of all teens surveyed claim that they either do not drink or have not used alcohol in over a year.

The family is a source of strength and nurturance for many Native American teenagers. Two-thirds of those surveyed believe their families care alot about them.

(University of Minnesota, 1992, p.42)

Indian youth with strong attachments to families, where culture and school are valued and abusive drinking is neither common nor positively valued, tend to be less likely to get seriously involved with alcohol or drugs.

(May and Moran, 1995, p.290)

When socio-economic status is controlled, comparable American Indian and non-American Indian groups show similar patterns of drug use. Findings suggest common influences, such as conditions of poverty, prejudice, and lack of opportunity. *(note: while not necessasrily a positive finding, it does indicate that external conditions such as poverty are to blame as opposed to inherent cultural or racial factors)*

(Beauvais, Oetting, Wolf, and Edwards, 1989, p.635)

Directions for the Future: Selections from the Literature

Academic literature also highlights promising practices in substance abuse prevention and treatment for American Indian and Alaska Natives. May and Moran (1995) present a review of comments made in the the literature related to promising practices. These observations include,

- Mail and Wright indicate that successful prevention programs will have to come from the communities themselves (p. 289).

- Programs that are implemented in Indian communities must be designed in a way that allows the content to be shaped and molded to fit the local structure. Furthermore, programs must assist people in their efforts of empowerment. Health promotion and prevention programs can be initiated by outside "experts" working with tribal leaders, but the continuation and entrenchment of the activities must be carried on by individuals in the local community.

  ...programs should be made relevant to local norms, values, and conditions through particular, culturally sensitive adaptations. May et al. describe seven steps that are useful in developing appropriate community-based prevention programs. These steps are (1) listen, (2) develop a relationship or rapport, (3) maintain a dialogue, (4) avoid polarization, (5) be flexible in response to resistance, (6) provide a menu of options, and (7) help the community members initiate options on their own.

  No single type of alcohol abuse prevention should be championed, but rather various programs and approaches would be fit or bound together in a mutually supportive and beneficial manner (p. 297).

- The consistent themes in school-based substance abuse prevention programs are building bicultural competence, increasing self-esteem and self-efficacy, improving peer-pressure resistance and overall discriminatory and judgment skills, and increasing the perception of the riskiness of alcohol and drug use. That is, building self-esteem alone will not solve the substance use and abuse problems, although building new perceptions, values, skills, and support systems along with self-esteem may be the key (p. 293).

- Rhoades et al. and, more particularly, the Indian Health Service call for broad programs of health promotion, particularly those that emphasize community change. May stresses primary prevention through social policy, environmental change, and broad-based action for normative change. OSAP focuses on both mental health and substance abuse programs for prevention and concludes with an emphasis on comprehensive prevention (p. 294).

- Beauvais pinpoints socioeconomic conditions as the major factors that have contributed greatly to substance abuse among the youth of most Indian communities. True prevention of many substance abuse problems will come from improvement in social structure (economic, family structure, and

cultural integrity), socialization (family caring, sanctions, and religiosity), psychologic factors (self-esteem and reduced alienations), and peer clusters (peer encouragement, and sanctions not promoting alcohol and drugs); ultimately, changes in these arenas will lead to lower levels of alcohol and drug use (p. 294).

Section II. Federal Involvement in Alcohol and Drug Abuse Prevention and Treatment among American Indians and Alaska Natives: 1985-1995

Unless we (the tribes) are allowed to participate as an equal partner....we foresee very little success in addressing the problem of AOD abuse on Indian lands ...we can ill afford another Federal experiment ...another government program benefiting only the Federal Bureaucracies. We are only asking that we be allowed to do for ourselves what others have failed so miserably to do for us. (Ms. Katherine Arviso, Director, Division of Health Improvement Systems, Navajo Nation, Testimony before the Senate Select Committee on Indian Affairs, Hearing on the Implementation of PL99-570, Nov. 5, 1987)

Introduction

No discussion of the development of alcohol and drug abuse prevention and treatment among American Indians and Alaska Natives during the past 10 years can avoid considering the role of the federal government and the agencies of the government authorized to provide services to Indian people and tribes. Most of the money that has been available for the "war on substance abuse" has come from the federal government via appropriations attached to a number of important public laws (see the Appendix for a "timeline" of legislation, governmental studies, and political events). Much of the debate surrounding the scope of the problem, the best ways to provide solutions, and the outcomes of programmatic efforts can be found in the language of the laws. There are also many reports generated by oversight groups, papers and written comments from the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA), and hundreds of pages of testimony before congressional hearings by tribal and community leaders. This discussion presents two "themes" in order to give Summit participants shared language and ideas to work from as they consider the federal role in their own plans and ideas about future directions and strategies.

Theme #1: The Promise and the Problem

Ever since the United States Government entered into treaties with the tribes, the Sovereign Nations within a nation have had to deal with federal efforts to live up to treaty and trust obligations. This includes living with and adapting

to the structures and processes by which the federal government makes decisions, authorizes, appropriates and distributes monies, and oversees the agencies and programs charged with carrying out these obligations. As one IHS-Headquarters West document points out:

> There is an inherent paradox between the concept of tribal sovereignty with a unique governmental relationship with more than 500 tribal entities and the structure of a Federal agency which receives appropriations to deliver regional services to eligible individuals. (IHS Year 2000 Plan, May 1993)

Progress made in the last 10 years seems to have happened in spite of how things move forward on Capitol Hill. Legislation that takes years to be passed into law may establish a foundation to work from , but there is always a great deal of "tinkering" that goes on afterward to try and make it fit the real needs of the target group. Congressional leaders hold hearing after hearing giving invited speakers 5 minutes to state their case. They appoint multiple "joint review panels" or "special investigations" groups, authorize additional studies, establish more "branches" or "offices" or "centers", all the while ignoring community-based or nontraditional ways to evaluate outcomes. This system takes money away from the delivery of direct services where it is most needed. Leaders in the field believe that giving money to the tribal people and community groups who are closest to the problems and have potentially the best ideas about how to develop culturally and spiritually sensitive solutions would be a better solution.

> **For too long solutions to Indian problems have been made in Washington. And many of these solutions have not brought about the desired results...We will seek solutions to Indian problems in Indian country.** (Senator Daniel K. Inouye, Chairman, Senate Select Committee on Indian Affairs, Hearing on the Implementation of PL99-570, Nov. 5,1987)

The elements of federal structure and process that create as many obstacles as solutions have been noted in numerous transcripts and reports. Among these elements are the following:

- **A lack of coordination exists within and between the federal agencies charged with carrying out the main sections of the substance abuse prevention and treatment laws.**

This problem persists despite the fact that PL99-570 mandated cooperation between the IHS and BIA and formal Memorandums of Agreement (MOAs), as well as Managerial Action Plans (MAPs) are in place. The pattern of non-coordination and autonomous operation are ingrained in the way the IHS and BIA relate and are embedded in the way they carry out their respective missions. Service areas do not necessarily overlap and even when they do, offices may not be located in the same vicinity or even the same community. In addition, the IHS and BIA have competed for turf, control, and scarce resources with each other and with tribes for so long that cooperation and mutual support are not easy to accomplish. These patterns are reinforced over and over by what many tribal leaders and Indian service providers see as the "paternalism" and tendency to operate unilaterally that characterizes the IHS, as well as the general lack of BIA responsiveness on the local level (see any of the oversight reports and hearing transcripts referenced in the Bibliography).

There was...a tendency for all the different (tribal) departments to be pulled strongly together with their respective Federal contracting agencies rather than with the tribe. This was not discouraged by the IHS and the BIA...Both the BIA and IHS, meanwhile, proposed their own plans for spending what they were receiving of which the tribe was informed only at the last minute.
(Ms. Katherine Arviso, Director, Division of Health Improvement Systems, Navajo Nation, Testimony before the Senate Select Committee on Indian Affairs, Hearing on the Implementation of PL99-570, Nov. 5, 1987)

- **High rates of administrator and staff turn-over throughout the system make continuity in planning, policy-making, and consistent delivery of direct services difficult.**

- **Federal policy and appropriations are subject to the "whims" of presidential administrations which creates an overall context of unpredictability.**

This makes long-range planning very difficult and creates obstacles for the development and implementation of strategies for change. In the decade between 1985 and 1995 there have been three presidents. Even though PL99-570 was enacted during his tenure, President Reagan's overall philosophy of "downsizing,

deregulation, and deficit reduction" impeded consistent program development. He vetoed reauthorization of the Indian Health Care Improvement Act several times, meaning that appropriations for IHS had to be renewed annually through congressional resolutions. This is a time-consuming and costly process that can interrupt the flow of funds. In addition, many of the appropriations were categorized as non-recurring. Failure to expend these monies within the time allotted would mean loss of the money, and often unilateral, hasty expenditures by IHS resulted in the ultimate dilution of some substance abuse efforts and/or the use of money for projects not responsive to tribally defined needs or programs (Hearings on the Implementation of PL99-570 and on S. 290).

- **Despite an overall increase in funding since 1985, funding levels are still inadequate. The demand and need far exceed the ability to deliver services. In addition, the bureaucratic requirements and regulations of the federal funding process make it difficult to deliver funds to target groups and programs in a timely fashion.**

According to numerous sources, the monies that are available for alcohol and drug abuse prevention and treatment have never kept up with the demands for services. In addition, the process for getting funds dispersed to IHS service areas and/or tribal groups often results in lost opportunities. Some experiences of the Phoenix area offer a good example. According to the testimony of Mr. Donald Antone, Sr., Governor of the Gila River Indian community and President of the Intertribal Council of Arizona, to the Senate Select Committee on Indian Affairs, Hearings on the Implementation of PL99-570, a joint committee was formed including representatives from IHS, BIA, and two tribal leaders from Nevada, Utah, and Arizona in immediate response the PL99-570. This group met regularly and submitted a proposal for a regional youth treatment center as required by the law. In his testimony, Mr. Antone describes what ultimately happened:

> There was great anticipation and expectation by tribes that these resources would be immediately available...however, this did not occur. The (OMB) held up the release of funds to the IHS until June of 1987. The IHS took time to develop distribution formulas and funds were not available to these areas until July of 1987. The Phoenix area, in turn, had to develop its own distribution formulas so that when the resources were finally divided up there was not enough time for the tribes that desired to contract for the funds...In the end, the Phoenix area IHS decided to use the additional resources to relieve the deficit in their fiscal year 1987 hospital and clinics budget by identifying services that were related to alcohol and drug abuse throughout all of fiscal year 1987. (Hearing Transcript, p. 5)

Few tribes in the Phoenix area took advantage of training monies authorized by PL99-570 that were made available by June 1987 through "638" contracts because the guidelines and criteria for the selection of trainers were very restrictive and the time frame for submitting proposals for training programs was only two weeks. Over and over, transcribed testimony and reports characterize the flow of money and opportunities as "untimely" and almost impossible to take advantage of. For the Colville Confederated Tribes in the Portland area for example, the funding made available was not sufficient to enable them to overcome the logistics and expense of travel and service delivery within a huge geographic region (from Eastern Washington and Oregon all the way to Western Idaho). The concept of establishing "regional" centers for service sounds good, unless you are many miles away from that location with little to no money in your budget for travel.

...the funding mechanism...is totally and absolutely all wrong...The authorizing bills, the separate programs, the funding agencies, the recurring and non-recurring funding. It is not possible to build a 5- or 10-year plan because the resources are indefinite. It is also not possible to build a comprehensive health care system because the resources are too regulated and prohibit full coordination. This particular problem is not relevant just to Indian tribes. (Ms. Juanita Learned, Chairperson, Cheyenne-Arapaho Business Committee, Concho, OK, Testimony before the Senate Select Committee on Indian Affairs, Hearing on S. 290, Indian Anti-Drug Abuse Amendments of 1991, May 23, 1991)

Theme #2: A Search for Balance

Many in the alcoholism constituency are fearful of false expectations raised by unfulfilled promises. (Ron Carlson, Associate Administrator, HRSA Planning, Evaluation, and Legislation Rockville, MD, Participant in 1985 IHS Alcoholism and Substance Abuse Prevention Initiative, 1985.)

The other major theme that emerges from a review of federal publications and the testimony of tribal leaders is a constant struggle to find a balance between two opposing world views. This struggle has had far-reaching effects on the war

on substance abuse among American Indians and Alaska Natives. It is the opposition of IHS and Native models - models of healing and health, standards for treatment, how to measure or evaluate outcomes/success, how to define and include roles for the family, community, and traditional medicine men or spiritual healers, and, finally, how to incorporate local, community- and tribally-based ideas and ideals across the continuum of prevention, care, and aftercare.

The Medical Model and the Indian Model. Historically, the IHS based its approach to service delivery on the Western medical model. Early approaches to alcoholism treatment within this overall framework focused on individual pathology and medical detoxification. Even when alcoholism was finally recognized as a disease and not a sign of moral or spiritual weakness, the need to heal the whole family or to see the disease as one that crosses generations and affects whole communities was not fully comprehended and certainly not institutionalized in the system. For doctors, treating the individual with symptoms came first. This is slowly changing as IHS builds its alcohol and drug abuse prevention and treatment system, and policies about the best ways to treat substance abuse among Indian populations evolve.

The (Indian) alcoholism movement started as a grassroots effort, not from the top down - individuals talking to one another, forming small groups, which grew into bigger groups, which became statewide, regional, and finally, nationwide in scope. (Mr. Ernie Turner, Alcoholism Counselor, Participant in 1985 IHS Alcoholism and Substance Abuse Prevention Initiative, 1985)

The Indian alcoholism movement began its developed from the grassroots level in the 1950's. Alcohol treatment centers run by Indian groups like the Seattle Indian Health Board, which were neither tribally nor federally funded, also developed years before the mid-'80s initiatives. Today these efforts persist and grow as well, reflected in the hundreds of tribal- and community-based programs funded through "638" contracts, Public Laws 99-570, 100-690, and 102-537, the "Buy Indian Act", Center for Substance Abuse Prevention (CSAP) initiatives, and some state, local, and foundation monies (see Section III of the Briefing Book). Much of the real progress in terms of appropriate, working models can be found in these programs which have evolved slowly over time in response to and out of local contexts. Testimony by Mr. Ralph Antone, Acting Alcoholism Coordinator, Tohono O'Odham Nation, Sells, AZ, before the Senate

Select Committee on Indian Affairs on S. 290 Indian Anti-Drug Abuse Amendments of 1991 (May 23, 1991) describes one such developing effort:

> Using the authorities and programs of PL99-570 and other resources, we have been able to establish some programs which have been effective...Where 3 years ago the only support group such as AA, Alateen, and Alanon...was in Sells, the tribal headquarters, now there are 19 groups in communities throughout the reservation which conduct frequent meetings. We have 3 prevention specialists who conduct presentations at schools and district meetings and 3 youth counselors who meet with adolescent groups in the summer...The Alcoholism/Substance Abuse Rehabilitation and Aftercare Branch (of the tribe) sponsors a family week which involves the families of those in treatment and has recently developed a Vision Quest Program for youth outpatient services. (Hearing Transcript, p. 41)

Within the last decade, the war on substance abuse among American Indians and Alaska Natives has been two-pronged: one from the top down involving IHS efforts delivered through the various structures of the health care system and one from the grassroots-up designed and delivered by tribal and community leaders. Since both parts of these two models were funded by some of the same legislative initiatives, the differences between them were bound to create some problems. The medical/pathology model is in many ways the opposite of traditional, holistic models based on cultural and spiritual understanding and practice.

> **IHS had no job descriptions for "medicine man" or "native practitioners" so the state of Minnesota developed its own. The Indian alcoholism movement has legitimatized the utilization of Indian spiritual counselors and has made effective use of them.** (Mr. Elwin Benton, Administrator, Mash-Ka-Wisen Treatment Center, MN, Participant in 1985 IHS Alcoholism and Substance Abuse Prevention Initiative, 1985)

Differing Models of Evaluation. The medical and bureaucratic oversight model defines, measures, and evaluates "outcomes" and success in highly restricted ways and doesn't seem to recognize or honor any other way. One report describing the state of affairs in Indian adolescent mental health began with this statement: "*Scientifically acceptable* information on the extent of mental health problems among Indian adolescents and on the availability, accessibility, and effectiveness of mental health services specifically for Indian adolescents is scarce" (OTA Report, 1990, p. 1). "Scientifically acceptable" is highlighted because it reveals a very strong bias that influences how federal policy makers

decide what is or isn't a good program, a good effort, or even good information. For example, federal agencies like CSAP must answer to Congress for the money they spend in the delivery of their programs. As a result, there is a strong movement within CSAP and other funding agencies to make "rigor" and scientific design more important for programs and a key element in the competition for funding. At a 1994 National Conference, CSAP introduced a new director for an "Office of Scientific Analysis" to coordinate the collection of outcome data for program and cross-site evaluations. CSAP's Call for Proposals in 1994 included the following language:

> CSAP will support only applicant projects that have well developed and comprehensive evaluation plans. The evaluation plan must be conceptually and procedurally integrated with the overall project, and must have both an outcome evaluation component and a process evaluation component...The evaluation plan must present a sound methodology for the collection, storage, analysis, and interpretation of data. The evaluation plan must utilize psychometrically sound measures and instruments for data collection... (High Risk Youth Program Announcement, 1994:17,18)

To its credit, CSAP makes an effort to seek out and fund innovative grassroots efforts. Yet, real differences exist between grassroots groups and their federal counterparts. These differences are highlighted in Table I on the next page. The impasse between the traditional evaluation paradigm based on the rigorous application of scientific principles and traditional American Indian and Alaska Native ideals may never be reconciled.

Standards. There are other pressures on the field to "professionalize", but in the minds of congressional leaders making the mandates and funding the programs this also has a narrow definition. Some reports criticize the IHS and/or the BIA because alcoholism counselors are not "certified." Another similar area that has slowed progress is the need for program "standards" and criteria. Indian leaders do not dispute either requirement, but they want policy and law makers to take local wisdom and practices into account. Additionally, they want programs and activities to be sensitive to the heterogeneity of tribes and responsive to local conditions.

Table I. A comparison of beliefs and practices between community-based, informally developed program efforts and the formal/technical federal bureaucracy

Grassroots group:	Federal bureaucracy:
1. A positive relationship between some program idea & the local culture of the tribe or community is accepted from experience	1. Relationship must be documented by research & evaluation using measurable objectives
2. Stories of experiences passed on in oral tradition, shared only when appropriate, may never be written down	2. Scheduled, written documentation required for accountability; the deadlines are pre-established and not related to local context
3. Work of the group organized around "professional friendships" and "family"	3. Bureaucracy built on accountability and formal structure
4. Nondirective leadership, responsible leaders, who" grew up" in the system, get things done when they need to be	4. Supervision must be directive in order to ensure adequate reporting by staff and proper program implementation according to formal guidelines/mandates
5. Non-hierarchical organizational chart stressing teamwork, few job descriptions, people do what they need to do to get things done, everyone helps	5. Top-down hierarchy with compartmentalized roles and formal job descriptions
6. Guided by a "shared vision" and model that evolved (learning/changing by doing, trial and error, and seeking wisdom from tribal elders and/or spiritual leaders)	6. Formal mandates/proposals act as guide in order to show compliance and "tangible", "measurable" results

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Standards and criteria should flow out of the experiences of the tribes and the agencies at the line level in a joint planning effort, not from the headquarters of the BIA and the IHS... (Mr. Kenneth Charlie, Chairman, Health Committee for the Tanana Chief's Conference, Alaska, Testimony before the Senate Select Committee on Indian Affairs, Hearing on the Implementation of PL99-570, Nov. 5, 1987)

Signs of Effectiveness

A number of challenges to the development of the Indian alcoholism and drug abuse prevention and treatment movement have been presented. There are also many signs of effectiveness and evidence of progress to be found in the public record since the 1985 IHS Program Review and Action Plan. The following graphic reviews the 9 areas of recommended action from that document and provides examples of actions taken with respect to each area:

Area for Action	Examples of Positive Developments since 1985
1. Planning	MOAs between IHS and BIA made and updated
	MOAs between BIA and DOE re: AOD programs in schools
	IHS Organizational Management Action Plans and Area Office Workplans developed
	Tribal Actions Plans (TAPs) completed by 70% of 546 tribes as of 1993
	IHS Year 2000 Plan
2. Monitoring	Chemical Dependency Management Information System (CDMIS) developed by 1993 to replace older Alcohol Treatment and Guidance System (ATGS); implemented in 52 sites as of May 1993; supposed to be in use throughout the system in 1995
3. Standards	Operating standards approved May 1991; supposed to have been delivered to Area Offices by July 1991
4. Resource Management	Increasing appropriations and expenditures though not always to the levels authorized; no detailed information found on management other than reports and general testimony that is critical or non-critical
	Resource Allocation Method (RAM) criticized in 1991 by some groups; reported as being revised

Area for Action	Examples of Positive Developments since 1985
5. Operations	In 1987 there is one operational regional youth treatment center (RTC); by 1993 there are 8 RTCs in 6 IHS Service Areas In 1986, prior to PL99-570, funding for the Alcohol and Substance Abuse Programs Branch of IHS is $26,131,000.00; by 1993 the funding is $82,334,200.00 A 1993 Guide to IHS-funded Alcohol and Substance Abuse Programs lists 320 programs across the 12 Service Areas By 1994 there are reportedly 30 programs across the country addressing Fetal Alcohol Syndrome (FAS) prevention Promising models developing and being disseminated (e.g., Alkali Lake, Red Road, CSAP-funded demonstration projects, use of Child Protection Teams, "Trainer of Trainers" models/curriculum, etc.)
6. Evaluation	Continued general testimony/mentions in reports of problems as well as IHS comments on strategies for improvement of data collection, compilation, and dissemination By 1994 CSAP tightens evaluation requirements for its AOD prevention programs for high risk youth
7. Coordination	National Clearinghouse for Alcohol and Drug Information (NCADI) formed as part of CSAP. This addresses one recommendation listed under this area. MOAs, MAPs, and Area Office Workplans

Area for Action	Examples of Positive Developments since 1985
8. Training	Publications like the IHS Primary Care Provider provide descriptions of training sessions and announcements of training opportunities available through IHS Many programs and tribal entities include training opportunities for staff as part of professional development; some tribes develop certification requirements through their own programs and TAPs Several local, regional, and/or national groups funded through a variety of sources develop/disseminate training models that are associated with the group (e.g., NANACOA, First American Prevention Center, GONA, White Bison, etc. See Section III for more details.) Successful models like Alkali Lake disseminated through videos and training Tribal colleges develop training/certification programs
9. Research	Regular publications in academic journals Some scholars (e.g., Phil May) and research centers (e.g., the National Center for American Indian and Alaska Native Mental Health Research) specialize in this area CSAP, NIDA, NIAAA, and NCADI support development and dissemination of research CDMIS should provide better tracking and data on AOD abuse, prevention, and treatment within IHS The Provider includes monthly bibliography

Section III. Substance Abuse Prevention Programs for American Indians and Alaska Natives

Efforts to combat substance abuse across Indian country have increased and diversified over the past decade. American Indian and Alaska Native communities are actively responding to the need for substance abuse prevention in a wide variety of ways through grassroots efforts and as participants in IHS and other government-sponsored programs. Several large scale surveys of prevention efforts have identified up to 600 programs serving American Indian people at any one time, although the number is impossible to calculate precisely. Efforts have been funded by the federal government through agencies such as the IHS, CSAP, and the BIA. Other sources of funding include local, state, and private foundation funding such as that provided through the Robert Wood Johnson *Healthy Nations* program. These have been relatively well documented. Prevention and treatment programs, like the Seattle Indian Health Board, have also been developed and implemented at the local community level without benefit of external funding.

What do we know about substance abuse prevention programs serving American Indian people? We know that prevention programs are as varied as the communities they serve. Despite the lack of abundant evaluation and research evidence, a core of promising practices is beginning to emerge from a review of several hundred program experiences over the past decade. For example, we know that programs have become more prevention oriented, as compared to an earlier emphasis on treatment. Single strategies are being replaced by comprehensive programs. Community based approaches are becoming the norm. Following is a description of what is known about the types of prevention efforts which have been developed for American Indians along with a discussion of programs and practices which appear to be particularly effective.

The program landscape: What is being done?

Prevention efforts are generally characterized as falling within three levels depending on degree of substance abuse involvement. *Primary prevention* refers to programs aimed at preventing abuse before it occurs. These are generally focused on community-wide strategies designed to promote healthy lifestyles, thus strengthening the ability to resist substance abuse involvement. *Secondary prevention* refers to strategies aimed at detection and early intervention among high risk populations such as youth and women in their child-bearing years before substance abuse becomes firmly entrenched. *Tertiary prevention* generally refers to treatment and is aimed at preventing existing substance

abusers from relapsing and at reducing the effects of abuse to whatever extent possible. There is a growing recognition of the importance of primary prevention efforts. In general, these approaches are developed by and for local communities and represent some of the most innovative ideas on the prevention landscape. Treatment approaches, while critical, are more tied to external "medical models" developed outside of the community, although promising innovations at the local level are emerging. Early intervention strategies fall somewhere in between primary prevention and treatment, representing a blend of tribal and federal initiatives and of innovative and mainstream approaches.

Several studies published throughout the past decade provide a portrait of substance abuse prevention activities in American Indian communities. In 1986, the IHS conducted a survey of 580 schools, programs, and agencies serving Indian communities in order to gather information about substance abuse prevention activities throughout the country (Owan et al., 1987). Several years later, OSAP reviewed sixty prevention programs aimed at American Indian populations including an indepth examination of a smaller number of OSAP-funded prevention programs in Indian communities (OSAP, 1990). Recently, May and Moran (1995) reviewed the literature from 1982 to 1994 on health promotion efforts for American Indians. Collectively, these studies describe current trends in prevention programming, including, but not limited to the following characteristics:

- community-wide prevention focus aimed at health promotion and risk reduction;
- comprehensive, multi-level strategies;
- education for high risk groups;
- training for service providers and other community members;
- incorporation of cultural and spiritual values and activities; and
- inclusion of recreation and alternative activities for youth.

Evidence of effectiveness: What works?

Along with the studies cited above, several others have begun to evaluate the effectiveness of prevention programs, identifying the most promising practices (GAO Report, 1992; OSAP, 1989; Tobler, 1986). It is important to note that medically and legally oriented practices such as Antabuse treatment, detoxification efforts, case management, and arrests for driving while intoxicated have been more frequently and carefully evaluated, sometimes giving the impression that they are more effective, a possibly misleading assumption. Many of the newer, more innovative, grassroots strategies show promise of being

effective in reducing the burden of substance abuse throughout Indian country. Often, however, traditional "scientific" evaluation approaches are inappropriate or difficult to apply to complex, comprehensive, and culturally based prevention strategies.

The following is not intended to be a comprehensive list of all effective strategies identified through formal or informal program evaluations. Rather, these are approaches which appear frequently in prevention programming, which are consistent with good theory, practice, and cultural teachings, and which are positively regarded by the majority of reviewers. They include:

- **Comprehensive program orientation**
  This is also referred to as a systems approach. Reviewers are unanimous in their belief that the most effective prevention programs are those which offer a variety of services (education, counseling, alternative recreational activities, affective skills training, etc.) which are targeted at multiple levels of the community (individual, peer, family, school, community-wide). Comprehensive programs also tend to offer these varied services through a single agency and to address individual and community needs from a holistic perspective rather than strictly focusing on substance abuse. Early intervention and treatment strategies are also included in the most effective comprehensive programming.

- **Creating change in the fundamental legal and economic structures of the community**
  In creating a comprehensive substance abuse prevention strategy, it is important to address the role played by the legal and judicial systems in effecting change within a community. Economic factors such as poverty and unemployment also contribute to social and individual stress and dysfunction and must be addressed to support lasting change.

- **Inclusion of cultural values and beliefs about wellness**
  The most successful programs recognize the role of cultural identity and pride in supporting positive mental health. Including and valuing spiritual beliefs is central to this strategy. Many programs have successfully involved elders to teach, model, and reinforce cultural values. Several reviewers suggest that developing competency in both tribal and mainstream worlds - bicultural competence - is another important strategy for both youth and adults.

- **Prevention orientation**
  Many programs recognize the wisdom in preventing problems before they start. In most cases, this means targeting youth before they are faced with the pressures of adolescence. It also includes a positive focus on developing community and individual strengths, rather than on weaknesses. The most fundamental causes of substance abuse and other related social ills such as historical trauma, poverty, social and cultural disintegration must be recognized and addressed as well as more "superficial" causes.

- **Indirect approach to prevention**
  Successful primary prevention programs tend to achieve substance abuse prevention objectives indirectly through activities such as recreation, cultural events, self-esteem development, community development, and the like, rather than focusing directly on substance abuse. Community members, especially youth, are more likely to participate when program activities are not related directly to substance abuse prevention.

- **Recognition of variety and uniqueness throughout American Indian communities**
  Prevention efforts must be tailored to the unique needs of each community or population. There is great diversity throughout Indian communities; one size does not fit all. This requires:

- **Community participation in program development and implementation**
  Social change efforts are only effective and lasting if they are the result of authentic community involvement. In this way, communities come to truly "own" social programs and are much more able to identify and solve problems as they arise. Community empowerment is an important result of this strategy.

- **Collaboration among community agencies and institutions**
  Strengthening the links between school, home, civic organizations, law enforcement, and health care providers is critical to effective prevention efforts. Communities must put forth a concerted, clear anti-drug message in order to change social norms and negative behavior.

- **Specific strategies for youth and families:**

  Peer programs. Effective programs channel potentially negative

peer influences into positive ones by providing positive role models, peer teaching, counseling, peer problem solving, decision-making, and conflict resolution, as well peer pressure resistance and refusal skills.

Youth empowerment models. Youth are empowered through participatory approaches in which they actively engage in experiential activities rather than passively listen to "experts" and other adults. Leadership training, role modeling, and general skills development are frequently used strategies.

Education. Awareness of the risks of substance abuse is effected through education of both youth and adults. Effective programs combine factual knowledge with affective education such as listening, conflict resolution, and self-esteem development; finding neither strategy alone to be very effective.

Role modeling. Effective programs provide positive peer and adult role models, especially important in breaking entrenched inter-generational cycles of substance abuse.

Family skills development. Effective programs implement strategies designed to strengthen the family and to enhance communication between children and parents. This may include parenting skills training, social supports, and involvement of parents in school and community activities.

Obstacles to program effectiveness

Even the most effective programs experience problems in implementing these strategies and achieving their goals and objectives. The most frequently identified obstacles and problems are:

- **IHS focus on treatment**
  Although IHS has made strides toward becoming more primary prevention-oriented and community based, their underlying focus remains more treatment oriented. Since the largest portion of federal funds available for substance abuse prevention efforts serving American Indians comes from the IHS, this is a significant issue. Recent collaborative activities, such as the *Gathering of Native Americans* training program conducted by CSAP for IHS indicate a move toward primary prevention.

- **Lack of stable financial resources to support program development, implementation, and operation**
  As discussed in the previous section of this briefing booklet, the availability of federal funding varies from year to year as do federal priorities regarding the use of such funds. Accessibility of funds is often limited by excessive and complex bureaucratic procedures. The bottom line for many programs is that funding is simply inadequate, from whatever source, to implement comprehensive strategies effectively.

- **Need for program leadership and staff commitment**
  There is a need to identify talented, creative, and dedicated leaders to administer and manage complex prevention programs. The stress level is often high and burn-out is a problem. Leadership development programs are needed to ensure a continuing pool of effective program leaders and staff.

- **Poor coordination of services**
  Due to problems with funding agencies, high staff turnover rates, and the like, prevention programs have had a history of inconsistent service provision. Services are offered for a year or two, then discontinued. Program offices change. This type of instability makes coordination with other service providers and community organizations and institutions difficult. Young people especially need continuity in relationships with programs and staff.

- **Difficulty in tracking program participants**
  Many programs are able to provide services for a limited period of time to participants, but find it difficult to maintain contact with participants for follow-up activities, feedback, and the like.

- **Need for program evaluation**
  Evaluation data are needed by program planners and staff in order to modify programs to make them more effective. In addition, evidence of effectiveness is a morale booster to staff. However, effective evaluation is costly, often requiring the services of outside evaluation specialists. Traditional evaluation designs utilizing control or comparison groups and requiring large numbers of participants for statistical meaningfulness are often not available or inappropriate. There is a need for balance between process/qualitative evaluation and outcome/quantitative evaluation. Finally, there is a need for program

evaluation which includes program staff and participants in meaningful ways and which presents results which are useful and timely.

- **Urban Indian populations are underserved**
  Many prevention programs have been designed for implementation on reservations or in Indian communities. This is especially true of primary prevention efforts. Indian people living in urban areas have difficulty accessing services and often do not come into contact with potentially effective practices until substance abuse problems have escalated to serious dimensions.

- **Need to address underlying political, legal, social, and economic issues**
  Many writers and program developers describe the relationship between substance abuse and fundamental problems of modern community life. For example, poverty has been identified as a major contributor to the increase in substance abuse in American Indian communities, however, only rarely do programs attempt to address this difficult issue through initiatives such as economic development and employment and vocational training programs. Obviously, coordination among many community organizations, institutions, and services is required to effect change at this most fundamental level.

Selected program illustrations

The following programs are presented here as examples of what is being done throughout Indian country to combat substance abuse and are meant to illustrate effective practices in prevention programming at all levels. Many, many other exemplary programs are providing prevention services to communities and individuals.

School-based programs and curriculums

First American Prevention Center (Red Cliff, WI, Red Cliff Band of Lake Superior Chippewas)
FAPC employs a curriculum developed through consultation with elders which emphasizes a healthy lifestyle embodying traditional values. A core group of community members is trained in the use of the curriculum which is utilized to reunite and re-empower communities. FAPC has developed a formal strategy for directly addressing community division on religious issues which includes fostering an attitude of respect and cooperation between various factions. The FAPC curriculum and training is available to Indian tribes and communities throughout the country.

Renewing Traditions
RT organizes and trains a site-based council in each program community to compliment the introduction of curriculum to Head Start programs.

Little Wound School (Kyle, South Dakota, Oglala Lakota)
LWS offers a full-credit peer counseling class to gradually transform the values and attitudes of the student body in that school. Older students who complete a rigorous training module based on the Johnson Center curriculum (*From Peer Pressure to Peer Support*) are paired with younger students throughout the school year. In addition, the peer counselors and their adult leaders develop schoolwide anti-substance abuse campaigns and run substance-free recreation activities (e.g., prom night school "lock-in").

Primary prevention for youth

The National Indian Youth Leadership Development Program, (Gallup, New Mexico and several New Mexico Pueblos)
NIYLP focuses on primary prevention by emphasizing positive outcomes for youth and helping youth focus on their personal and cultural strengths through a process of *habilitation* and the development of service leadership. Summer camp and school-year programs based on experiential education and wilderness training models, including Search and Rescue training, bring school-aged youth together with teen and adult role models. NIYLP programs have been developed in many American Indian com- munities where the basic model is adapted to fit local norms and to develop a sense of local ownership of programs. NIYLP takes an indirect approach to substance abuse prevention, recognizing that negative topics such as alcohol, drugs, and suicide are best approached indirectly through metaphor, story telling, and other means such as self esteem development. School and community bonding are encouraged through participation in service activities. Training for parents and teachers and developing positive peer groups are essential components of the model.

Training models

NANACOA (National Association for Native American Children of Alcoholics)
NANACOA provides a unique model of intensive training that helps individuals take the next step in their personal healing journey while building a community of safety and support with others. It has developed a prevention campaign to train a core group of grassroots community leaders.

Gathering of Native Americans
GONA is a collaborative project of the Center for Substance Abuse Prevention and the Indian Health Service designed to bring together Native American communities involved in local health and social service issues and to provide training specifically tailored to Native Americans.

Culturally sensitive treatment approaches

White Bison
White Bison is an American Indian organization that provides direct services, community development training, and leadership development programs. The White Bison model combines the wisdom of the medicine wheel with a 12-Step approach to sobriety, a wellness teaching uniquely suited to American Indians.

St. Cloud Veterans Administration Hospital
At the St. Cloud Veterans Administration Hospital, alcoholics undergo treatment in sweat lodges led by a medicine man in order to purge their pasts and reunite them with goodness. The sweat lodge has been incorporated into the 12 Steps of Alcoholics Anonymous.

Hope for the Future

This summary discussion of the substance abuse problems facing American Indians and Alaska Natives includes some daunting information. A reader could be left feeling overwhelmed and hopeless, but this should not be the case. Many good and smart people are working on the problem and progress is being made. More and more is understood about what makes substance abuse prevention and treatment work in American Indian and Alaska Native communities. These communities are creating programs of their own with an emphasis on culture and tradition that help youth learn the skills that will allow them to "walk in two worlds" yet stay connected to their communities. The importance of elders, of prayer, and of the family is playing a role as communities redefine the fight and look inward for answers to this problem. The introduction to Returning to A Natural State of Good Health: A Report on the National Summit on Indian Health Care Reform (1993) contains the following passage,

> The brightest ray of hope...arises from Indian Country itself. Across the nation - on reservations and in cities - Indian people are stepping forward as health care professionals to address Indian health issues directly. Some are graduates of top medical universities. Others have gone through community training programs. And many learn through prayer and traditional guidance from tribal elders to find balance in their healing practice (p. 3).

In the same document mentioned above, Gerald L. Hill, M.D. (Klamath) shares this note of optimism which seems to be a fitting conclusion for this Briefing Book, as well as a call for action for Summit participants:

> **Despite the problems...we must remember that this is not our natural state. Our natural state is one of good health in all the ways that we as Indian people think of health. It has been but a brief period in the history of Indian people that we have lived in a state of poor health.**
>
> **These bad times, though, are beginning to change. Over the past few years, Indian communities, in both urban and rural areas, have become increasingly determined to improve the health of the people. As tribes, we know that we are only as strong and healthy as the individuals within our tribes. Communities know that to survive as a people we must become healthy again.**
>
> **The dedication of Indian people to improve our health is astounding. It is especially important that we also know that to be healthy again we must do so as Indian people...We know that health does not lie in giving up**

National Native American Summit on Substance Abuse Prevention, Briefing Book: Page 33

our culture, but that it is an integral part of our culture.

Today, throughout the country, Indian people are building sweat lodges, learning the language, fighting the negative influences of alcohol and drugs and poor nutrition, and learning more about their culture.

We are coming to understand that to complete the circle of health, we need to do so as healthy Indian people.

(Hill, 1993, pp. 6 & 7)

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1985-1995 Timeline of Significant Federal Legislation,
and Correlated Events

YEAR	SIGNIFICANT LEGISLATION - EVENTS - FINDINGS
1985	IHS Plenary Session/Program Review/Development of Action Plan (51 recommendations in 9 areas): 1. Planning 2. Standards 3. Resource Management 4. Operations 5. Monitoring 6. Evaluation 7. Coordination 8. Training 9. Research
1986	PL99-570 - Omnibus Drug Act, Subtitle C - "Indian Alcohol and Substance Abuse Prevention and Treatment Act" • IHS and BIA mandated to work cooperatively for the first time in the history of both groups • Office of Substance Abuse Prevention (OSAP) created; becomes a source of additional funding for alcohol and other drug abuse (AOD) prevention programs in American Indian/Alaska Native (AI/AN) communities U. S. Congress, Office of Technology Assessment (OTA) publishes Indian Health Care, an overview of IHS/health care delivery for AI/AN. Although alcohol and alcohol-related causes of death are discussed in every section, there is no specific mention of services within IHS for AOD prevention/treatment. Alcoholism treatment is included as part of "Direct Clinical Care" which overall accounts for 62% of the IHS budget. Only 8% of the IHS budget goes to "Preventive Health, with no specific mention of AOD prevention.
1987	Memorandum of Agreement (MOA) between IHS and BIA published in the Federal Register Senator Daniel K. Inouye becomes Chairman of the Senate Select Committee on Indian Affairs, vowing through his leadership to bolster the importance and care taken of Indian Affairs in the Senate.

YEAR	SIGNIFICANT LEGISLATION - EVENTS - FINDINGS
1987	Senate Select Committee on Indian Affairs holds hearings on the implementation of PL99-570, Subtitle C. Testimony from AI/AN leaders reveals difficulties such as: • lack of coordination/cooperation between IHS and BIA, particularly in regard to providing tribes and community agencies with technical assistance in the development of Tribal Action Plans (TAPs), proposals to get regional treatment centers (RTCs) • preemptive, unilateral actions by IHS and/or BIA in spite of the fact that many tribes were working on TAPs and other proposals; in some areas speakers estimate IHS used the money for their own purposes (including making up budget deficits for services already delivered) • inadequate amounts and/or untimely distribution of funds many of which were "non-recurring" • too restrictive criteria and too short time frame for taking advantage of program RFPs and training opportunities • lack of BIA participation in local level activities and use of BIA funds only for programs in BIA schools even though most AI/AN students go to non-BIA schools The overall effort was characterized as "fragmented, delayed, and diffuse." (Katherine Arviso, Director, Division of Health Improvement Systems, Navajo Nation
1988	Fourth attempt to re-authorize the Indian Health Care Improvement Act of 1976 is vetoed by Reagan (who vetoed such bills in 1984, 1986, and 1987). Indian health care had been operating without authorization since 1983/84. In the absence of reauthorization, funding was preserved through continuing appropriations resolutions. George Bush elected President. The Reagan years are over and "Reaganomics", with an emphasis on "downsizing, deregulating, and deficit reduction" end. PL100-690 - Anti-Drug Abuse Act of 1988 amended PL94-437 the Indian Health Care Improvement Act and PL99-570, Subtitle C. Among other things, it extended mandates to urban Indians, called for coordination of AOD programs with mental health programs, made some mandates more flexible (like allowing use of tribal facilities for treatment centers where no federal facilities were available), and provided additional resources to expand services (e.g., to include family members of youth in treatment through contract health services, community rehabilitation and aftercare, etc.)

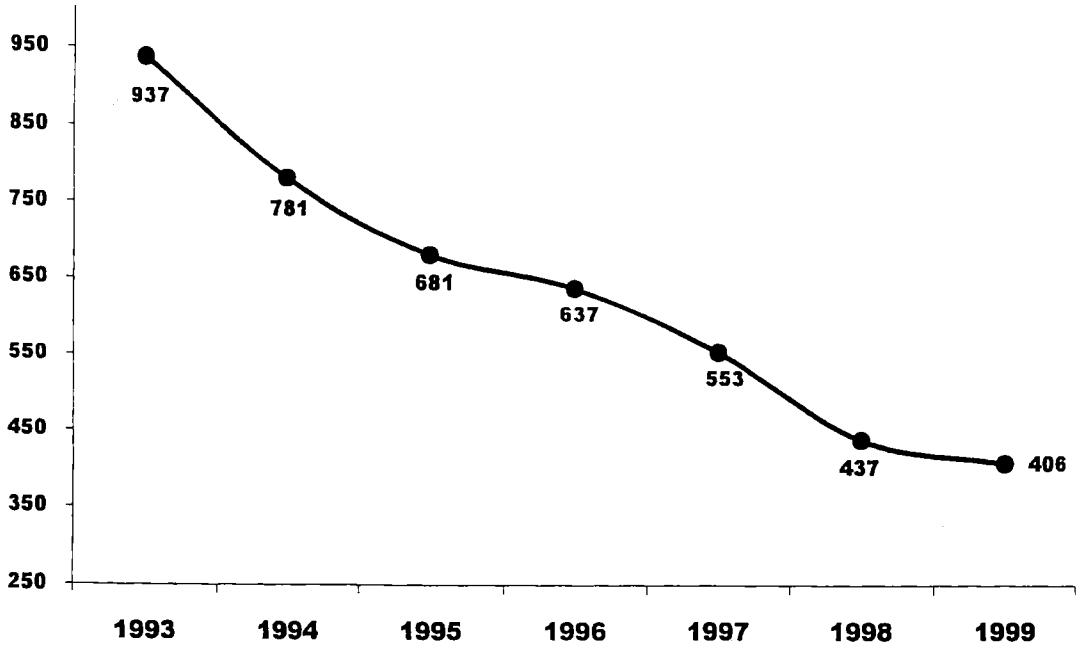
YEAR	SIGNIFICANT LEGISLATION - EVENTS - FINDINGS
1988	Special Investigations Panel of the Senate Select Committee on Indian Affairs begins 15 months of hearings on the BIA, the possibility of "dismantling" the agency, and giving money directly to tribes in the form of block grants. There is opposition to this "new Federalism" among the tribes because, for better or worse, the BIA is still seen as the only official group in Washington that represents AI/AN interests. NANACOA founded.
1989	President Bush calls for increased spending in the "War on Drugs." IHS and BIA recommended to receive more money.
1990	IHS develops National Plan for Native American Mental Health Services. IHS requests money from the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to fund a study of AOD programs, the request is turned down. The Department of Health and Human Services, Public Health Service (PHS) reorganized. ADAMHA (where OSAP is housed) is abolished. NIAAA and NIDA (AOD research divisions) are moved to NIH; AOD prevention and treatment services (e.g., OSAP) are assigned to a newly named division - the Substance Abuse and Mental Health Services Administration (SAMHSA). OSAP Technical Report #3 published, describing 60 AOD abuse prevention programs serving AI/AN populations, including 18 OSAP-funded programs. 11% of all OSAP awards for prevention programs for HRY made in 1989 and 1990 went to AI/AN tribal and/or community groups.
1991	Department of Health and Human Service (DHHS), Office of Inspector General (OIG) publishes Indian Health Service Youth Alcohol and Substance Abuse Programs. This report listed several critical findings including: • IHS Headquarters West had only completed a draft of the alcoholism treatment standards mandated by PL99-570

YEAR	SIGNIFICANT LEGISLATION - EVENTS - FINDINGS
1991	• IHS Headquarters West had failed to meet quality assurance objectives • the IHS Management Information System (MIS) was outmoded • only 6 of 12 regional treatment centers mandated by PL99-570 had been completed • 2/3 of working alcoholism counselors were not certified • there was evidence of misappropriation of funds and • the BIA had not established emergency shelters for youth as mandated by PL99-570. Senate Select Committee on Indian Affairs holds hearings on Senate Bill 290. Indian Anti-Drug Abuse Amendments of 1991. The Vice-Chairman of the Committee, having read the above-noted Report from the OIG, calls for a "joint review" of all Indian Alcohol and Drug Programs, both youth and adult.
1992	PL102-537 - Indian Health Care Amendments Act passed; reauthorized IHS and PL99-570, increased appropriations for IHS beyond recommendations in Bush's final budget, extended services for women including mandated study/prevention of FAS, provided for community-based training models for tribal use, called for more data compilation, and demonstration projects. (Note: According to a 1993 Headquarters West document printed in May, the funds authorized by PL102-537 had not been appropriated 7 months later.) Bill Clinton elected President. DHHS, OIG publishes Indian Alcohol and Substance Abuse:Legislative Intent and Reality. This report listed several findings - both critical and noncritical - including: • major provisions of the 1987 MOA between the IHS and BIA remain incomplete and it has not been reviewed for 4 years • there are barriers to coordination between the IHS and BIA including differing missions and headquarters staff structures, lack of area office/headquarters collocation, high staff turnover/burn-out, a crisis mentality, and a lack of full-time BIA area alcohol and substance abuse coordinators • there is no comprehensive continuum of care (especially lacking is prevention and aftercare) • no BIA money goes to the 50% of Indian students who go to public schools

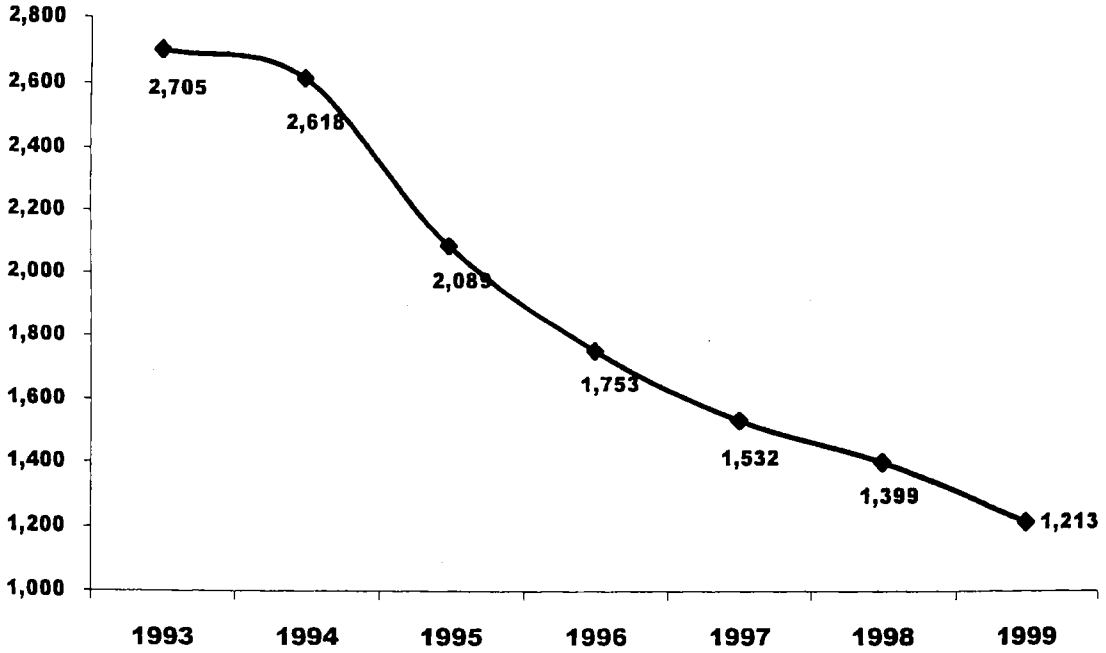
YEAR	SIGNIFICANT LEGISLATION - EVENTS - FINDINGS
1992	On the positive side this report noted: • TAPs or LAPs were in place for 381 of 546 tribal groups • coordination at the local level occurs regardless of what goes on at area offices • The Child Protection Team approach (incorporating staff from multiple agencies) does the most to foster coordination and focus attention on the problems of AOD abuse in communities (in one area the team approach increased the ability to handle clients from 300 to over 1,600 per year!) U.S. Department of Interior, OIG publishes Alcohol and Substance Abuse Program, Bureau of Indian Affairs. This report listed several findings including: • the total amount of money received by the BIA between 1987 and 1991 was just over half of the amount authorized by Congress; the Bureau could not document the expenditures made against these appropriations at the time of the review • the BIA had not complied with the Act's staffing requirements • the BIA had not adequately monitored or evaluated the program's effectiveness and • the BIA had not properly coordinated program activities at the field level. 1-day survey of IHS hospitals completed to determine % of hospital admissions that are alcohol related: 21% of all adults and 35% of all adult males are admitted for alcohol-related problems IHS, NIH, and SAMHSA discuss joint research venture to determine scope of AOD problems in Indian country; Office of Management and Budget (OMB) develops a plan to fund the research with $700,000.00 from the IHS budget, money which IHS said it could not spare. Traditional Cultural Advocacy Program established within IHS to provide a national focus for AI/AN traditional beliefs and practices.
1993	The IHS Alcohol and Substance Abuse Programs Branch budget for FY1993 is almost triple the budget for AOD programs in 1986! U.S. General Accounting Office (GAO) publishes Indian Health Service. Basic Services Mostly Available; Substance Abuse Problems Need Attention. Seven years after the passage of PL99-570 and

YEAR	SIGNIFICANT LEGISLATION - EVENTS - FINDINGS
1993	five years after the passage of PL100-690, AOD services were still "substantially less available in most locations" (IHS service areas/units) and AOD services were the "greatest unmet health care need for Indian people." An IHS Headquarters West guide to AOD programs lists 320 programs throughout the 12 IHS service areas offering a variety of services across the spectrum of prevention and treatment. The funding sources are all directly or indirectly linked to the federal initiatives noted above (PL99-570, PL100-690, Urban Equity monies, IHS direct, and the "Buy Indian Act"), as well as PL93-638 (75% of the programs received some 638 money). Among these programs there are 47 residential treatment centers and 11 halfway houses spread across the 12 IHS service areas. AI/AN leaders in Indian Health Care meet with the First Lady to discuss/plan Indian Health Care Reform as part of the overall National Health Care Reform initiative. No Health Care Reform Bill was passed
1994	IHS publishes updated FAS Resource Guide (first published in 1992). According to the guide: • 10 of 12 IHS service areas have FAS Coordinators • there are 30 FAS/FAE programs across the country (15 funded through federal money, 3 each funded with state and tribal money, 6 funded by non-profit groups, and 3 funded by other sources) • there are 12 newsletters addressing FAS/FAE issues published in 10 states Two CSAP-funded prevention projects in American Indian communities selected as National Replication sites Republicans elected in record numbers; legislative climate changes with the Contract with America The future in terms of public funding for substance abuse prevention and treatment is unclear
1995	Two CSAP-funded prevention projects serving American Indian communities selected as National Replication sites NANACOA, NCAI, NIHB, and CSAP bring a decade's worth of effort full circle with a National Native American Summit on Substance Abuse Prevention.

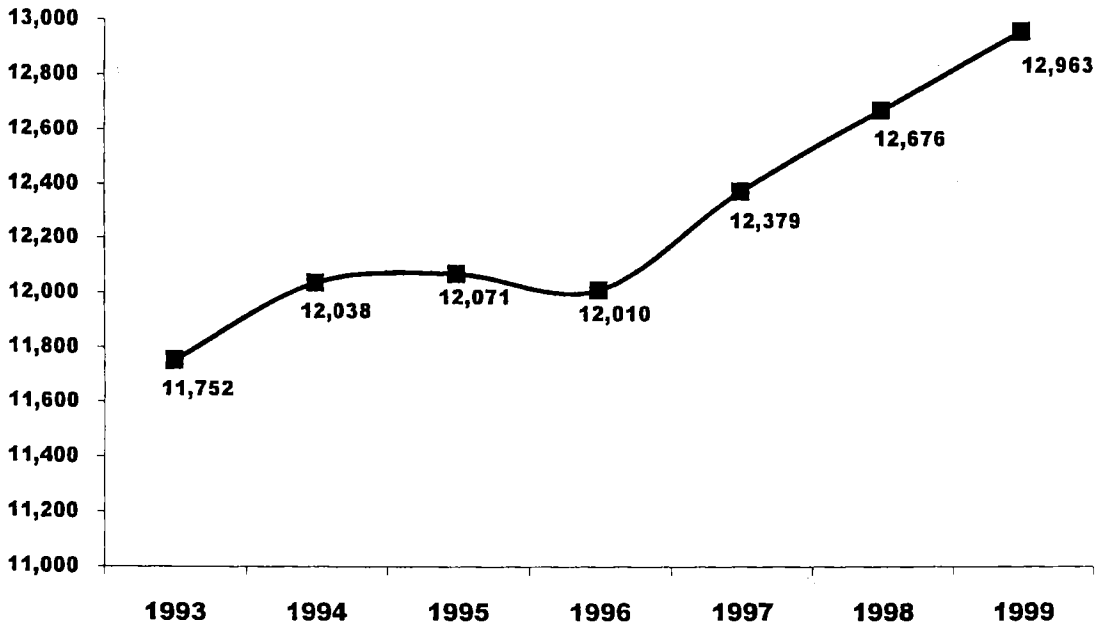
Indian Health Service Employment: 1993 - 1999
Headquarters decreased by 531 FTE (-57%)



Indian Health Service Employment: 1993 - 1999
Area Offices Declined by 1,492 FTE (-55%)



Indian Health Service Employment: 1993 - 1999
Service Units increased by 1,211 FTE (+10%)



IHS FTE: Area, Service Unit, HQ, & Total

	1993	1994	1995	1996	1997	1998	1999
Area Offices	2,705	2,618	2,089	1,753	1,532	1,399	1,213
Service Units	11,752	12,038	12,071	12,010	12,379	12,676	12,963
Headquarters	937	781	681	637	553	437	406
TOTAL	15,441	15,511	14,865	14,422	14,464	14,512	14,582

HEADQUARTERS:
Total percentage decline of 57%
Many function were streamlined, consolidated or reassigned to the field
FTE reductions at Headquarters are a result of combined trends listed below for the Areas

AREAS:
Total percentage decline of 55%.
No Area Office was closed but most downsized substantially.
Total percentage decline of 55%.
FTE reductions are a result of several trends acting together and include:
Transfer of area functions and dollars to tribes under self governance
Reassignment of staff and functions to service units
Reductions due to cuts in administrative funding

SERVICE UNITS:
Federal employment in the Indian Health Service units increased by 10% during a period in which over all Indian Health Service employment decreased.
Reflects agency concentration of effort, resources, manpower in health delivery rather than administration.