

## **DO WE CARE ENOUGH TO ATTEMPT CHANGE IN AMERICAN INDIAN ALCOHOL POLICY?**

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The problems created by and consequences of the style of alcohol consumption reported by observers of the North American Native peoples are well documented (Mail & McDonald, 1980; Mail, 1990). In this volume, Dr. Philip May provides a broad and clear summary of these problems, and proposes some specific steps that might be taken to address the seemingly insoluble conditions of Indian drinking. The caution that it is unwise to assume widespread alcohol abuse is well taken. While some tribal groups have been extensively studied and reported (e.g., Navajo, Sioux, and Apachean peoples of the American Southwest), there is virtually no information or epidemiology from many other tribal communities (Mail, 1984). Although the capacity to conduct reservation-specific epidemiology is available, this has not been accomplished. The alcohol use patterns of tribes are assumed or inferred from those for which data exists. There are almost no follow-up studies that might demonstrate any changes over time. Whittaker's research among the Standing Rock Sioux, and Westermeyer and Peake's work in Minneapolis are the major exceptions (Westermeyer & Peake, 1983; Whittaker, 1962; 1963; 1982).

May observes that there are drinking patterns and behaviors that do not pose a significant problem for Indian people, and thus their behavior may not be a target for preventive intervention. The literature about Indians and alcohol may be largely characterized as negative, adding to the Indian sense of deficiency and lack of control over their lives. Yet any health professional who works in Indian country knows that there are Indian social drinkers, for whom alcohol is not a problem. These individuals are never discussed and never studied, although they may serve as important role models for Indian young people, and their ability to manage alcohol may provide important clues to learning other styles than the style characterized as "Indian drinking."

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This article was written by Patricia D. Mail in her private capacity. No official support or endorsement by the U.S. Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration is intended or should be inferred.

Research never seems to acknowledge another widely held empirical reality. For many individuals, drinking is pleasurable, and socializing with alcohol is fun. Knowing what limits to set differentiates the boundaries between control and intemperance. For some communities, there needs to be an expanded range of options from (a) it is acceptable to be abstinent, all the way to (b) it is acceptable to be a moderate user of alcohol. What should not be acceptable is acute or chronic intoxication; use of alcohol while pregnant; use of alcohol and other drugs in the workplace; and sale of, provision to, and use of alcohol by minors.

In developing a more accurate view of Indians and alcohol use, it seems that it would be useful to study the behavior and attitudes of the nondrinkers. In every community, in addition to those who visibly abuse alcohol, there are a significant number of individuals who abstain, whether for reasons of health, personal preference, and/or religion. In the hundreds of studies seeking to explain the causes of Indian drinking, there is a paucity of reports on abstinence. It seems curious that no one has ever sought to determine what protects or supports the individual who makes a nondrinking decision, because in the ability to choose not to drink may lie clues for the rest of the community.

### **Community Approaches**

There are some excellent models for conducting community epidemiology. These have their roots in Lalonde's (1974) original working paper on the health of Canadians. It was Lalonde who first proposed the Health Field Concept, which attempted to define the multiple cause/multiple effect nature of health and disease (Dever, 1984). This conceptualization depicted health in four primary divisions: human biology, environment, life-style, and health care organization. The concept of life style (more accurately, self-created risks) was divided into three elements: leisure activities, consumption patterns, and employment participation and occupational risks (Dever, 1984). This is the aspect of the Health Field Concept that has received the greatest amount of attention, and not a little misperception.

Lalonde's concept, and the implementation in Canada, spurred the United States to also begin developing plans for health promotion and disease prevention. These were first promulgated in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (DHHS, 1979). This was immediately followed by the publication of the *1990 Objectives for the Nation* (DHHS, 1983) and more recently, *Healthy People 2000* (DHHS, 1991). Dever (1984, 1991) provides clear guidelines for community-based self-assessments that help people compile relevant data and prioritize risks and solutions according to their own perceptions.

An even more holistic model is the one developed by Tony Whitehead. His "Cultural Systems Approach to Planned Change" incorporates a community-based analysis of cultural elements inherent within that specific culture, accompanied by the application of a planning model and an evaluation protocol for assessing impact of the planned change (Whitehead, 1990). Individuals familiar with the framework of the model can involve community leaders and lay people alike in conducting their own needs assessments and defining solutions.

In this volume, May observes that simplistic solutions are all too often advocated by those who are politically absolute, moralistic, and extreme. Most often, the emphasis is placed on treatment, with prevention receiving lip service, with no adequate resources or evaluation. Policy continues to be made, for the most part, by the federal government for implementation at the local level. Even tribal self-determination, as expanded by the passage of the Indian Self-Determination and Educational Assistance Act of 1975 (P.L. 93-638 and reauthorizations), is conducted cautiously because there always exists the possibility that funds might be reduced or redirected if decisions and actions are not in keeping with the general guidelines from Washington. All too often, self-determination translates into business-as-usual or "doing it the way it has always been done," instead of really innovating or adopting true local decision-making and policy guidance.

The key questions continue to be: (a) Where is the leadership for prevention? (b) How should prohibition be addressed? and (c) What should be the nature of prevention and treatment programs: community-wide or targeted interventions for high-risk families? To date, there has not been one well-designed nor carefully evaluated preventive intervention. May, in this volume, observes that a good research design at the beginning of a prevention project would pay important benefits for the community and the federal government. Many health professionals would agree with this sentiment, but few actively advocate for such rigorously planned interventions.

Prohibition, in those communities that continue struggling to maintain and enforce it, is an artifact of law. It is not a reality within Indian communities. What are the implications for veracity and law enforcement when there are codes and ordinances on the books that are as flagrantly flaunted as prohibition? Does this contribute in some manner to disrespect or disregard for other laws? A few individuals who supply liquor to "dry" communities drain away community resources without much return to the community. Although May's early research into prohibition and legalization suggests that such changes in law did not really make matters worse (May, 1975), tribes selling liquor, such as the White

Mountain Apache, do not appear to have been extensively analyzed for the economic impacts of liquor sales. Research in this area is incomplete.

There appears to be general agreement among several authors that solutions to substance abuse and other community issues should be sought within the indigenous community and not imposed from the outside (Beauvais & LaBoueff, 1985; Brown, 1985; Cooley, 1980; Mail & Wright, 1989). Innovative approaches, like the Indian Fire Fighters Drug-Free Workplace conference held in Tucson during April 1991, are seeking ways to bring larger societal programs into Indian communities. This conference focused on the concepts of drug-free work places and the importance of mutual support in hazardous work. While the risks of alcohol, tobacco, and other drugs were reviewed, the emphasis was on pride, employment, income, and safety.

Although self-determination legislation provides for tribes to resume their own political management, prevention leadership could be provided by the Indian Health Service (IHS), an agency of the U.S. Public Health Service. The IHS has a multidisciplinary health professional team that is able to provide public health education, social service support, psychosocial counseling, and medical care (as well as environmental health services). The IHS, in consultation with tribal health boards, would be a logical agency to provide the leadership and/or technical assistance for planning and implementation of targeted prevention programs.

Although little evidence exists to support the efficacy of primary prevention programs (Moskowitz, 1989), it is clear that the American health care industry is becoming progressively less cost-effective. The implications from the ever-increasing spiral of costs strongly suggest that greater attention and commitment to prevention must be undertaken (Kristein, Arnold, & Wynder, 1977). A climate must be established in Indian communities that is consistent with the surrounding majority community so that the messages offered are consistent with the public media.

It also seems essential that all non-Indian staff seeking to work within the Indian cultures need specific training in cross-cultural sensitivities and perspectives. Basso (1979) provides several clues to cultural sensitivities in his discussion of Apachean joking relationships. These might serve as guides in an orientation program.

A review of history, legislation, and vital data provide public policy implications that complement May's recommendations in this publication:

- Legislation exists that provides flexible guidance for program formulation, planning, and interagency cooperation. This must be used to develop clear and coherent strategies that make use of current research in health behavior change, health psychology,

social marketing, risk assessment and management, health communications, and targeted interventions. Several long-range risk-reduction programs exist that can provide important information for Indian health planners (Shea & Basch, 1990).

- The legalization of alcohol provides an opportunity to normalize the sociocultural environment around the use of alcohol and other drugs. Given this change, community sanctions of “deviant behavior” can be addressed in other than law enforcement terms (May & Smith, 1988). Current approaches to prohibition are inconsistent with reality.
- Services need to be improved and coordinated that focus on: (1) high-risk children; (2) high-risk and problem families; and (3) coordinated treatment services, including well-managed aftercare programs for prevention of relapse. In this volume, May clearly makes the point that the understanding and recognition of the consequences of alcohol abuse are widely known and understood within the Indian communities. He then suggests strategies for practical community-based programs.
- Programs should be essentially community based, involving schools, health care facilities, tribal government, police, social services, and churches. Approaches should combine the strengths of enforcement, health promotion, and regulation and statute. An increased sense of self as corporate entity might provide new options.
- The federal government, in collaboration with tribal governments, should encourage the undertaking of well-designed prospective studies that test prevention strategies over time to determine what does work. Existing tribal and IHS staff, in cooperation with a major university, could mount efficient, cost-effective research.

May recognizes the reality of Indian drinking and makes practical suggestions to address the direct and indirect problems arising out of the inappropriate use of alcohol. His observations include those that are sometimes discussed but rarely set down in print. Obviously, the problem is considerably larger and more complex than can be addressed in a monograph. The importance is that it is being addressed at all. Moreover, community empowered approaches to planned interventions and formulation of public policy have implications for a wider approach that addresses all health problems. Tribal people have more than 200 years of experience with alcohol, first being subjected to a unique brand of chemical warfare and later as a learned response in the form of recreational and psychocultural release. The past does not have to be repeated

in the future. The key is: What kind of Indians do native peoples want to be in the twenty-first century?

It is never too late to embark on new paths, to look ahead, and to work for the future while drawing on the positive heritage of the past. May's courageous approach to the issues and controversies of Indian drinking reaches beyond current stereotypic responses and shotgun solutions to recommend specific strategies and ways to initiate change. There is no doubt that his paper will stir up a hornet's nest of buzzing, some stinging rejoinders, and a great deal of discussion. Concerned and thoughtful individuals welcome this dialogue.

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