

MUCH REMAINS TO BE DONE

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Dr. Philip May presents a highly competent discussion of the major considerations attending morbidity and mortality associated with alcoholism on Indian reservations in the United States. Unfortunately, his article in this publication is mostly applicable to the period prior to 1985. Since 1985, the profile of chemical dependency in Indian country has been dramatically altered. A proliferation of substances ranging from black tar heroin to designer drugs, often used intravenously, have taken hold on reservations across the United States. In addition, consequences of chemical dependency have altered. Instead of risking a bad hangover and the occasional multifatality automobile accident, today's drug abuser faces the risk of AIDS. The sexual promiscuity associated with alcohol abuse intersects with the long-standing risks associated with needle sharing to place both drinkers and druggers in a risk pool the dimension of which is significantly expanded since the early 1980s.

The year 1986 was a watershed in terms of chemical dependency in Indian country for a variety of reasons. The film, "For the Honor of All," which detailed the triumph of sobriety at Alkali Lake, was released. The Anti-Drug Act of 1988, Public Law 99-570, was enacted, providing for the first time resources and direction to the Indian Health Service (IHS) and Bureau of Indian Affairs to coordinate their efforts and make a priority of the problem of alcohol and drug abuse among Indian tribes and their members.

The year 1986 was also a turning point in the epidemiology of chemical dependency on many reservations. Historically, Indian populations have suffered from a diabetes pandemic. Needles and injections were a painful daily ordeal for many. Intravenous drugs, especially Asian heroin, were too costly for most Indians to consider. In 1986, the prevalence of black tar heroin became impossible to ignore. This addiction soon became as cheap as alcohol and almost as available. An epidemic of injectable methamphetamines, manufactured in rural laboratories across the South and West, occurred at approximately the same time. These low-cost, highly addictive drugs changed the face of chemical dependency in Indian country in a very fundamental way. Forty ounces

and a joint was once the basis for a party. Now parties come in needles, and chemical injections to avoid withdrawals occur around the clock.

In 1986, sexual promiscuity and substance abuse were identified as risk factors for infection with the human immunodeficiency virus, which causes Acquired Immune Deficiency Disease (AIDS). Although the Centers for Disease Control did not add American Indians to the demographics of its surveillance forms until August of the following year, those familiar with the epidemiology of substance abuse in urban and reservation communities became aware that the price tag on Indian alcoholism was about to escalate dramatically. The combination of sexual promiscuity traditionally associated with alcohol abuse, plus steadily increasing intravenous drug abuse in the Indian population, was a potent disease problem. This was true especially on remote reservations that lacked laboratory support to help prevent the spread of sexually transmitted and blood-borne diseases.

Other Indicators of Alcohol Problems

Mortality data is an excellent indicator of alcohol problems, for it is not duplicative. Its biggest problem, at least in the Northwest, is that people who are born Indian often die "Other," and thus the figures lack integrity. Collected mortality data lacks death from alcoholic gastritis, pneumonia (prior to AIDS, most Indian pneumonia deaths were alcohol-related), esophageal varices, and so on.

Morbidity is another good indicator, although it is rarely seen in a patient chart. After passage of P.L. 99-570, IHS service unit directors and tribes were instructed to review their alcohol morbidity data. At one northwest reservation whose trans-generational alcohol problems are at least as entrenched as one might expect, review of patient charts revealed only six instances in which alcohol was recorded as a factor associated with morbidity.

Impact on the Family

May's article contains a detailed analysis of the impact of alcoholism on the individual and the community. It would have been useful if he had focused on an interim unit, the family, in presenting the disease process and systemic impact of alcoholism. Analysis of alcohol abuse in the family process is vital to understanding such problems as sexual abuse and domestic violence.

Alternatives to Chemical Dependency

May acknowledges some value in primary prevention, intervention (which he terms “secondary prevention”), and residential treatment (“tertiary prevention”), but focuses on a process of community consensus and community-based regulation as vehicles for achieving long-term reduction of alcoholism. While the idea of enacting and enforcing rules and regulations developed by consensus within the community has some merit, this focus overlooks a major cultural reality that supports chronic alcohol abuse in rural communities, Indian and non-Indian alike.

Since the 1930s, rural activities directed at obtaining food for subsistence have decreased. Food comes in cans. Food is purchased at stores, with wages or welfare. Only the very traditional people will dry salmon, some jerky, dig roots, and dry berries. Even poor people have refrigerators and can openers; many have freezers. In addition to a diminution in the amount of work required to place food on the table, communities have incurred a major breakdown in associated group activities. Village cultures that once consisted of clusters of housing now function on individual plots and allotments. Group work and group recreation are victims of this trend, and group drinking has managed to fill a great deal of the resulting void.

By and large, the chance to earn a living wage with which to purchase food at the store has been minimal. On many reservations, except for seasonal work in agriculture or fishing, 80% of the men may be chronically unemployed. In a capitalist country, where one’s dignity and status are measured by the type of work and size of salary, such conditions are the equivalent of emasculation. In the absence of constructive alternatives, the enforced leisure, in the company of friends and a bottle, is difficult to redirect.

Similarly, rural communities offer few recreational alternatives. Most are fortunate to have a single indoor basketball court. Often the basketball court is in the center of a building that also houses offices, courts, and social services; this means it cannot be used for loud children’s play during the day. In the evening, young adults pre-empt the space; then we wonder how and why children turn to other forms of entertainment, including drinking. Resources to support consistent, supervised youth athletics and activities, including those for youngsters and young adults, simply do not exist.

Prevalence Studies

May has written that to help set the stage for public debate on alcohol policy, it is helpful to have a discussion or study of the prevalence of drinking in the community. There is some utility in prevalence studies,

particularly where they focus on individuals and communities. Generalizations about Indian drinking abound, and generally exaggerate the size of the problem. Moreover, prevalence of alcoholic behavior often varies markedly, even from one district to the next on the same reservation.

Prevalence studies can be misleading, however, and should be accompanied by an impact analysis. Frequently only one or two families are engaged in behavior that gives the appearance of a communitywide problem. Individuals with severe drinking problems often consume two to three times the amount of alcohol as others who drink. Understanding the prevalence, severity, nature, and impact of a community alcohol problem is an important aspect of assessment and problem-solving.

Alcohol and Human Behavior

May takes the position that communications can effectively set and enforce limits on human behavior, including that which is associated with intoxication. Indeed, treaties and tribal codes frequently specify prohibitions against alcohol, intoxicated behavior, use of alcohol by minors, and related conduct on reservations.

There are ways that Indian communities can control the public aspects of alcohol-related behavior. For example, the Warm Springs Reservation in Oregon has recently set up comprehensive road blocks and sobriety checks. The tribal court regularly incarcerates pregnant women who abuse alcohol or other drugs. These practices discourage drunk driving, and tend to cause chemically dependent pregnant women to seek treatment or leave the reservation.

Primary Prevention

May has written that "health education that focuses only on the negative health consequences could probably be de-emphasized on many reservations." Yet he has also pointed out that knowledge, in and of itself, does not change chemical dependency behavior. However, this does not mean that we should abandon or relax emphasis on primary prevention. As with antismoking campaigns, a considerable investment in public awareness over time is necessary before significant numbers of people correlate their knowledge with the consequences of risk behaviors.

Knowledge impacts behavior when individual awareness of the actuality and severity of consequences dawns. With the antismoking effort, which began in earnest in 1963 with the first Surgeon General's Report on Smoking and Health, major changes in smoking behavior became evident a decade later. In Indian country the two watershed events,

equivalent to the Surgeon General's Report, were Alkali Lake and Public Law 99-570 in 1986.

In terms of the impact of primary prevention efforts to reduce alcohol abuse in Indian country, we are in the antismoking equivalent of 1963. We cannot expect too much too soon. With Indian alcoholics, we are dealing with a population that has yet to respond to either antismoking or alcohol prevention messages. However, in other segments of the Indian population, antismoking messages are making headway, as are sobriety messages. The results are apparent in public behavior. Indian conferences once took place in smoke-filled rooms and adjourned to the nearest bar; pow wows were drunken brawls. No longer. Smoking and drinking are strongly discouraged in tribal activities and functions. Alcohol is not permitted at pow wows, and intoxicated individuals are promptly ejected. Progress, as measured by fundamental shifts in public behavior, is being made at a steady pace.

Public Health Approach

In this publication, May finds that the public health approach to Indian alcoholism is correct. The limitation of this approach, which works well for diseases like measles, is that alcoholism and the unacknowledged, but related problems of intravenous drug abuse and AIDS are not neatly packaged. They are, at their core, social problems with medical consequences. Public health approaches, including education and community response, are helpful. However, just as treatment of cholera requires facilities for treatment of sewage, prevention of chemical dependency depends on providing opportunities for personal growth, including employment, education, and recreation.

Ultimately, people for whom addiction is a reality will not have the motivation to undertake a daily battle unless they know and fully fear the consequences of failing to terminate life-threatening habits.

Summary

Beginning in 1986, due to fundamental shifts in the problem of alcohol and drug abuse, the perception of the problem of alcoholism and the risks associated with chemical dependency brought profound changes in social behavior and values in many Indian communities. To a limited extent, those changes are supported by public resources. Under P.L. 99-570, for example, tribes drafted Tribal Action Plans. Many addressed issues of economic development on the reservation. Many planned recreational facilities and programs to provide alternative activities for their members. Some tribes undertook expansion of alcohol/drug

programs, including in at least one case establishing their own primary residential treatment facility.

May is to be commended for assembling a genuinely thoughtful and useful analysis of the epidemiology, mortality, and morbidity of Indian alcoholism. His contribution will be helpful to many who continue complex problem-solving in this field. His proposed solutions are not without merit; they simply do not deal sufficiently with the realities of the problem.

Public health efforts, including prevention and treatment, are making progress and should be continued and increased. Public awareness of the consequences of alcoholism and drug abuse, virtually numbed by two centuries of blood and tears, is increasing because there is finally some hope of progress. More importantly, it is becoming apparent to tribal leaders and Indian health professionals that the price of failure is about to become incalculable. The advent of intravenous drug use by Indians, in the context of the AIDS epidemic, has changed the entire calculus of risk behavior. The question is whether efforts at prevention and rehabilitation will take hold sufficiently and in time to avoid great tragedy.

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