ALCOHOL POLICY CONSIDERATIONS IN AMERICAN INDIAN COMMUNITIES: AN ALTERNATIVE VIEW

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Dr. Philip May has provided an unusual and valuable public service on behalf of the American Indian and Alaska Native populations and of all who are concerned about the impact of alcohol on public health and social welfare. His article on alcohol policy considerations for Indian reservations and bordertown communities in this issue can be a valuable tool. We also should be grateful to this journal for making it available, together with comments by colleagues.

As a professional who has conducted both intensive and extensive research on alcohol and Indian people for several years, May is well qualified to evaluate the epidemiological data. As a sociologist whose work has often been cast in terms of practical implications rather than theoretic or conceptual issues, he is skillful at relating those data to a variety of alternative policies. In addition, as a writer who has worked closely with various American Indian groups, he has succeeded at the difficult task of being an effective broker of information; he has offered a broad survey of the diverse and widely scattered literature, digesting the sometimes complex and highly specialized findings, and "translating" them into clear, concise, and usable terms for readers who may not have familiarity with academic or scientific approaches to the subjects of alcohol and Indians.

I am in hearty agreement with the greatest portion of Dr. May's article. I admire the way he has touched on so many important points, explained them neatly, and realistically offered "the ingredients for a comprehensive policy," while emphasizing that "each community needs to work out its own recipe."

In a very real sense, there is nothing in his article with which I seriously disagree, nothing that I consider incorrect or irrelevant (Heath, 1983, 1987, 1989). In another sense, however, I find it somewhat frustrating. I must confess to having some minor concern about the overall balance of the piece, especially with respect to recommended policies. There were many places in the paper where I wanted to say, "Yes, but . . ."

It could even be said that Dr. May and I would list the same ingredients in an article, although perhaps in slightly different order. It is not that we

disagree; on the contrary, I would rather have Dr. May more strongly defend his convictions. For example, although he has been careful throughout most of the paper to leave it to the reader to choose among alternatives, there are a few points on which he takes a clear stand. One of the most striking is his assertion that "*the most profound and permanent social changes in public health occur from value and behavioral shifts in primary social groups*" (p. 11, italics in original). I completely agree. Yes, but how I wish that the rest of the paper reflected that fact.

With such a realization about how meaningful changes occur, one might expect that among policy options, the section on "education, information, and training" would be given the most attention. After all, Dr. May earlier wrote, "given the current scientific evidence, both the causes and solutions of alcohol abuse problems in an Indian community lie in the social and cultural realm of the Indian community itself, the subcultures within it, and the social structures in the surrounding region" (pp. 7–8). He even introduced his paper with examples of how inaccurate beliefs about drinking interfere with prevention and treatment approaches in many Indian communities.

However, when it comes to describing policy alternatives, he devotes fully 10 times as much space to the category of "controlling the supply of alcoholic beverages through statute and regulation" as he does to "shaping drinking practices directly." Dr. May is correct in writing: "Probably the most common and agreed upon approach to minimizing alcohol-involved problems both past and present among all human groups, has been controlling the availability of alcoholic beverages" (p. 27). Yes, but how successful has that approach been? He himself outlines some of the problems that have occurred with prohibition on Indian reservations; even prohibition appears to have been the choice of a majority of members of the local community. He mentions, for example, bootlegging and the use of other more dangerous substances as intoxicants.

Some other dangers of prohibition that May did not mention are cited by Waddell (1990) among the Papago (or O'Odham): the pattern of quick consumption (resulting in rapid and sometimes dangerously high blood-alcohol levels); greater risk of accidents, police action, etc.; profiteering by bootleggers and disproportionate expenditures by Indian drinkers; as well as considerable conflict within the community. One of the few systematic studies that compares drinking patterns among Indians of various tribes and location noted: "The persistence of prohibition as a tribal policy on a majority of the Indian reservations is in contrast to widely held and longstanding opinions that the policy (1) does not work [with references . . .], (2) contributes to the problem of high rates of alcohol abuse among reservation Indians [more references . . .] even in the wake of research findings that neither prohibition nor its repeal significantly

changes Indian drinking behavior [yet more references . . .]" (Weibel-Orlando, 1990, pp. 295–296). By comparing Navajo, Sioux, Five Civilized Tribes, and indigenous California Indians in both rural and urban settings, Weibl-Orlando demonstrated that those living on "dry" rural reservations generally drink more, and also drink more often, than those in the "wet" cities. She concluded: "Reservation prohibition remains an essentially ethical stance rather than an effective social policy" (p. 318). A similar estimate has been made about prohibition in many other areas where it has been tried. This does not mean that prohibition is meaningless — an ethical stance can be symbolically important — but it would be sad for a community to embrace prohibition expecting it to be an effective policy.

In his more rigorous doctoral dissertation, May (1976) himself demonstrated that alcohol-related rates of mortality (including liver cirrhosis, alcoholism, suicide, homicide, and traffic fatalities) were generally higher on reservations with prohibition than on those without; the same was true of alcohol-related arrests. Others have found the same pattern while studying other Indian groups (e.g., Stull, 1973; Wiebel-Orlando, 1990), prompting one researcher to generalize: "Prohibition may have had some beneficial effects, but in general has not been very effective in containing the problems of alcohol abuse and alcoholism in Indian communities. In fact, there are those who claim it has made the problem worse" (Moss, 1979, p.1). The smuggling, moonshining, and related lawlessness that grew out of the United States' "noble experiment" with nationwide prohibition have led most to view it as a failure; other prohibitions in Canada, Finland, Iceland, India, and China have similarly been repealed as not only ineffective, but actually more harmful than regulated availability. Recently, the Soviet Union gave up after a brief experiment with limiting the availability of alcohol (Heath, 1991). Ironically, among the Navajos, I found almost no change in drinking patterns after the repeal of federal prohibition (Heath, 1964).

Of course, there are many kinds of restrictions or controls less drastic than total prohibition. Increased taxes and prices are mentioned by Dr. May and are being widely recommended by the United Nations' World Health Organization. Yes, but recognizing how much people will pay a bootlegger suggests that increasing the cost of alcoholic beverages through legal channels might be more likely to hurt the family budget of heavy drinkers than to help them. Similarly, on a community level, such a policy might increase poverty and all the associated problems of public health and social welfare.

Restrictions on advertising are mentioned as another regulatory control that might result in fewer alcohol-related problems. Yes, but as May indicates, research has not demonstrated that advertising affects drinking. Perhaps more to the point, we certainly know that glue- or

solvent-sniffing, and abuse of lysol, marijuana, cocaine, heroin, and other substances are not the result of advertising. The experience of American Indian communities is not unusual in this respect; major portions of eastern Europe and Scandinavia, both areas where alcohol abuse is a big concern, have long forbidden the advertising of alcohol, and the use of hard drugs flourishes in both the United States and Canada despite both prohibition and a total absence of advertising.

Increasing the minimum age for the legal purchase of alcoholic beverages is supposed to keep young people from drinking. Yes, but we have all seen (and researchers confirm) that too often adolescents drink anyway, in more dangerous ways than they would if it were legal and with a spirit of risk-taking and bravado that tends to be associated with many other kinds of problems. In contrast increasing the minimum age for legal driving is an unusual, but promising, suggestion, perhaps more justified because of the way in which unskilled driving endangers so many people.

The variety of options that Dr. May offers for "reducing the physical, social, and environmental risks" are all worth trying, although in this connection I would underscore his warning that none of them, singly or in combination, should be expected to have a major impact in changing patterns of those individuals who already cause problems for themselves and others because of how they drink and behave "under the influence."

All these comments about the limitations on the effectiveness of the options offered by Dr. May should not be interpreted as saying that nothing can or should be done. Just the opposite. My point is that, although "the control model" we have discussed above appears to hold little promise for many Indian communities, "the sociocultural model" that he mentions only briefly may hold more promise and deserve more attention (Heath, 1988). In most of what is written about alcohol policy, little is said about all those cultures around the world where alcoholic beverages have long been easily available and where there have been few "alcohol-related problems" (Heath, 1982). Portugal, Spain, Italy, and Argentina are some of the countries with the highest average consumption of alcoholic beverages in the world by both sexes and all ages, with low taxes on alcohol, many outlets open day and night — and yet they have relatively low rates of almost all of the so-called "alcohol-related problems" that are reported at high rates in many Indian populations.

The answer, of course, has to do with the major point made by MacAndrew and Edgerton (1969) to which May refers repeatedly: "drinking patterns can be shaped and so can behavior of those under the influence" (p. 10). The quest for consensus, the focus on problems rather than on drinking in itself, the concern with community and not just individual drinkers, and the appeal to recognize and define "safe drinking practices" are all important and positive recommendations that Dr. May

offers. Similarly, he has suggested that Indian communities shift their focus of attention from "alcoholism" to "alcohol-related problems." Yes, but why not shift it a little more, to encompass many other kinds of dangerous, risky, and unhealthful behaviors? Or, to put it more positively: why not put more emphasis on safer, risk-avoidant, and healthful behaviors.

Such a shift is not unrealistic; larger and more heterogeneous communities have worked at it for years. The heart-health program in Farmingham, Massachusetts, has grown for almost 50 years and now involves most of the population in exercise, reasonably nutritious eating, safe work and play habits, and many other patterns that have significantly reduced both mortality and morbidity from many causes; many other communities have shorter but similarly encouraging experience. A brief explanation of the model is discussed by Rootman (1985), and a few communities are recently beginning to experiment with a similarly broad community-based approach, using alcohol and drugs as the focus (Giesbrecht, Conley, Denniston, Glicksman, Holder, Pederson, Room, & Dhain, 1990).

Dr. May is quite correct in attributing the popularity of "the control approach" partly to the broad appeal of a "magic bullet" or quick and easy solution. He also is right in suggesting that it fits with the inclination of many people to rely on "the authorities" to solve whatever problems may arise.

The main point of his paper is that there is no simple answer, and he is right in stressing that there is no single solution that would be appropriate for all Indian communities. Yes, but there is ample evidence that education can and does change beliefs and behavior in ways that can significantly improve health and welfare. The reason many people put little faith in education is that they take a narrow view that includes only what goes on between teacher and child in the classroom. But education is an ongoing process that can — and should — involve people of all ages, regardless of their work, social status, or tribal, religious, or other affiliation. It is a process that can be carried out by anyone, no matter how little schooling they have. And it is a process that ought to reflect the attitudes, values, and norms that are important to the community.

Dr. May says that communities must work to define and clearly communicate what alcohol-related behaviors are totally unacceptable and those that will be allowed. Yes, but why not drop the word "alcohol-related" and work to define and clearly communicate what behaviors — in *all* respects — are totally unacceptable and those that will be allowed? It is not so much the alcohol that constitutes a problem. Neither is it the drinker. The problem is (and the problems are) what people do or don't do. Most of what we find objectionable "under the influence" would be just as objectionable in a sober person.

This brings us back to Dr. May's recurrent theme, derived from MacAndrew and Edgerton (1969), that we ought to pay more attention to keeping people's behavior "within limits," following the rules of the game.

The integration and beauty that so many people around the world admire in American Indian cultures is not just a romantic image that predates the introduction of alcohol. It is an image well documented until very recent years in many Indian communities of a harmony that was firmly grounded in consensus about what is right and what is wrong. It is not naive to hope that some such state can be achieved again if people work toward it. Obviously, the situation is not yet hopeless, or people would not so actively be searching for options.

An approach to health promotion, involving traditional values as well as new media and involving old as well as young, food as well as drink, work as well as play, norms about what one should do as well as what one shouldn't, and so forth, can be the basis for real changes that could become both broad and deep. It is just such "value and behavior shifts in primary social groups" that Dr. May referred to as the basis of "the most profound and permanent social changes in mental health." I applaud this effort on the part of Dr. May and many colleagues to discuss with American Indians the ingredients of change, and hope that this alternative viewpoint may highlight some of those ingredients that might otherwise have attracted less attention.

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