LET THE DEBATE, STUDY, AND ACTION CONTINUE: RESPONSE TO TWELVE CRITIQUES

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First of all, I would like to thank Dr. Spero Manson, editor-in-chief, Judy Kuntze, former journal manager, and Iva Roy, current manager, for the initial evaluation of the paper and for devoting the time, energy and space to this forum. I believe this opportunity will substantially advance the topic of alcohol policy for Indians.

My first reaction to the twelve critiques submitted in response to the alcohol policy paper was surprise and gratification at how most respondents agreed with the major direction of the prevention suggestions. It may be that alcohol policy for Indians will be a topic of importance and an area of emphasis in the coming decade. I certainly hope so, and I thank the respondents for taking the time to review the manuscript.

Common Themes

Most of the stronger criticisms or areas of disagreement dealt with degree of emphasis. The three most common themes were: (1) that there was not enough emphasis on change in the primary groups; (2) that issues affecting individuals were not addressed; and (3) that I did not guide tribal leaders enough.

That the most profound and permanent social changes that affect public health occur in primary groups is well established. I firmly believe this, and believe it applies most directly to behavioral health issues. The vast majority of the reviewers seem to share this belief, and most seized on this statement in the paper. But the common criticism was that I did not go far enough in documenting how this change in family and sociocultural variables is facilitated or made. Frankly, I do not know an exact path or method for such change. I do know that individuals, families, and tribal communities must work on this within their own social and cultural contexts utilizing the strengths that exist now and were also there in the past. Studies of success (see Neumann, Mason, Chase, & Albaugh, 1991) and successful family and peer group intervention programs must be pursued, and ideals of success must be brought into the debate on alcohol problems.

The paper I wrote for this volume addresses alcohol problems from the community level. Broad community initiatives will eventually impact primary groups. Primary groups do react to community standards as put forth in policies, laws, knowledge bases, and other milieux. They then translate and adapt the information and perspectives for smaller groups. This is why large smoking cessation initiatives have worked with many people and groups. Further, the paper is intended to document the successful prevention efforts published in the literature, and they typically tend to be large-scale, community-based, policy-oriented efforts. The challenge I would like to make to other scholars/individuals is this. Examine and summarize the knowledge base on family and primary group change, write it up, and disseminate it to those of us who do not specialize in these approaches. There needs to be a coordination of approaches from several levels of human interaction.

A second theme in the critiques is that the paper did not address individual issues sufficiently. Again, that was not the intent of the paper; community-based, policy-oriented issues was the focus. Yes, there is variation in individual drinking style among Indians. It is affected by a variety of influences such as genetic variation, family characteristics, peer groups, exposure, learning, spiritual beliefs, and psychiatric variables. But all individuals live within a web of influences in society and community. If the community and society reflect consistent, predictable, powerful, and positive messages regarding alcohol use and abuse, individual variation and problem behavior are reduced. Prescriptive and proscriptive norms and policies not only affect exposure to alcohol and substances but over time become part of the individual's knowledge, attitudes and beliefs. They therefore guide his/her behavior preventing some individual pathology.

Again, a challenge is in order here. The extant behavioral science understanding of Indian alcohol abuse needs to be pulled together and more objectively understood from a comprehensive etiological point of view. A beginning exists in the document *Indian Adolescent Mental Health* (U.S. Congress, 1990), but a more explicit emphasis on substance abuse is needed. Furthermore, several groups of authors/scholars have published a number of insightful works in this area (see for example, Oetting & Beauvais, 1989; Winfree, Griffiths, & Sellers, 1989), but a broader and more general knowledge base is still needed. Such an understanding can be brought about from further testing, coordination, and a great deal more sharing of ideas and results between groups of scholars. Many scholars tend to ignore the works of others, the studies and variables are rather particular to each research group, and the use of the results across settings has not been frequent enough.

The third major theme is that the paper does not guide tribal leaders enough, that the paper is too general and may confuse those who are not familiar with the topics addressed. I have tried to make the paper as clear as possible and may not have succeeded. But I have great confidence in tribal leaders, their advisors, and in the body of public health officials and scholars. These people can work together to take this information and apply it in the most culturally relevant and appropriate terms possible for their communities. No one blueprint will work for every community. In a paper such as this, one can only lay out the options for consideration, and that is why I wrote the paper. It is a call to promising action with a documentation of possibilities.

The most gratifying part of the whole review process was the reviews that document and explain how action has been taken in various communities. The pieces by Norman Dorpat, Candace Fleming, Carol Lujan, Patricia Mail, Ron Peters, and, particularly, Mark Van Norman are exactly what I had hoped would emerge in some of the reviews. Each of these authors gives specific examples of successful programs of a preventive nature, and these examples give credence to the wide array of approaches, which can be implemented under the particular conditions. Some involve schools, some involve communitywide public initiatives, and some involve legal and criminal justice measures. I hope that all readers of this volume will focus on the positive tone and motivating ideas in these reviews, and also on the many similar programs described in the bibliography of the main paper.

Specific Issues Raised

There are several specific issues raised by reviewers that I must briefly address. This is done in a positive vein and is not intended to be defensive or hypercritical.

Dwight Heath raised the issue that sociocultural change will go much farther in reducing and preventing alcohol problems than the measures I proposed in the figures of the paper. He is correct, and the solutions in the paper are intended to be stimuli for sociocultural change. They are limited if taken individually and considered on a static basis, but they are dynamic and should be considered only as parts of a larger group of interventions for socio-cultural change. I believe Dr. Heath has and will continue to show how sociocultural change can be used to prevent alcohol problems. We are not in opposition, but I am not sure that he shares, or appreciates, or is as optimistic about, the role of policy measures in stimulating sociocultural change as I am.

Dr. Heath also makes a strong statement about the value of legalization of alcohol on reservations and is puzzled why I did not take a stronger

stand. I believe legalization can be a tremendous tool for many communities. Indeed, the majority of the policies in the paper are contingent on legalization. Many tribes should legalize to most fully improve upon control over alcohol-related problems. But alcohol legalization is not a panacea any more than prohibition. Laws and policies must be matched to the local conditions; any community alcohol initiative must be comprehensive, vigilant, and dynamic. A simple policy that is none of these will fail whether it is legalization or prohibition. Therefore, I was careful not to imply an easy solution and utilize polarizing words such as legalization or prohibition. To do otherwise would not have been wise for raising the issue to Indian populations or for encouraging debate.

Aron Wolf suggests that my discussion on physiological susceptibility ignores the "blackout" issue as it affects Alaska Natives. My discussion of psychological susceptibility is specifically aimed at inherited, basic metabolic, and liver structural issues. These traits vary somewhat among individuals, but the averages from ethnic groups are not significantly different (Reed, 1985). Life and drinking experience modify a person's processing of alcohol making those with particular diets, body weights, prior and frequent drinking experience, and variable states of health different in the face of alcohol. Blackouts are a behavior/experience that results mainly from life experience, not inherited/genetic traits. To quote one of the articles used in Dr. Wolf's critique, "Blackouts were positively associated with severity and duration of alcoholism, extent and duration of alcohol consumption per drinking episode, capacity for drinking large amounts, 'loss of control,' neglect of meals, gulping drinks, and a history of head trauma" (Goodwin, Crane, & Guze, 1969). Blackouts are, therefore, mainly a product of life-style, not inheritance and, therefore, not related to the discussion. Further, the one controlled study Dr. Wolf quotes is the article by Fenna, Mix, Schaefer, and Gilbert (1971), which has been highly criticized as being flawed. All of the articles addressing physiological issues quoted in the policy paper are controlled, state-of-the-art studies that specifically relate to inherited susceptibility exclusive of prior drinking or sociocultural experience. Having reviewed the bulk of those references cited by Dr. Wolf, none rule out prior drinking experience or sociocultural considerations in any structured way, and some do not even touch on any of the issues raised in the critique (e.g., Phillips, Wolf, & Coons, 1988). In light of the existing, best evidence, to perpetuate the arguments of innate physiological susceptibility for Indians or Natives is pernicious. Such arguments merely obfuscate and mystify the problem, increase fatalism, and therefore delay solutions. It is virtually impossible to begin prevention programs at all if these myths are extant in the population (May & Smith, 1988).

James Thompson raises two issues that I will address. He claims that the primary prevention model works best for infectious disease and may not apply to alcohol problems. I believe that Bloom (1981) and many of the other authors quoted in the paper contradict this statement in a variety of ways. Further, mental health and substance abuse problems are not synonymous when it comes to the applicability of prevention. Mental health and substance abuse issues are frequently confused in his discussion. Secondly, Dr. Thompson states that the Indian health data used in the paper leave out Oklahoma Indians and urban Indians. This is not true. Table 2 includes all Indians in 33 reservation states, including Oklahoma and both rural and urban data for most of these states. In Tables 3 and 4, the data include all Indians in and surrounding reservation areas (by county) served by an IHS program or contract program. Furthermore, IHS now produces service unit specific data which many tribes and communities can access to further specify the nature of their alcohol problems. I would encourage all communities who can get such data to do so. The opportunities for considering the policies in the paper are immense, and any community, Indian or non-Indian, rural or urban, or eastern vs. western, must assess whether they apply to their setting and how. That is why no one policy was spelled out to fit all Indians or all situations.

Moving on to Levy's critique, a very good point is made about comparison groups. Levy reminds us all that it is generally preferable to compare Indian data to other residents of the states and counties adjacent to the Indian populations. This is truly preferable in many studies, and one should strive to do so. In this paper the opening presentation of mortality data was to set the stage for the prevention discussion and to define *patterns* of death that were substantially different from mainstream patterns. As Dr. Levy points out, in many rural, western U.S. areas, trends of suicide and other behavior-related problems may have a similar etiology and period prevalence among Indians and non-Indians. But this is not always the case, and I suspect that it is least true regarding highly alcohol-specific variables. For example, Indians and non-Indians in the states of Montana and New Mexico, and in counties therein, have very different rates of death for motor accidents, and alcohol relatedness and blood alcohol levels at death (May, 1989). Further, Levy and Kunitz's own work would lead one to suspect a divergence in this pattern regarding rates of cirrhosis of the liver.

The final issue that I will address is found in the review by Delores Gregory. Dr. Gregory calls 1986 a "watershed year" in alcohol and behavioral health awareness among Indians because of IV drug use, AIDS, and the anti-drug laws. While that may be true in the Pacific Northwest, other, more remote areas of the West seem to be "business

as usual." None of the three forces mentioned are large issues among the Southwest Indian populations and, it seems, among many other areas such as the Plains. It may be that the watershed year is yet to come in many communities and the awakening to these health risks is only prevalent among health professionals. To date, many tribal organizations have not seriously considered most of the issues of policy mentioned in the paper, and alcohol abuse intervention/prevention efforts are limited to small treatment programs and school-based curricula.

Concluding Remarks

This exercise in research, writing, response, and reaction has been interesting. I am gratified that it has stimulated twelve interesting and generally positive reviews from peers and colleagues. I hope that it will do the same among tribal leaders and their advisors as well.

One major problem with prevention of substance abuse is that it is complex and complicated. That is a truth well told in dozens of articles and books reviewed for this paper. As such it may be a truth that will scuttle prevention efforts in many communities.

> The truth is sometimes a poor competitor in the market place of ideas — complicated, unsatisfying, full of dilemmas, always vulnerable to misinterpretations and abuse.
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> — George F. Kenman, *American Diplomacy 1900–1950,* 1951

Most people want a simple solution and there are none. And as Fred Beauvais has pointed out, we are not always able to implement all that we know. I would like to see us all try harder. But debate and consideration of the many approaches from the experience of other humans will be necessary for tribal groups and communities if they are to gain more control over alcohol problems. Too often we scholars, health officials, and citizenry alike have focused on the problems and ignored the positive actions that can be taken to deal with at least some aspects of the problem. We must move forward in a positive vein with great expectations. We should assist in the solutions. All the while we must acknowledge that there are many paths to alcohol problems and, therefore, that many solutions are possible. No one paradigm or approach will do unless it allows for embracing a multitude of directed influences. Let us move towards the goal of a broad reaching, yet comprehensive plan.

I hope, to a great degree, that the final sentence in Patricia Mail's review comes true, for opening up this area for debate is what I wanted to do. I am not so sure I wish the same for all parts of the next to last sentence.

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 the dialogue.

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