NATIVE ALCOHOL POLICY OPTIONS. YOU'VE BEEN GIVEN A MAP: BLAZING A TRAIL IS UP TO YOU

RON PETERS, M.A.

Dr. May has performed a valuable service by giving us a general framework for conducting communitywide dialogues on alcohol abuse and dependency. His framework covers general planning principles for how these dialogues should proceed and maps the policy territory to be covered along the way in broad, but useful, strokes.

The principles he outlines are essential ones. Natives are an extremely diverse people: historically, politically, economically, socioculturally, demographically, and in terms of urban-rural differences. This diversity finds its natural and necessary reflection in the Native nations' styles of living and dying. Thus, Dr. May warns severely against the myth of the one-shot quick-fix and the lure of the "magic bullet." Diversity is best served by a well-coordinated system of broadly based community approaches and by an evolutionary, not a revolutionary, perspective. As my friend Dr. Ralph Masi (of the Canadian Council on Multicultural Health) says, although all people may be created equal, they are certainly not created the same. Thus, when one treats people the same, one treats them unequally. Responsive and useful service systems can only emerge from a sound base of consistent policy that is informed by and consonant with local needs. This takes time, effort, goodwill, and motivation, which are things the community itself must provide. But it also requires a framework and some guiding principles, which is what Dr. May has provided.

Equally important is his emphasis on entire communities, starting (not ending) with primary social groups and branching out to include broad sectoral representation. Mental health service providers must face up to a basic fact: far from being the first choice, we are most often the last resort of Native peoples who have serious alcohol problems. We must ask ourselves why this is and what we can do about it, but we must also learn to meet the world as it is halfway. Friends, family, extended family, and a host of other community gatekeepers are the real front line for Natives with serious alcohol problems. Effective planning efforts must be oriented around this basic fact as a primary referent or fail.

As an example, a few years back I helped to conduct an assessment of the mental health needs of Native youths in Vancouver, Canada (Peters, 1987). This included talking with American Indian parents and older teens about things like their definitions of mental health problems among youth, and asking them to name the kinds of helpers they would turn to if such problems were identified. When asked where they would turn to for help, outside of family and close acquaintances, the number one answers were "call the police" and "phone the welfare office." Psychiatrists and public health facilities tied for last place in the list of options identified by American Indians themselves. This is the community as it actually is, and so it defines our point of entry for opening dialogues with and among Natives. There may be elements of the community that we would like to see changed; there most definitely will be things that the community wants to see us do differently. In other words, effective change in this area must involve a process of mutual accommodation.

Equally then, in terms of sectoral representation, it must be recognized that school teachers, police officers, welfare workers, elders, Native government representatives, and other human service providers effectively control important resources that are needed to tackle the entire problem of Natives challenged by alcohol. These other stakeholders, our partners in planning, must also make changes that complement and supplement those made by mental health service providers, accommodating their services (and if need be their mandates) in ways that lead to effective total solutions. New types of "mid-way" roles — service brokers and expediters, coordinators and facilitators of mutual education — are badly needed as catalysts of change in these areas.

Dr. May mentions Alkali Lake as an example of a successful community response to problems with alcohol. Certainly, indigenous peoples from around the world have visited there to look at their programs. Again, though, it is the principles involved in how this community proceeded to tackle its problems that are transferable, not the particulars of their response. Alkali happened to go "dry" and reports a 95% success rate, but this may not work for everyone. In addition, the people at Alkali Lake have come to realize that their community faces many other challenges besides alcohol, and so have more recently begun to consider how they can deal with concerns such as widespread family violence.

Another good illustration comes from the work of Dr. Jack Ward at the Manitoulin Island reserve in Ontario (Ward, 1979). Dr. Ward was approached by the Native leadership for consultation following an epidemic of suicides and other violent deaths among youths in this small rural community. Nearly all of these deaths involved concurrent alcohol abuse or dependency. In working with the community leaders, the problem was defined not as involving an isolated psychiatric concern, but as

a symptom of a broader community malaise requiring a total community solution. Community involvement, commitment, and consensus were the keystones of the planning process. Eventually some counselling positions were created, but the main thrust of the communitywide response centered on such things as promoting alcohol-free cultural events, arranging opportunities for bringing youth into social contact with elders, organizing after-school recreational opportunities, and developing preventive educational programs and Native cultural content for the school curriculum. The focus was not, therefore, solely on suicidal behavior, but equally on related public health concomitants and broader cultural and community development approaches relevant to primary prevention. These activities were planned and implemented by the community, without, as it turned out, one cent of government funding.

On follow-up, the results included: decreased rates of suicide and other forms of violent death; decreases in suicide attempts, arrests and convictions; smaller numbers of youth on probation; and a lower school drop-out rate. We need to learn from these successes, and Dr. May provides a good overview of the planning principles that must be followed for this to occur.

The emphasis that is given in Dr. May's paper to a public health perspective is also of great importance. Ideologically, it takes us out of the "blaming the victim" mode that has historically characterized policy and planning around the topic of American Indians and alcohol use (Ryan, 1976). Psychologically, it broadens the scope of our thinking from a fixation on the individual Native person who is "broken" and needs to be "fixed" (true as this may be) to include the broader social-structural factors and processes within whole communities that are directly linked to root causes. Practically speaking, it provides the only realistic framework for implementing the kind of broad, multisectoral, communitywide policy and programming that is needed to address the entire problem.

I would also like to especially reinforce Dr. May's repeated references to the need for local needs assessment and information on evaluative outcomes. Native alcohol abuse is a topic fraught with emotionally laden, insistently held, and diametrically opposed views. However, in terms of knowing what works, for whom, under what circumstances, it is also an area where (considering the size of the literature) we are surprisingly information-poor. Dr. May has done a good job of sifting through the literature to point out and evaluatively comment upon some of the more useful and consistent findings.

However, in the absence of practical, objective local data on needs and outcomes, the debate can only continue on an emotional and philosophical plane. As Dr. May points out, at the local community level such debates often get deadlocked on the "wet-versus-dry" issue. When

this happens, both sides dig in their heels and all real communication grinds to a halt. The great danger here lies in how this can be expected to affect decision-making about funding. The emotions and the value-orientations expressed on the subject of alcohol within Native communities are real and valid enough in themselves. Yet when no better basis is available, funding decisions will necessarily be made on a purely political basis. This, in turn, will often have little or no bearing on what is actually needed.

I haven't spent much time here on Dr. May's mapping of the policy territory involved, which is, after all, the main substantive content of his paper. Suffice to say that this ground is ably covered, and the real responsibility for filling in any remaining gaps lies with each of us in trying to put his framework into action in our own communities. You have Dr. May to thank for the fact that you now have a good map of the terrain. It's up to you to decide on the best route for blazing a trail.

References

Peters, R. (1987). *The mental health needs of Native youths in Vancouver.* Vancouver, British Columbia: Greater Vancouver Mental Health Service Society.

Ryan, W. (1976). *Blaming the victim.* New York: Vintage Books.

Ward, J. A. (1979). *The response of an Indian community to a suicide epidemic: A follow-up report.* Presented to the Tenth International Congress for Suicide Prevention and Crisis Intervention. Ottawa, Ontario: Canadian Mental Health Association and International Association for Suicide Prevention (Canada) Inc.