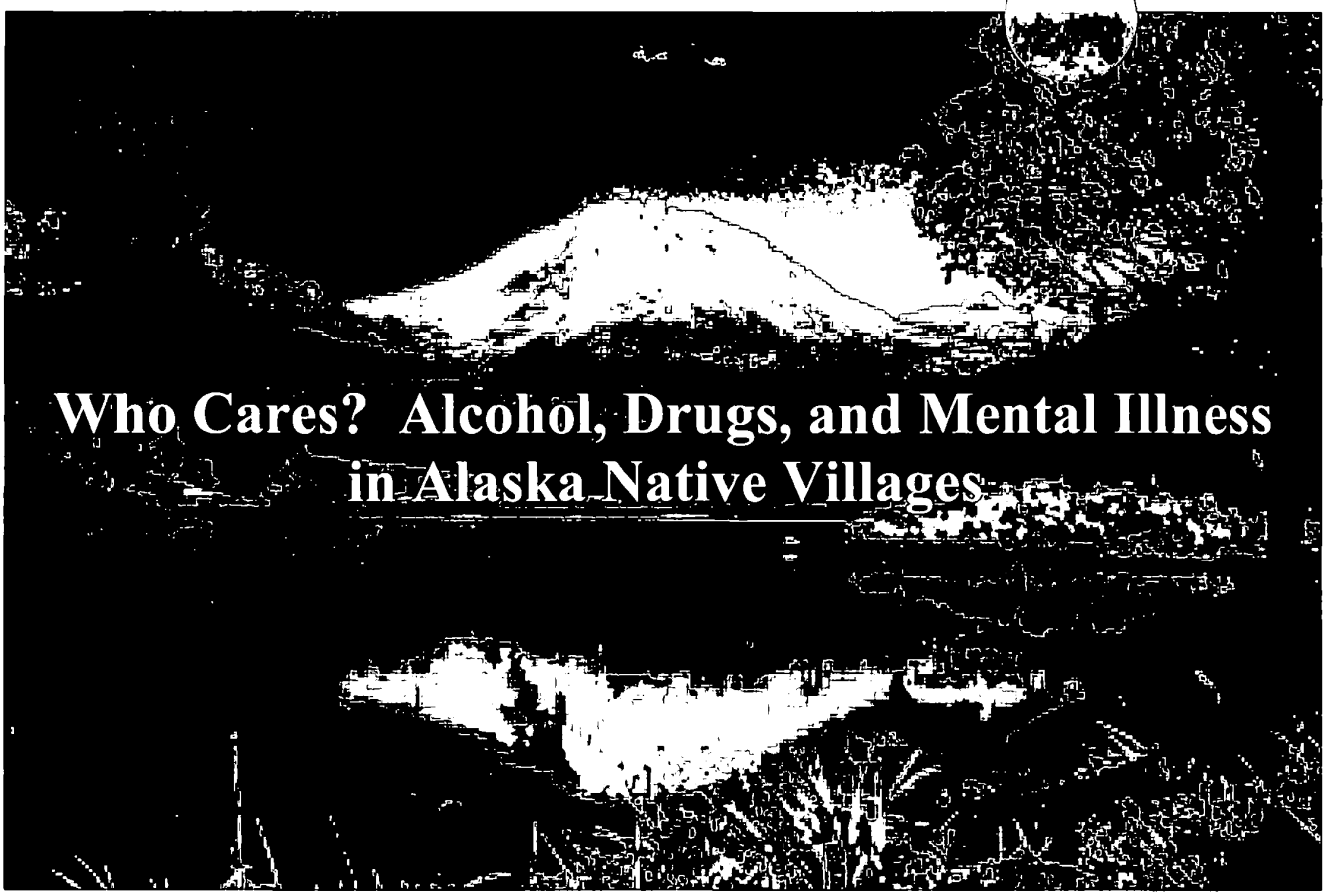
If you have issues viewing or accessing this file, please contact us at NCJRS.gov.

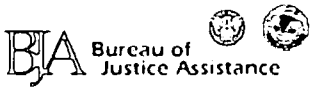


Who Cares? Alcohol, Drugs, and Mental Illness in Alaska Native Villages

David C. Maas
Elsie R. Boudreau

203447

September 2001



This publication was made possible through a grant (1999-DD-BX-0045) from the Substance Abuse and Mental Health Services Administration and the Bureau of Justice Assistance, U.S. Department of the Justice. Opinions are those of the authors or cited sources and do not necessarily reflect U.S. Department of Health and Human Services or U.S. Department of Justice policy or positions.

203447

Service (NCJRS)

Contents

Executive Summary ..... **i-iv**

Acknowledgments ..... **v**

Introduction **1-5**
Introduction **1**
Origins of Study **4**
Endnotes **5**

Chapter II. Native Peoples of Alaska **6-18**
Population Estimates and Trends **6**
The Epidemiology of Substance Abuse & Mental Illness in Alaska **7**
Summary **14**
Endnotes **16**

Chapter III. Substance Abuse Treatment in Alaska **19-36**

The Control of Alcohol **20**
Mental Health Services in Alaska **21**
Substance Abuse Programs in Alaska **26**
The Evaluation of Substance Abuse Services **30**
Endnotes **35**

Chapter IV. Community Perspectives **37-59**

Introduction **37**
Interviews: Methodology **37**
Interviews: Living With Drugs and Alcohol **39**
Interviews: Perspectives on Treatment **43**
Interviews: Envisioning Alternatives **45**
The Value of a Village Treatment Program **52**
Endnotes **57**

Advisory Council Members **60**
Condensed Bibliography **61-66**
Appendix A. Village Backgrounds **67-72**

Appendix B. Sources of Funds **73-84**

Maps and Tables

Map of Indigenous Languages in Alaska **2**
Table I Population Changes in Rural Alaska **6**
Table II Population Trends in Rural Alaska Villages **8**
Table III Comparative Alcohol-Related Problems A & B **10-11**
Table IV Crime and Race in Alaska **13**
Table V Alcohol-Related Problems: 1970-1998 ..... **14**
Table VI Regional Variations in Mortality **15**
Table VII Mental Health Services in Alaska **23**
Table VIII Alaska State Mental Health Expenditures **24**
Table IX Mental Health Site Reviews **27**
Table X Alaska Rural Substance Abuse Services (Regional) **31**
Table XI Cultural Competence and Substance Abuse Services **33**

Executive Summary

Purpose of Study

The Native peoples of Alaska have shown great resourcefulness, ingenuity, and imagination over thousands of years in adapting to their surroundings. They continue to draw on these qualities in facing many current issues and conflicts. Among the most serious are the social pathologies that affect every village and city: domestic violence, child abuse and neglect, excessive alcohol and drug use, and crime. In responding to these problems communities are hampered by inadequate treatment, limited resources, poor enforcement, state resistance and distrust, and federal inattention. Many leaders and professionals think local organizations must be given more authority and responsibility to effectively deal with these problems. The Alaska Natives Commission supported this course of action in their **Final Report**: "Approaches to substance abuse treatment for Alaska Natives must be reconstructed to emphasize community-based, family-oriented, and culturally relevant strategies developed at the village level." The intent of this work is to explore the possibility of building a village prevention and treatment program for families suffering from substance abuse and mental illness.

Overview of Substance Abuse, Mental Illness and Crime in Alaska

According to the National Household Survey on Drug Abuse, Alaska has the highest past month dependence on illicit drugs (2.8%) and illicit drugs or alcohol (7.3%) of any state in the union. The state ranks fifth in alcohol associated deaths, drunk driving arrests, and individuals in treatment. While Alaska is near the top in difficulties coping with alcohol use it is below average in offering treatment services.

A Gallup survey for the State Division of Alcoholism and Drug Abuse found 9.7% of adult (over 18) Alaskans were dependent on alcohol. Another 4.1% abused alcohol. Rates of alcohol dependence were higher for men and rural residents. Alaska Natives had the "highest estimates of alcohol dependence" (14.9%). The report calculated that 12.6 percent of Alaskan adults need treatment for alcohol problems and 1.2 % need care for both alcohol and drugs.

American Indian and Alaska Native youth (12 to 17) have the highest rate of alcohol use (19.6%) of any group in the United States. In 1993-94 71% of Indian students said they tried alcohol, 55% had been intoxicated, 54% had smoked marijuana, 25% used inhalants, and 73% smoked cigarettes. The prevalence of drug use among younger Alaska Natives is comparable to other American Indians. In 1999, according to the Youth Risk Behavior Surveillance study by the Center for Disease Control, 80% of Alaskan high school students had tried alcohol, 47% were drinking, and 34% drank heavily.

The effects of substance abuse on the health and behavior of Alaska Natives in comparison to other Alaskans and American Indians are significant:

- **Infant mortality for Native babies is 39% higher than for other groups in Alaska. Fifteen percent of the fatalities were related to maternal a lcohol or drug use.**
- **Fetal Alcohol Syndrome (FAS) and Alcohol Related Birth Defects (ARBD) are much more prevalent in Native children. Between 1977 and 1992 the numbers ranged from 1.4/1,000 to 4.1/1000 in 1985. For other groups the rates fell between 0.1 and 0.3.**
- **Death from alcoholism is 627% higher for American Indians than other Americans. The rate for Alaska Natives is 976% higher.**
- **The rate of suicide for Alaska Natives is 274% higher than the national average, and 117% higher than for other Ame rican Indians. Seventy-nine percent of Native suicide victims had detectable levels of blood alcohol.**
- **Rate of accidental death for Alaska Natives is 4.6 times the national average and 30% higher than for other American Indians.**
- **Years of potential life lost for Alaska Natives is 99% higher than for other people.**
- **Native life expectancy is 10% lower for men and 11% lower for women than national average.**
- **Thirty-four percent of the adult reports of harm to the state were Alaska Native.**
- **In Alaska, alcohol is a contributing factor in 97% of Native criminal offenses.**
- **Homicide rates in Native communities are 36% higher than national average. The number of deaths and injuries from firearms is three times higher.**
- **In 1998 Native men committed 56% of the sexual offenses and 44% of the domestic assaults in Alaska.**
- **Of the 4,019 reported cases of domestic violence in Anchorage in 1998, 21% of the aggressors and 24% of the victims were Alaska Native.**
- **In 1995, 34.9% of the youth correctional referrals were Alaska Native.**
- **36% of prison inmates in Alaska are Native**

Care and Treatment in Alaska

Almost 90% of public appropriations for the care and treatment of the mentally ill are given to urban communities. Villages provide only a small fraction of the services. In Alaska cities there is a full complement of mental health programs, i.e., crisis intervention; therapy and treatment for youth with severe emotional disturbance; medical, vocational, rehabilitation and other support for those facing depression, suicide, and other psychiatric problems. Rural communities depend primarily on paraprofessional workers and itinerant aids. Alaska Natives, particularly younger people, are over represented in admissions to mental health facilities, correctional centers, and medicaid financed services. Cities and towns connected to Alaska highways received most (88%) of the appropriations for mental health services.

There are five general criticisms of mental health care in Alaska rural communities:

psychological and psychiatric services are limited; there are no programs available to families; there is little employment or vocational training; fragmented health and social services and poor communication between providers, agencies, schools, and police; and cultural insensitivity.

There are 74 approved substance abuse treatment programs in Alaska. Fifty-one are in urban areas, 14 in regional centers, and 9 in rural villages. Most were established in response to drug and alcohol problems. Forty-six programs offer outpatient care and 28 provide residential services. Only 6 accommodate families, mostly women and children. Substance abuse programs serve an average of 208 patients every year. More than half (55%) are Alaska Native. Fifty-seven to 60% complete treatment. Of those who do not finish, 56% are Alaska Native.

Among the most important criticisms of substance abuse treatment programs in Alaska are:

- **Inappropriate or culturally insensitive treatment services. There are few Native counselors, managers, or physicians. Cultural traditions, rituals, or ceremonies are seldom part of a plan of treatment. Many non-Natives are unaware of important cultural practices.**
- **Programs removed from peoples day-to-day lives. Individuals undergoing treatment, often because of a court order, are removed from their families, their communities, and their culture. They are then sent back to the village with no provision for follow-up or relapse care.**
- **In treatment there is a focus on the individual patient or client which overlooks family conflicts and breakdowns, economic deprivation, unemployment, bootlegging, and other community problems.**
- **Little emphasis on the prevention of alcohol and drug problems particularly among Native youth.**
- **State reviews of treatment programs found a failure to involve patients in the development of their treatment plans, inadequate documentation, poor planning, faulty assessments and placement criteria, unclear lines of authority and communication, and high staff turnover.**
- **Communities are not involved in the care of their residents. There is a sense that professionals know best and thus slight elders, family members, and traditional healers who could be a valuable source of support and wisdom.**

Community Proposals for Reform

Community or self-determination would be the fundamental principle of a village mental health and substance program. Community determination requires strong and effective local governments to deal with the effects of alcohol and drug abuse, a vibrant culture, a healthy and sustainable economy, and the support and respect of outside public and private organizations, e.g., state and federal agencies, service providers. Within this context a comprehensive prevention and family treatment program would include:

- **Services for assessment, detoxification, outpatient and residential care. The residential program would include several components: education about alcohol and drug abuse and their effects; skills (communication, problem solving) development; counseling for individuals and groups; Native cultural and spiritual values guided by elders and village leaders and inspired by(depending on the area) Iñupiat, Yup'ik, or Koyukon traditions, customs, and ceremonies; and, family participation, where people could learn to resolve past conflicts and problems and figure out how to grow together.**
- **Opportunities for individuals to connect to their families, their culture, their community, and their spirituality or those things that give identity and meaning to all of us.**
- **Use of traditional methods of healing such as sweat baths, traditional ceremonies and rituals, elder consultations, spirit camps.**
- **A place not only for healing, relaxing, learning, and praying, but singing, dancing, playing, and recreation.**
- **More emphasis on prevention through increasing public awareness and knowledge, education, alternative activities (especially for the young), legal restrictions, and enforcement.**
- **Village control and direction of the treatment program, prevention work, and efforts to change the cultural, economic, social, political conditions that give rise to the problems related to mental illness and substance abuse.**

There are at least four potential impediments to a comprehensive village mental health and substance abuse program: It will be difficult to fund, coordinate, and evaluate. Significant gains in community influence could lead to conflict and opposition those threatened by such changes. Most research and training is focused on individual difficulties and treatment. Lastly, health and social work professionals and providers are not accustomed to working with communities and answering to local leaders.

These difficulties are outweighed by the important advantages of a village approach to their health and other social and economic problems and issues. Study after study has found that treatment does not work in a setting that is fragmented, hierarchical, alien, and isolated from the lives of those being treated. Villages would offer a comprehensive program that addresses both the sources and the symptoms of pathological drinking and drug use. The services would be informed, timely, and culturally relevant. It would be a responsive program that would actually work to strengthen families and reintegrate them into the life of the community. It would enable the state and federal governments to reduce costs and to direct assistance where it is really needed. Villages could begin to deal with troubles before they become serious.

Acknowledgments

This study would not have been possible without the support of the villagers of Nulato, Quinhagak, and Unalakleet and the work of our staff. A special thanks to John Smith (Tribal Judge in Quinhagak), Wassillie Bavilla (President of the Native Village of Kwinhagak), Weaver Ivanoff (Executive Director of the Native Village of Unalakleet), and Elizabeth Wofford and Sharon Demoski (Nulato Village Traditional Council) for arranging and hosting visits to their villages. We are indebted to Deborah C. Thomas, from the Department of Psychology, who almost singlehandedly scoured the library and the net for sources related to the study. Anne Hawkins Leonard spent many hours interviewing the staff of service providers throughout the state and expertly reviewing and correcting the translations of the meetings where Yup'ik was spoken. At the beginning of our work, Martha Vlasoff infected the office with humor and enthusiasm, and pointed us in the right direction. Jennifer Kormendy stepped in near the end of the project and made sense out of the statistical information that was collected from the substance abuse program surveys. Finally, Marty Waters took time from a busy schedule and helped us prepare for the first two advisory group meetings.

Members of the advisory group generously shared their time and knowledge. We benefitted enormously from the long experience of Judge Borbridge and Doug Modig. Aquilina Bourdukofsky, Pauline Harvey, John Smith, and Victor Joseph deepened our understanding of village perspectives of the health and social services they receive. Scott Prinz and Elizabeth Sunnyboy, and Susan Soule introduced us to key individuals working in the fields of mental health and substance abuse. Augusta Reimer, David Sam, Sheri Burreta, and Ed Krause offered insightful commentary and sharp criticism, when it was needed. Lori Namyniuk and Kimberly Martus cleared our thinking, at least temporarily, and gave us invaluable advice and references. The grant supporting this study was prepared in part by Ms. Namyniuk, and skillfully administered, with considerable patience and sensitivity, by Dara Schulman.

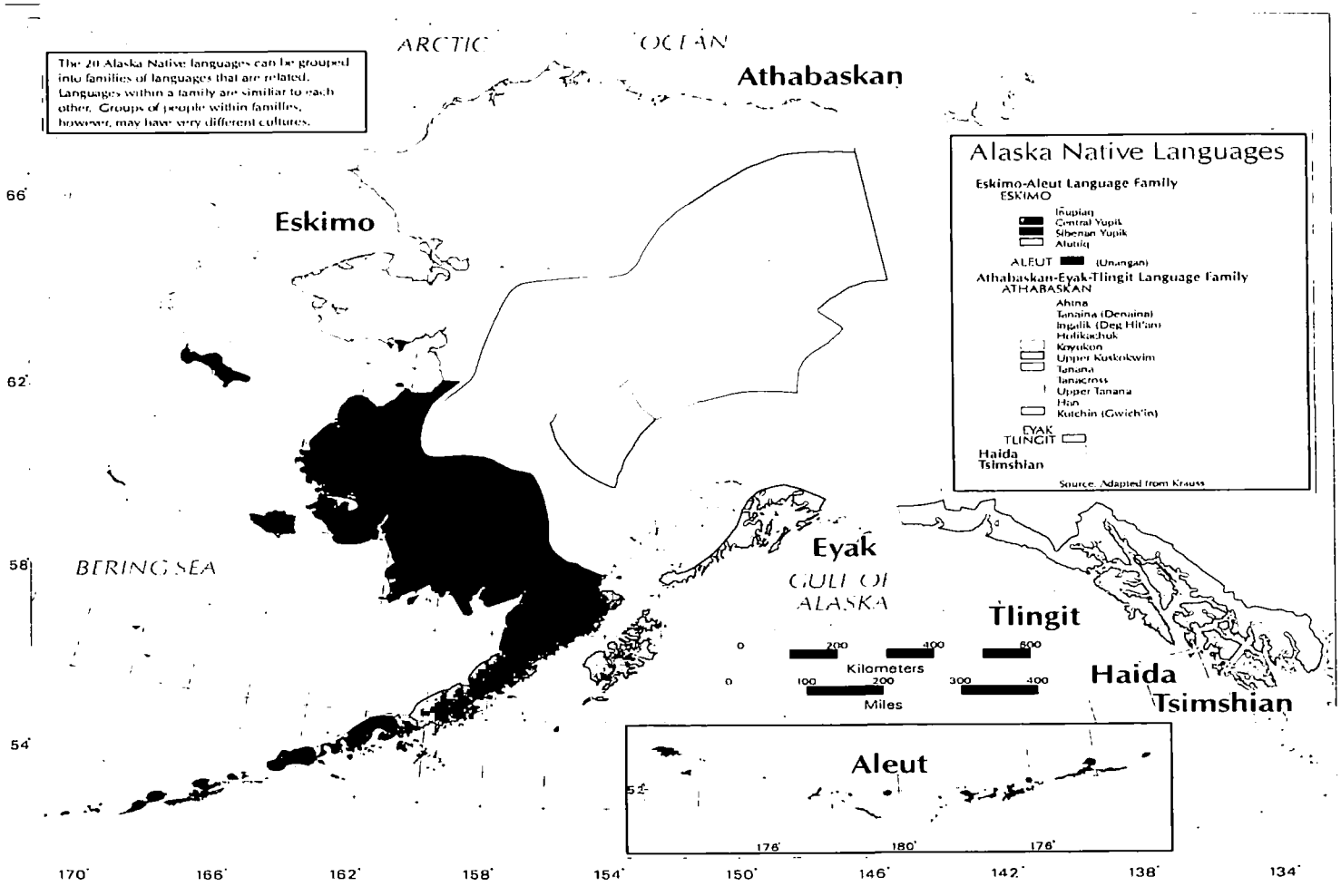
Who Cares? Alcohol, Drugs, and Mental Illness in Alaskan Native Villages

Introduction

> For Years, we have been trying to tell people that we need to focus on the strengths of our communities, the strengths of our traditions, and the strengths of ourselves. These are the things that we focused on a long time ago, and we've been waiting for 75 years for these things to be focused on again. I am a fisherman. Fishermen have a common understanding. When we're out fishing, if the boat should get a hole in it, we know we must act quickly. If we are in sight of land, we try to slow the leak and made a run for the harbor where we can safely work to repair the damage. However, if we are out of sight of the land, we know that we must repair the damage because we have little hope of making it to safety. (Village elder, 1998)

The intent of this work is to explore the possibility of developing a village prevention and treatment program for Alaska Native families who suffer from mental illness and substance abuse. The misuse and dependence of alcohol, marijuana, inhalants, and other drugs are related to theft, domestic violence, child abuse, disabling accidents, and occasional suicides. The results are broken families, deception, mistrust, neglect, separation from community and loved ones, isolation, resignation, and despair. No one is left untouched. Many are devastated. It is important though to keep these problems in perspective. Most Alaska Natives do not drink, or drink in moderation. Second, alcoholism and drug addiction are not defining elements for a proud and successful people. Rather, the history of the Natives peoples of what is now called Alaska, is a story of remarkable ingenuity and adaptation.

The Iñupiat, part of the Iñupiaq-speaking circumpolar world that extends from Northern Siberia to Greenland, inhabit northern Alaska (**See Map of Indigenous Languages in Alaska**). Their hunting prowess evolved to a point where they could capture a Bowhead whale with handmade tools, tow it to land, and then butcher it with a few sharp instruments. One hunter described the intelligence behind whaling: "In the beginning, the great whale was observed by many hunters for many seasons. Each sighting revealed a trait of the whole previously unknown. Its actions, the season it made its presence, and the waters and the ice were intensely studied by the hunter. All



Indigenous Languages in Alaska

relevant observations, however small, were discussed carefully and studied when the hunters met at the *kashgi*." (Anungazuk, 1995) Further south are the Yup'it people who are the preeminent fishers of the territory. They devised funnel shaped fish traps, set with wooden weirs, which efficiently ensnared salmon in the larger rivers, and white and black fish in the smaller streams (Oswalt, 1990). To the west were Aleuts who occupied a vast chain of land and islands from the Alaska Peninsula to Kupreanof Point near the Siberian province of Kamchatka. Through the skillful exploitation of marine resources and construction of large subterranean houses they developed an impressive intellectual, artistic, and linguistic culture that seems at odds with the harsh environment of the Aleutians. (Laughlin, 1980) Northern Athabaskans live in the interior of Alaska, the Yukon Territory, and northern and central British Columbia and Alberta. Because of the rough terrain and the wide temperature fluctuations, Athabaskans created a "dynamic economy" which followed seasonal changes and the accessibility of game. They developed a keen awareness of the environment and a complex network of trade with coastal peoples to obtain copper, sea mammals, and skins. The more settled Tlingit and Haida villages in southeastern language produced cultures rich in ritual, craftsmanship, symbolism, and social organization.

The Russian, European, and American invasions of Alaska, which began soon after the voyages of Bering and Chirikov in the middle of the eighteenth century, profoundly altered the lives of Alaska Natives. First, was the undermining of Native polities through the displacement of leaders, military subjugation, and the imposition of new rules. Second, was the attack on indigenous cultures through Christian missionaries, education, and segregation. Third, was the reorientation of traditional or subsistence economies through the expropriation of aboriginal lands and waters. Last, was the assault on human life with the spread of infectious diseases. Native communities did not endure these hardships quietly. The Aleuts occasionally, and the Tlingit regularly, launched violent reprisals. The "Orthodox Chiefs" of the Tlingit nations petitioned President McKinley in 1897 asking him to prevent traders, commercial enterprises, and missionaries from trespassing on their lands, taking their fish, and establishing saloons.

The Alaska Native Brotherhood, the first modern Native political association, fought for equal protection and the elimination of segregated schools (Cole, 1992). In 1915, Indian chiefs from the interior tried to gain more protection for their lands, a decent system of education, and better jobs (Patty, 1971). Suits were initiated in federal courts contesting land withdrawals and condemnations. In 1959 Tlingits and Haidas sued, successfully, for the loss of aboriginal lands. In 1967 regional associations and the Alaska Federation of Natives organized a movement that led to the passage of a comprehensive claims settlement in 1971.

Over the last thirty years Alaska Natives have fought to protect their lands, protect and enhance their cultures, and strengthen their communities. It is the view of many (not all) that strong and effective tribal governments are needed to accomplish these ends. Tribal governments are important in Alaska. In ninety-four rural villages they are the only government that exists; in other communities tribes provide services along with state municipalities. All Indian Health Services in Alaska are contracted out to Native tribes. There are currently 14 self-governing compacts that cover 156 rural villages. Tribes manage 7 hospitals and 21 health centers. Most villages are served by

community health aides which work in locally run clinics. Health expenditures for Alaska Natives in 1997 were slightly above $380 million. Bureau of Indian Affairs funding for tribes this year is over $24 million. A large percentage of the appropriation goes directly to tribal governments; the remainder is divided between human services, community development, resources management, trust services, and administration. More villages are forming tribal courts. Tribal courts and councils typically deal with children's issues, (e.g., custody, traditional adoptions, guardianship) and the enforcement of local ordinances, particularly alcohol related offenses. The Department of Justice supplies funds for drug courts and tribal police, programs to help abused women, and training for tribal judges. (Alaska Judicial Council, 1999)

There is growing support in rural Alaska for expanding the responsibilities of tribal organizations. At an Alaska Conference on Tribes in 1998 delegates from 170 villages approved a "Declaration of the Inherent Rights of the First Nations of Alaska" which encompassed rights to develop and maintain distinctive customs, traditions, and tribal governments; the right to self-determination; rights to decide and build meaningful economic and social programs; the right to own, use, and control community lands; the right to be informed and to participate in policy-making; and, the right to consent to decisions that effect local residents (Rural Alaska Community Action Program, May 1998). At the beginning of this year the Alaska Federation of Natives asked Congress for broad authorization to strengthen tribal governments, protect cultural traditions, and to promote local economic opportunities. [1]

Origins of Study

It is this quest by tribes and Native leaders for recognition and local influence that led to this study. In 1994 President Clinton issued a memorandum directing each executive department to "operate within a government-to-government relationship with federally recognized tribal governments." This and his "Directive on Law Enforcement in Indian Country" to Attorney General Reno and Secretary of the Interior Babbitt led to a "listening conference"[2] on sovereignty and criminal justice issues between Alaskan tribal leaders and officials from the U.S. Department of Justice. The consultations moved quickly from opening comments about self-determination, self-government, and trust responsibilities to real and substantive concerns. Foremost are the social pathologies that beset every Alaska village; domestic violence, child sexual abuse and neglect, alcoholism, drug, and inhalant use. In responding to these problems communities are hampered by inadequate resources, poor enforcement, state resistance and distrust, and federal inattention. Alaskan speakers were in agreement that local organizations responsible for local family and justice issues, tribal councils, tribal courts, and police, must be accorded more influence, responsibility, funding, and training.

One of the many ideas to grow out of these discussions was to a village program that would directly confront alcoholism, drug abuse, mental illness, and criminal behavior. The Alaska Natives Commission recommended this course of action in their report: "Approaches to substance abuse treatment for Alaska Natives must be reconstructed to emphasize community-based, family-oriented, and culturally relevant strategies developed at the village level."[3] This approach has several

advantages over current methods of treatment. Communities could then use the funds, that would normally go to a regional or state entity, to define their own problems and design their own solutions. Health professionals, counselors, and aides could draw on families, friends, and elders for information, support, and wisdom in preparing a plan of care. Presumably decisions would be more informed and appropriate to one's circumstances. The result could be, healthier families and communities.

What follows is a study of the feasibility of developing a mental health and substance abuse center in a village, that would offer both care and preventive services. The first chapter looks at the population of Native peoples and the dimensions of substance abuse and mental illness in Alaska. The intent is to document the range of pathological drinking and drug use and their connection to personal and family tragedies, illness, and criminal behavior. Chapter Three describes the mental health programs that are available in Alaska and evaluates the care that is offered to individuals and families in rural and urban communities. Information is drawn from state and private accreditation reports and a survey that was given to all Alaskan licensed service providers. The final section is the heart of the research effort. It summarizes what was learned from extended visits to three villages to learn more about (1) the patterns of alcohol and drug use and related problems (abuse, domestic violence, mental illness); (2) local opinions about existing mental health and other counseling services; and, (3) community recommendations for the development of a family and residential treatment program.

End Notes

1. Whitney, David (January 5, 2000) "Natives Request Powers." Anchorage Daily News.

2. Consultations were in Anchorage, Akiachak, Ft. Yukon, and Sitka (April 28 to May 1, 1998)

3. Alaska Natives Commission. (May 1994) Joint Federal-State Commission on Policies and Programs Affecting Alaska Natives. **Final Report**. Volume II, page 78.

Chapter II. Native Peoples of Alaska

Population Estimates and Trends

There is little information about the number of indigenous people in Alaska before the Russian voyages in the seventeenth century. Based on archaeological evidence and the records of early explorers, hunters, and missionaries, there may have been 80,000 to 100,000 people living between the western Aleutians and the Canadian border. More than a third were Yup'ik and Iñupiat, followed by Aleuts, Tlingits, and Athabascans. Today there are approximately 105,000 Natives in Alaska. Fifty percent are Yu'pik and Iñupiat, more than a third are American Indian (Athabascan, Tlingit, Haida, and Tsimshian, and other Native Americans), and 12 percent are Aleuts. The rate of population growth in rural areas exceeded the overall state average since the last census in 1990. (See **Table I on Population Changes in Rural Census Areas**) Higher fertility rates explain most of the changes. The largest increases in Native peoples were in the Arctic, western Alaska, and Yup'ik communities in the southwest. From 1929 to 1990 the Native proportion of the total population steadily dropped from 50.6% to 15.6%. Beginning in 1991, this downward trend was reversed. By 1998 the percentage of Alaska Natives had climbed to 16.8%. The percentage of Alaska Natives grew in every region except the Arctic Slope and a few areas in southeastern Alaska. The exodus of non-Natives because of base closures, production declines in fishing and timber, and higher Native birthrates explain the change. Alaska Natives are now a majority in most of the state's interior, the northern region, and the southwest, with the exception of Bristol Bay and the western Aleutians.

Table I. Population Changes in Rural Alaska: 1990-1999

Census Area	1990 Population	1999 Population	Change
Yukon-Koyukuk	6,714	6,372	-5.00%
Nome Census Area	8,288	9,311	12.00%
Northwest Arctic Borough Area	5,979	7,413	24.00%
Aleutian East Census Area	2,464	2,151	12.00%
Aleutian West Census Area	9,478	5,285	-44.00%
Bethel Census Area	13,656	16,167	18.00%
Lake & Peninsula Census Area	1,668	1,791	7.00%
Wade Hampton Census Area	5,791	7,060	22.00%
Totals/Averages	63,214	62,732	9.63%*

*Average excludes Aleutian West Census Area because of unusual decline in population due to closing of naval base at Adak

Alaska Natives are younger than the general population: Their median age is 23, 11 years below the national average. Forty-five percent of Natives are under 19. The average Native family is larger and the dependency of children on Native employment is higher than for other Alaskans. In 1999 every 100 Alaskan workers supported an average of 52.1 persons; for Natives eligible to work, the number of dependents totaled 87.2. According to the Alaska Department of Labor: "(T)his added burden is exacerbated by the higher unemployment, lower labor force participation, and lower incomes of many Alaska Natives."[1]

While Native households have declined in size (from 4.6 children in 1970 to 3.2. in 1999) they are still larger than non-Natives families (2.3 in 1999) Slightly over 56 percent of Alaska Natives live in rural communities. At the same time, more village residents are moving to urban areas. Native residents in Alaska's seven largest cities increased almost 16 percent between 1990 and 1998. Anchorage and Kenai experienced the largest increases, followed by Fairbanks, Juneau, and Sitka. Anchorage now has more Alaska Natives than any other area in the state. The populations of regional service centers such as Dillingham, Bethel, Nome, Barrow, and Fort Yukon have grown as well. While these migration patterns are important, they should not overshadow the relative stability of Native communities. In Wade Hampton (Calista), for example, 92.1 percent of the residents in 1990 lived in the same area five years earlier. In Fairbanks, Anchorage, Juneau, and Kenai, the percentages were between 60 and 72 percent.

The demographic changes in rural villages are more complex. In a study of rural Alaska two decades ago the authors forecast the growth of village populations and a shift in the size of rural communities.[2] Between 1970 and 1999 the average number of village residents has risen by 72 percent (See **Table II Population Trends in Rural Alaskan Native Villages**). More people today are living in larger communities. In 1950 almost half the villages had less than 100 people, in 1970 less than a third did, and in 1999 the percentage dropped to about one sixth (17 percent). The number of medium-sized places also decreased 13 percent. In 1970, outside of the regional hub communities like Barrow or Bethel, there were no large villages. Now there are 26. No doubt government spending and regulations have effected this trends. For example, last year the Indian Health Service's budget for Alaska was close to $380 million dollars. Forty two percent of this money was spent in Anchorage. Another 43 percent was distributed to eleven regional health or non-profit organizations in Anchorage, Fairbanks, Juneau, and rural service cities like Barrow, Bethel, Dillingham, and Kodiak. Those in search of work or assistance will naturally gravitate to these areas. Only a small portion of the health budget went directly to communities.

The Epidemiology of Substance Abuse and Mental Illness in Alaska

The most recent investigation of substance abuse in Alaska was a statewide and regional telephone survey by the Gallup organization for the State Division of Alcoholism and Drug Abuse. The survey found that 9.7 percent of adult (over 18) Alaskans were dependent[3] on alcohol. Another 4.1 percent abused alcohol. Rates of alcohol dependence were higher for men and rural residents. Alaska Natives had the "highest estimates of alcohol dependence" (14.9%). However, alcohol abuse[4] is less widespread in Bush[5] regions. Marijuana was the only other drug used by more than one percent of the population (1.1% are dependent, 0.4% are abusers).

The report calculated that 12.6 percent of Alaskan adults need treatment[6] for alcohol problems and 1.2 percent need care for both alcohol and drugs. Treatment needs were slightly higher in Bush communities (13.5%) and southeastern Alaska (14.4%) than urban areas (12.3%). Over 40 percent of those who desired more help were women of childbearing age.[7] In smaller districts and boroughs,[8] the incidence of alcohol dependence was highest in Yukon-Koyukuk (13.78%), North Slope (13.78%), and Bethel (12.94%); it was lowest in Kodiak (7.75%), Kenai

Table II. Population Trends in Rural Alaska Villages: 1970-1999

Rural Region Census Area	Number Villages	Average Size 1970	1999	Sm. Villages 1970	1999	Med. Villages 1970	1999	Lg. Villages 1970	1999
Yukon-Koyukuk	23	378	570	14	11	9	11	0	1
Nome Census Area	13	211	385	5	2	8	6	0	5
North Slope Borough Area	7*	200	413	3	0	2	5	0	2
Northwest Arctic Borough Area	10	223	380	3	2	7	6	0	2
Aleutian East Census Area	6	184	358	3	3	3	1	0	2
Aleutian West Census Area	4	182	240	2	3	2	0	0	1
Bethel Census Area	30	176	319	12	6	18	17	0	7
Lake & Peninsula Census Area	16	84	101	15	13	1	3	0	0
Wade-Hampton Census Area	13	276	541	3	2	12	5	0	6
Totals/Averages	122	213	367	60	42	62	54	0	26

Compares trends from 1976 study (Alonso & Rust, March 1976) with latest estimates from the Alaska Department of Labor (May, 2000) *In 1970 there were 5 villages (outside Barrow); now there are 7.

(8.5%) and Matnuska-Susitna (8.96%) valley north of Anchorage. Rates of alcohol abuse were highest in Aleutians West, Prince of Wales, and Juneau, and lowest in Dillingham, Wade-Hampton, and Bethel (DADA p. 25) Marijuana dependence is 2 ½ to 3 times higher in rural areas (North Slope [2.88%], Wade-Hampton[2.81%], Northwest Arctic [2.70%]) than more populated communities like the Matnuska-Susitna valley (0.59%), Sitka (0.85%), or Haines (0.85%). Treatment needs were highest in coastal communities like Prince of Wales (17.77%), Aleutians West (16.90%), and Ketchikan Gateway (15.59%).

According to the Center for Disease Control and Prevention alcohol consumption in Alaska (8.3%)[9] is just above the national average (7.8%). The State Division of Alcohol and Drug Abuse even reports a decline over the last ten years (1985-1995) in the per capita consumption of alcohol (from 3.5 gallons to 2.6 gallons a year).[10] In the most recent national survey however, Alaska has the highest past month dependence on illicit drugs (2.8%) and illicit drugs or alcohol (7.3%) of any

state in the union.[11] Alaska has severe alcohol related problems. The state ranks fifth in alcohol associated deaths, drunk driving arrests, and individuals in treatment. [12] The alcohol mortality rate was the highest in the United States between 1991 and 1993.[13] While Alaska is near the top in difficulties coping with alcohol use it is below average in providing treatment services. With regard to drugs, Alaska's problems are less serious, at least among adults. The state ranks 40th in overall drug-related offenses, 33rd in drug mortality, 41st in drug arrests, and 44th in furnishing drug abuse services.

Alaskans generally start using alcohol and drugs at an early age.[14] Thirty four percent started drinking before they were 13, over 17 percent smoked marijuana. Both percentages exceed the national mean figures. The number of high school students who drink alcohol is below the U.S. average (46.9% v. 50%) but the number of heavy drinkers is higher (34.4% v. 31.5%) The proportion of young marijuana users in Alaska is also higher (30.7%) than the national mean (26.7%).[15] The use of alcohol and drugs by younger American Indians is considerably higher than for the general population. In an important study that has surveyed drug use among Indian adolescents for 20 years, the author found that Indian youth show higher rates of use than youth in other national samples for all substances. The National Household Survey of Drug Use found that Alaska Native/American Indian youth (12 to 17) had the highest rate of alcohol use (19.6%) of any group in the U.S. In 1993-94 71% of Indian students[16] said they tried alcohol, 55% had been intoxicated, 54% had smoked marijuana, 25% used inhalants,[17] 12% had taken cocaine, 21% experimented with psychedelics, and 73% smoked cigarettes. The prevalence of drug use among younger Alaska Natives is comparable to American Indians and other Alaskans. In a study of Alaskan students in grades 7-12, a large percentage had tried alcohol and marijuana. More Native students had smoked marijuana (71.3 percent v. 48.5 percent for non-Natives) and cigarettes and used smokeless tobacco. The rates for cocaine (26%) and inhalants (12 to 15%) were similar.[18]

The effects of substance abuse on the health and behavior of Alaska Natives are partially found in the public statistics on health, suicide, and crime. The most useful national sources on the health of American Indians and Alaska Natives are the annual publications compiled by the Indian Health Service, **Trends in Indian Health** and **Regional Differences in Indian Health**. **Table III (A & B)**summarizes some of the effects of alcohol on Alaska Natives in comparison to the general population and other American Indian groups. The percentage of Native mothers who drink during pregnancy is 8 times higher than the national estimate, and 3 times more than for other Indian women. The mother's use of drugs and tobacco also effects the overall health of the infant. American Indians infant mortality rate is 22 percent greater than for other groups in the United States. In Alaska the rate for Native babies is 39 percent higher. The plurality (43.2) of Indian babies die from either sudden infant death syndrome or congenital anomalies; in Alaska, Native infants also suffer from disorders related to short gestation periods or low birth weight (8 percent). The Indian Health Service attributes these differences to poor prenatal care. Native children are also afflicted with fetal alcohol syndrome. In a recent check of medical records and patient files researchers found that symptoms of either FAS or Alcohol Related Birth Defect (ARBD) were much more prevalent in Native babies. Between 1977 and 1992 the average rate of FAS was 0.8 for every 1,000 live births. Among Alaska Natives the numbers ranged from 1.4 per 1,000 in 1977 to 4.1 in

Table III. Comparative Alcholol-Related Problems (A)

Categories	Mothers Who Drank During Pregnancy		Years of Potential Life Lost All Causes		Death from Chronic Liver Disease/Cirrhosis		Deaths from Accidents & Adverse Affects	
U.S. All Groups	1.50%		53.7				4.00%	
All IHS Areas	4.50%		91.5		4.7%(c)		14.10%	
IHS Area Offices:								
Aberdeen	6.30%	4(b)	127.6	1	8.00%	2	13.80%	7
Alaska	12.30%	1	106.8	5	9.1%(d)	1	18.30%	2
Albuquerque	3.40%	9	86.2	8	7.40%	3	16.30%	3
Bemidji	6.20%	5	118.8	3			12.80%	9
Billings	7.50%	3	102.9	6	4.40%	7	15.10%	5
California	10.00%	2	64.6	12			9.40%	12
Nashville	1.60%	12	78.6	10	4.90%	6	10.40%	10
Navajo	3.10%	10	90.6	7			21.80%	1
Oklahoma	1.90%	11	74	11			9.50%	11
Phoenix	4.10%	7	107.8	4	7.20%	4	15.90%	4
Portland	4.40%	6	85.1	9	5.50%	5	13.50%	8
Tucson	4.00%	8	122.4	2	9.10%	1	14.20%	6

a: Information from Indian Health Service, Regional Differences in Indian Health 1998-99. b: Refers to area rank. c Percentage of deaths from liver disease. One of the five leading causes of death in area.

1985. For other groups the rates fell between 0.1 and 0.3. While the figures are alarming, the authors of the study counsel skepticism. They question the reliability of the figures because of the diagnosis of GAS is often subjective, the syndrome is poorly defined, and the data sources are incomplete.[19]

Alcohol dependence and abuse is directly tied to Indian mortality. Death from alcoholism, which includes psychoses, liver disease, overdose, cardiomyopathy, gastritis, and poisoning, is 627 percent greater for Indians that other Americans. The rate for Alaska Natives is 976 percent higher. Alaska Natives are almost twice as likely to die from liver disease or cirrhosis that stems from alcohol abuse. Alcohol use is also related to suicide and accidental deaths. The Alaska Natives Commission found that 79% of Native suicide victims had detectable levels of blood alcohol.[20] The rate of suicide for Alaska Natives is 274 higher than the national average and 117 percent higher than

Table III. Continued (B)

Categories	Suicide	Alcoholism Deaths		Life Expectancy: Males		Life Expectancy: Females		Infant Mortality Rate (1994-96)	
U.S. All Groups	11.2a	6.7 (c)		72.5		78.9		7.6(d)	
All IHS Areas	19.3	48.7		69.8		74.7		9.3	
IHS Area Offices									
Aberdeen	29.7[2]b	109	1	60.6	12	70	11	14.1	1
Alaska	41.9[1]	72.1	2	65.6	8	73	7	10.6	4
Albuquerque	19.2[8]	70.7	3	69.9	3	75.8	5	8.2	10
Bemidji	19.7[7]	39.2	8	62.4	10	67.8	12	10.1	5
Billings	24.3[3]	60.6	5	63.6	9	70.8	10	9.3	7
California	11.7[11]	27	10	72.5	1	80.2	1	8.3	9
Nashville	11.0[12]	30.8	9	69.4	4	76	4	11.7	3
Navajo	15.9[9]	50.1	7	68.3	6	76.7	3	8.2	10
Oklahoma	11.9[10]	21.7	11	70.8	2	77.5	2	7.5	11
Phoenix	23.4[4]	72.1	2	65.8	7	72.3	8	9.7	6
Portland	22.8[5]	56	6	68.6	5	73.4	6	8.4	8
Tucson	21.0[6]	68	4	62.2	11	72	9	10.8	2

a: Rate per 100,000 population. b: Area rank in IHS system. c: Rate per 100,000 population. d: Rate per 1,
live births.

for other American Indian communities. Drinking is involved in 15 to 61 percent of motor vehicle crashes, falls, fires, drownings, and other unintentional injuries in the United States.[21] In Alaska, alcohol is related to Native deaths 3 times more often than non-Native fatalities. The rate of accidental death for Alaska Native is 4.6 times greater than the national average, and 30 percent higher than for other American Indians. The frequency of premature deaths among Alaska Natives leads to 99 percent high rate of years of potential life lost[22] than for other American. Native life expectancy too, is 10 percent lower for men and 11 percent lower for women than the U.S. average.

Alcohol and drug use are frequently associated with crime. In homicide cases, for example, 60 percent of the offenders and a third of the victims were drinking when the offense occurred. A high percentage of the offenders were habitual drinkers.[23] In a study of American Indians and crime, more than half of violent crimes against Indians involved alcohol and drugs, far more than other groups.[24] In Alaska, alcohol was a primary or contributing factor in 80 to 95 percent of criminal offenses; for Alaska Natives the percentage rises to 97%.[25] The rate of homicides in Native communities is 36 percent higher than the U.S. average; the number of injuries and deaths from

firearms is three times higher.[26] According to the State Department of Public Safety, the level of violence and crime in the Bush is proportional to the level of alcohol that is consumed. For example, the year after Barrow prohibited alcohol use, felony assaults decline 79 percent, suicide attempts by 34 percent, and domestic conflict calls dropped 27 percent. There were also significant decreases in fetal alcohol problems, alcohol-related injuries, and outpatient visits to the hospital.[27]

Table IV on Crime and Race in Alaska classifies the kind and number of criminal offenses committed by Alaska Natives and other major groups. There is a clear pattern of Native crime. First is the link between sex and aggression. Native men committed 56 percent of the sexual offenses and 44 percent of the domestic infractions (domestic violence and abuse) in 1998. Second, is the prevalence of extreme violence and force, rape, murder, and suicide, in many rural communities. Third, is the low percentage of Natives who engage in taking other people's property. For the thefts that do occur, most are for small amounts.[28] Natives account for over a third (36%) of prison inmates in Alaska. Most are males (93.7%), under 40 (68.9%), and incarcerated for a felony (70%). Over 50 percent committed a serious violent crime, i.e., murder, rape, robbery, or the sexual abuse of a minor. Other misdeeds include violations of liquor laws (9.8%), burglary (10.5%), and parole/probation infractions (19.8%).[29] Native parolees find it particularly hard to meet the conditions of their release, because they must live in a city where the probation officers are. According to one prisoner:

> In most cases, the Native inmate that is eligible for parole or mandatory release could make it if he or she could go back to the village and live with family and friends. They could adjust better to the outside this way. By making them stay in the city and get a job, it's harder on them. We need to get in an environment we are comfortable in. Most Natives, once in their village, can most likely make it. Telling them they have to work and stay in the city is a hardship on them, before they even get a chance to make it on the outside. (Alaska Natives Commission 1994, p. 161)

It is very difficult to know whether there have been significant changes in Native health and behavior over time. Population estimates in the past were even less reliable than today. A statewide mental health and public safety reporting system did not exist twenty years ago. Healthcare was less accessible to the ill and needy, particularly to those who lived in rural Alaska. Therefore the few reports that do exist were based on fragmented, incomplete, and conservative information.[30]

One study in 1968 of the discharges from the seven Alaska Area Native Service hospitals found alcoholism to be the most serious mental problem for Native patients.[31] In 1979, a more comprehensive work examined state mortality data and the treatment of Alaska Natives by the Indian Health Service (IHS), the Alaska Psychiatric Institute, and the 19 Community Mental Health Centers established in 1975. The percent of individuals admitted to Alaska IHS hospitals, that were diagnosed with drug and alcohol problems, increased from 3.1% to 4.6% between 1971 and 1977. The number of persons visiting a hospital for the first time, with drug problems, almost doubled

(39.7/1,000 to 75.8/1,000) during the same period. An increasing number also began using the Community Mental Health Centers for addiction troubles.

Table IV. Crime and Race in Alaska [a]

Offense	Whites[a]	Blacks	Indians	Asians	Percent: Alaska Natives	
Murder:					1991	1998
Arrest	14	5	12	1	29.00%	38%
Victim	26	2	12	1	36.00%	29%
Rape	39	9	61	1	48.30%	55.50%
Robbery	109	36	31	6	15%	17%
Aggravated Assault	661	108	364	18	38.10%	31.60%
Burglary	513	34	361	19	29.80%	38.90%
Larceny	2392	424	660	140	19%	18.30%
Motor Vehicle Theft	252	78	116	4		25%
Other Assaults	1962	312	1192	91	37.00%	34%
Sex Offense	94	1	128	5	56.10%	56%
Narcotics [sale]	64	24	34			28%
Narcotics [poss]	195	89	35	4		11%
Marijuana [poss]	620	37	158	3	38.90%	19%
Family/child	141	48	149	2		44%
DWI	2941	139	713	64		18%
Liquor Laws	482	17	539	34	49.00%	50%
Disorderly Conduct	314	40	191	18	49.30%	34%

[a] Statistics from Department of Public Safety. Crime Reported in Alaska, 1991 & 1998. [b] Categories used by Department of Public Safety.

Then, as now, accidents and injuries were a leading cause of Native fatalities. The rate of injuries grew by a third between 1971 and 1976. (198.2/1,000 to 263.1/1,000). Many of these accidents were tied to alcohol (11.5 to 17.8%). Incidences of suicide attempts also climbed in the 1970's (21%). Alcohol was involved in most of the cases (60-73 percent). Between 1950 and 1974 the average annual suicide rate more than doubled from 14 to 33/100,000. In 1970, violence, which includes accidents, homicides, suicides, and alcoholism, was the leading cause of death in Alaska. Natives though, were 71 percent more likely to die from accidents than non-Natives, 4 times more likely to die from alcoholism, and over twice as likely to perish from self-destruction or murder.[32]

Table V provides a rough comparison of three decades for alcohol related problems. Since 1970 violence has become, by far, the leading cause of mortality for Alaska Natives. Death from injuries and accidents increased 76% between 1970 and 1991. The rate of suicide in 1996 was 42%

Table V. Alcohol-Related Problems: 1970-1998 [a]

Categories	Natives	Alaska	U.S.	Natives	IHS	U.S.	Natives	IHS	U.S.
	1970			1989 to 1991			1998		
Years of Potential Life Lost				139.1	87	56	107	92	54
Mortality Rate				771.8	714	520.2	781.5	610	504
Death from Violence	41%	32%		58%	42%	23%	58%	54%	25%
Deaths from Injuries and Accidents	199.4b	116.9	56.4	351.1	206	92.1	329.6	225	97
Suicide	29.6	13.2	11.6	34.6	21.3	11.5	41.9	19.3	11.2
Homicide	27.6	10.6	8.3	17.5	18.4	10.2	12.8	15.3	9.4
Alcoholism Mortality	41.4	10.9	n/a	43.2	52	7.1	72.1	48.7	6.7
Life Expectancy:				68.4	70.2	75.4	65.6	67.6	75.8
Males				63.6	66	71.8	65.6	69.8	72.5
Females				74	74.7	78.8	73	74.7	78.9

[a] Information from Kraus & Buffler (1979), Kelso (1975), Regional Differences in Indian Health 1989 to 1991 & 1998 to 1999. [b] Rate per 100,000 deaths.

higher than in 1970. Alcohol fatalities over the last 30 years have risen 74 percent. Native communities suffer more from accident, injuries, and suicides than any other population in the United States. Only the northern plains loses proportionally more Indian peoples from alcohol illnesses than Alaska Natives. The physical and mental consequences are clearly revealed in the average life expectancy for Alaska Natives which has declined in the last decade. From a public policy perspective something is not working in Alaska.

Summary

> A growing sense of helplessness simmers in alcohol throughout the Bush. Among a growing percentage of Alaska Natives, life has become equal parts violence, disintegration, and despair. An epidemic of suicide, murder, and self-destruction threatens to overwhelm cultures that have for centuries survived and prospered in the harshest environments on earth (Anchorage Daily News, 1988).

The interrelated effects of drug dependence and abuse on Native children, couples, families, and communities are serious and alarming. The physical and mental infirmities endured by Native peoples is largely the result of alcohol dependence. Near all of the crimes committed by individual Natives, including child abuse, battering, murder, rape, are associated with alcohol. Many clinicians

". . .feel a significant but unknown increment of physical illnesses among Natives, such as diabetes mellitus, heart disease, certain neoplasms, cirrhosis of the liver, influenza and pneumonia, gonorrhea and other venereal diseases, nutritional disturbances, and complications of pregnancy are either caused by or aggravated by alcohol use. A family unit disrupted by alcohol is a fertile breeding ground for a variety of physical, psychological and social disturbances."[33]

However, the numbers by themselves do not tell the full story. Criminal, morbidity, and survey statistics simply total the number of cases, incidents, or responses that are reported. One analyst reviewed eight large studies of alcohol use on different Indian reservations. He found "tremendous variation in the prevalence of drinking from one reservation to the next and also from one time period to the next.[34] In some areas Indian people drank less than the national average, some consumed below, and others drank at similar levels. Further, it was discovered that there were many Indians who abstained and others who quit when they were older, a pattern that exists in many parts of society. The same variation can be found in Alaska. **Table VI, Regional Variations in Mortality,** shows the alcohol-related mortality figures for each Indian Health service area. In certain areas like the Northwest Arctic suicide is more serious than in the southeastern panhandle. There are less fatalities from accidents in cities than in rural communities. However, there are more homicides in Anchorage and some of the regional hub centers. Within each region too, there are divergent trends because of the small number of cases from year to year.

Table VI. Regional Variations in Mortality [a]

Indian Health Service Regions	Unintentional Injuries	Suicide	Homicide	Alcohol-Related Deaths
Anchorage	102.5	23.9	22.3	53.3
Barrow	139.4	49.2	32.8	32.8
Bristol Bay Area	148.8	32.4		32.4
Interior Alaska	118.4	35.5	17.8	44.4
Kotzebue	84.1	74.2		29.7
Mt. Edgecumbe	70.5	25.2		40.3
Norton Sound	112	51.7		42.3
Yukon-Kuskokwim	139.4	49.2	32.8	32.8

[a] From Alaska Area Health Summary 2000. Rates are averaged from 1994, 1995, & 1996.

There are also significant differences among villages. In a case study of substance abuse in two southwestern villages near Bethel, the authors found in one, a high percentage of heavy users, bootleggers, and home brewers. Drinking and partying pervaded the entire village. The behavior

of intoxicated individuals was public, boisterous, and aggressive, frequently accompanied by gunshots. Injuries, accidents, and premature deaths were a daily concern. In the second community, along the Kuskokwim River, very few people drank. There was no public drunkenness, no illegal importation of alcohol or drugs, and no home distilleries. There were relatively few mishaps or deaths from excessive consumption.[35]

The concentration on patterns of Indian substance use and behavior both perpetuates the popular "drunken Indian story," and ignores other factors associated with the misuse of alcohol and drugs. The unemployed, for example, are much more likely to engage in binge (five or more drinks on one occasion) and heavy drinking (binge drinking on five or more occasions in a 30 day period), that individuals who work full time.[36] Other research has found that economic backgrounds are more important in explaining drug use and abuse than culture. A few studies point to social integration and degree of control that a community has over individual actions.[37]

The epidemiology of substance use and mental illness may also blind us to the underlying conditions that lead to heavy drinking and the unfortunate consequences that follow. Without an understanding of privation, stress, physical abuse, loss of culture, powerlessness, and history and other circumstances, the treatment of alcohol abuse and dependence will remain elusive. Alternative treatments and their effects are the subject of the next section.

Endnotes

1. Alaska Department of Labor (May 2000) **Population Overview: 1999 Estimates.**

2. Alonso, W. & Rust, E. (March, 1976) **The Evolving Pattern of Village Alaska.** Anchorage: Federal-State Land Use Planning Commission for Alaska.

3. The survey used three criteria for **dependence**: (1) undesired excessive use, including resulting tolerance and withdrawal sickness; (2) problems in a person's life that are result of excessive use; (3) failed attempts to control substance use without help. (DADA 1999, p. 11)

4. **Substance abuse** has two components: (1) continued use despite recurrent social, occupational, psychological, or physical components; (2) recurrent use in physically hazardous situations.

5. **Bush** areas are not connected to the highway system.

6. **Treatment need** is defined as being in a state of substance abuse or dependence and requiring help to stop or cut down on substance use, to prevent relapse, or to recover from

the effects of use. The operational definition of treatment need is a diagnosis of a substance abuse disorder, either abuse or dependence. (DADA p. 13)

7. Alaska Division of Alcohol and Drug Abuse. (May 2000) **State Plan**. Page 17.

8. **Boroughs** are used to describe an areawide local government which are (theoretically) more unified, flexible, and powerful than county governments. (Alaska Constitution, Article X, Section 3)

9. Represents the percent of individuals who drank from 21 to 31 days in the last month. The question was: During the past month, how many days per month did you drink any alcoholic beverages, on the average? From CDC's Behavioral Risk Factor Surveillance System. Alaska ranked 22nd.

10. Advisory Board on Alcohol and Drug Abuse (January 1999) page 10.

11. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (1999)

12. Only New Mexico, Colorado, California, and Wyoming had higher proportions of alcohol related problems.

13. The latest period for which there are complete records from every state.

14. There has been an increase nationally in the new use of alcohol among youth from 117.6 to 216.8/1,000[of potential users) between 1992 and 1997 (SAMSHA 1999).

15. The figures on youth are taken from the Center for Disease Control's State and Local Youth Risk Behavior Surveillance System (YRBSS) survey completed in 1999. The data does not include the Anchorage School District, which chose not to participate in the study.

16. The study corrected for students who dropped our of school (national average for Indian students is 50%) before graduating. Other studies often miss drop outs which often have the most difficult psychological and social problems to deal with.

17. A 1998 study of inhalant use among high risk youth found 33.5 percent of those in treatment, and 52.7 percent in corrections, had tried inhalants (Prinz, 1999). The national rate of first use of inhalants for youth (12 to 17) rose from 11.6/1,000 to 28.1/1,000 [potential first users] between 1990 and 1998. (SAMSHA, 1999).

18. Beauvais and Segal (1992) page 84.

19. Egeland, G.M. et al. (May, 1998) Fetal Alcohol Syndrome in Alaska, 1977 through 1992. **American Journal of Public Health**. Volume 88, Number 5.

20. Alaska Natives Commission. (May 1994) **Final Report. Volume II.** Page 71. The association of alcohol and suicide for Alaska Natives and other groups is higher. In two studies reviewed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) the percent of suicide victims that had a positive Blood Alcohol Count was 36% and 50% respectively. (NIAAA 1997 page 259).

21. NIAAA (1999) page 247.

22. The Years of Potential Life Lost is a mortality indicator that is calculated by subtracting the age of death from age 65 and summing the results of all deaths.

23. NIAAA (1999) page 259.

24. Bureau of Justice Statistics (1999) page 9.

25. Alaska Commission on Rural Governance and Empowerment (1999)

26. Indian Health Service (2000) pages 65-66.

27. Alaska Criminal Justice Assessment Commission, page 23.

28. Bureau of Justice Assistance (1999) pages 24-25.

29. Alaska Department of Corrections (1999)

30. Kraus, F.B. & Buffler, P.A. (1979) Sociocultural Stress and the American Native in Alaska." **Culture, Medicine, and Psychiatry**. Volume 3, pages 111-151.

31. Kraus & Buffler, page 121.

32. All of this information is from the Kraus and Buffler article, "Sociocultural Stress and the American Native in Alaska: An analysis of Changing Patterns of Psychiatric Illness and Alcohol Abuse Among Alaska Natives." (1979)

33. Kraus & Buffler, page 149.

34. May (1996)

35. Shinkwin & Pete (1982)

36. SAMSHA (1998)

37. Beauvais (1993) and Silk-Walker, P. et al (1988) Alcoholism, Alcohol Abuse, and Health in American Indians and Alaska Natives. **American Indian and Alaska Native Mental Health Research. Volume I**, pages 65-93.

Chapter III
Substance Abuse Treatment in Alaska

Claire is a middle-aged woman from a small village in southwestern Alaska. Her father was chief in the village. Her mother was a well-known furrier. She has five brothers and three sisters. Though she lives in Anchorage, she returns home every summer to help her family fish and gather food. Claire suffers from depression and alcohol abuse. She is also an incessant gambler. She recently lost her driver's license because of a Driving Under the Influence citation. Because of her problems, Claire's daughter lives with her sister in her home village. When Claire is not working or gambling she is sleeping. She has gained more than 50 pounds in the last few months. She began drinking soon after entering college. She "partied" with other students or soldiers stationed in Fairbanks. Her drinking kept increasing and she "blacked out" for longer periods. After four years she joined a recovery program. She regularly attended Alcoholic Anonymous meetings and therapy sessions. She returned to her village and remained sober for two years. She then moved to Bethel and resumed treatment. She successfully completed the program in 1992 and met her current husband. She stayed sober for seven years. She and her husband then moved to Anchorage. Her husband lost his job and stole money from Claire to buy alcohol and drugs. She turned again to drinking and gambling. Claire then sent her daughter to live with her sister because she could work and care for her at the same time. Her Anglo husband does not like Claire's Yu'pik friends or traditional foods. He is physically and emotionally abusive. Her consumption of alcohol increases daily. (From a clinical history at the Alaska Native Medical Center)

Claire's story, while unique to her, is found in the personal history of many Alaskans, and far too many Alaska Natives. Her life with depression and alcohol raises important questions about how we treat people suffering from substance abuse and dependence: about how we classify individuals, how we define illness and addiction, and what we expect from mental health services. Is Claire, for example, an inveterate drinker and gambler who will forever divide her time between desperation at home, instability at work, and recovery in a clinic? Or perhaps she is a person that occasionally needs help dealing with stressful episodes like separation from family, loss of a job, or living with a violent husband. What of the treatment she has accepted? She has moved in and out of recovery programs over the last ten years, finding temporary relief, and then faltering. Should the care she has received be condemned as a failure? Or have the programs at least permitted Claire to help her family, nurture a daughter, find some happiness, however fleeting, with a mate? What are the criteria for a successful substance abuse care program? Should we look for success in individuals? In the quality of community life? Consideration of these and other questions require a careful look at how substance abuse problems are conceptualized and how the issues are addressed.

Societies have adopted two broad approaches in approaching substance abuse problems: one

is by restricting the supply of drugs and alcohol through pressure on manufactures. The frontal assault on Andean coca growers by the Columbian government, backed by U.S. military aid, is a good example. A second, more common approach, is to try and reduce the demand for substances through preventive measures, e.g., education, student assistance groups, avoidance training, and clinical treatment.

The Control of Alcohol

National programs to stem the distribution of drugs have been criticized as shortsighted, unrealistic, costly, and ineffective.[1] The record in Alaska is more mixed. Through much of the early history of the Territory, from the Treaty of Cession to the ban on the production and sale of alcohol in 1916 (the Bone Dry Law), federal alcohol control laws served as a pretext for the supervision and civilization of Natives by the military, marshals, teachers, and missionaries. They were especially damaging to local initiative and self-government. According to one student of the period:

> One particular harmful effect of the Western legal approach to the use of alcohol among Natives was that the introduction of Western legal constraints prevented the development within Native law of means to contain drinking behavior. Alaska Natives were, in effect, taught that under the influence of alcohol they were incapable of controlling their own lives. It was implied, through the patterns of control and enforcement established over time, that only the presence of white legal authority could restrain Natives in the use of alcohol. (Conn & Moras 1986)

In 1936 the Indian Reorganization Act (IRA) was extended to Native villages in Alaska. The legislation enabled Native village councils to pass and enforce ordinances against the possession and sale of all spirits.[2] Though prohibition ends after the repeal of the eighteenth amendment in 1933 and the end of federal restrictions on alcohol in Indian country in 1953, Native village governments continued to regulate home brewing, drunken behavior, and bootlegging (unlicenced sales). However, federal authorities refused to cooperate and the state did not recognize Native or tribal councils. At the same time, formerly isolated rural areas were more connected to the growing regional hub communities, which offered services and supplies, including alcoholic beverages. There was little village authorities could do to stem the trade and presence of liquor, wine, or beer. There were no local courts or jails. There was no one to enforce the rules. Moreover, some local residents, particularly the young, questioned the need for local restrictions. The absence of community resources and consensus, combined with state inaction, left villages with to fight with, against the rising numbers of accidents, crimes, suicides, and alcohol-related illnesses.

In 1972 Alaska passed the Uniform Alcoholism and Intoxication Treatment Act, which decriminalized public drunkenness and intoxication and supported medical care for individuals who abused alcohol. While urban police welcomed the reform, village officials were left defenseless. Protective confinement was their only instrument for sheltering public inebriates; there were no medical facilities. With mounting pressure the state legislature approved a local option law in 1980. The law authorized villages to hold an election and choose one of several alternatives in regulating

alcohol. They could prohibit the sale of alcoholic beverages, prohibit sales except for licenced retail stores, prohibit sales except for a city run store, restaurant, or bar; prohibit the sale and importation of alcohol; or, forbid the sale, importation, and possession of alcohol.[3]

Since the inception of the option law 99 rural communities, which are home to 52 percent of the Native population, have elected to limit alcohol use. Ten percent of the villages have banned sales, 54% prohibit the sale and importation of alcohol, and 28% forbid possession, along with sales and importation.[4] Fifty-nine other villages that do not have bars or liquor stores, have chosen not to formally pass an option law. The Annette Island Reserve, the only congressionally recognized reservation in Alaska, is the only Indian community that uses federal statutes that presume alcohol is forbidden, unless residents act to legalize it.

An early review[5] of the effects of the local option law raised a few issues that are essential to understanding the dynamics of alcohol use and control in bush communities. First, it was the view of many villagers that the "alcohol problem" is largely external. It was introduced by traders and explorers. Natives are then prohibited from consuming alcoholic drinks by the federal government in 1867 and by the territory in 1915. Ironically too, it is the attorneys and other professionals in distant cities, who craft the legal solutions and the medical/psychiatric remedies for villages troubled with drugs and alcohol. In practice, village councils used local option laws along with more flexible and tested sources to combat the effects of alcohol abuse. In different cases they relied on traditional proscriptions and penalties, or federal/tribal restraints, city charters, or private land laws. Out of frustration, some local officials engaged in questionable constitutional practices, such as personal searches and the banishment of repeat offenders. Other villages lacked the capacity to do much, and asked for more state and federal assistance. A third of the communities did not think state rules were necessary. Some saw the law as extending village authority, others feared that it diluted, and in some cases, replaced local influence.

A few villagers did notice, after passing the option law, some declines in public drunkenness and a few alcohol-related problems, e.g., number of violent incidents. However, they were not sure if these changes were a result of a drop in the consumption of alcohol, differences in reporting patterns of drinking, cultural sanctions, or simply transferring their problems somewhere else.[6] A more recent study did document a significant reversal, a decrease in binge drinking and lower rates of death related to alcohol, e.g., motor vehicle injuries, homicides, hypothermia, in villages that voted to restrict sales and imports (a.k.a. dry villages) than in wet communities.[7] While these improvements are welcome, Native leaders contend that other initiatives, (e.g., better health care, more enlightened leadership, added employment opportunities, state and federal support for stronger local organizations, more popular participation, the development of a fairer and more effective systems of justice, better prevention and education programs, spiritual rejuvenation), have to accompany the changes in law and policy, in order to build and sustain healthier communities in rural Alaska.

Mental Health Services in Alaska

The Alaska Mental Health Board estimated that in 1997 there were 44,500 individuals (about 7 percent of the population) who had a serious mental illness or emotional disturbance. A third were children, fifty-eight percent were adults, and the rest were either institutionalized or homeless. (Alaska Mental Health Board, 1998) Alaska Natives, particularly younger Natives under 22, are over represented in admissions to mental health facilities, correctional programs, and Medicaid supported services. Roughly half[8] of the individuals that are mentally ill receive treatment through either the state psychiatric hospital, a community health program, Medicaid, or the Department of Corrections. Persons undergoing treatment for a serious mental illness are most commonly young, female (except for ages 6-16 where males are more often in therapy), single or divorced, lower income, and unemployed or working part-time. Alaska Natives, particularly younger people, are over represented in admissions to mental health facilities, correctional programs, and medicaid supported services.

Alaska mental health organizations provide four general types of services: crisis intervention, which involves emergency services to those in need; medical, vocational, rehabilitation, and other kinds of support for adults with chronic mental illness; therapy and treatment for youth with severe emotional disturbances; and limited services for those facing depression, suicidal thoughts, and other psychiatric problems. Table VII below (**Regional Mental Health Services in Alaska**), presents an overview of the kinds of services that are offered. It also illustrates the tremendous difference in resources between rural and urban areas. In the urban regions, like south-central and southeastern Alaska, there is a full array of professional mental health counselors, physicians, social workers, and educators who work in a variety of clinics, hospitals, group homes, and private practices. In contrast, rural communities depend on paraprofessional workers or itinerant mental health aides. There are trained rural human service providers in 50 villages, but their time and skills are limited.

The maldistribution of mental health responsibilities is also revealed in the expenditure of public health funds. In 1999, Alaska's Division of Mental Health and Developmental Disabilities received $25,846,300 for community mental services. In this appropriation was support for adults with severe mental illness, youth with emotional disorders, psychiatric emergency services, and evaluation and treatment programs. Sub-regional communities, e.g., Galena, Mcgrath, were portioned 4 percent of the money, regional hub centers 8 percent, while cities and towns on the highway system received 88 percent of the total appropriation (See **Table VIII Alaska State Mental Health Expenditures**). These allocations do not imply that villages did not benefit from state funded mental programs; but that villages provide only a fraction of the services.

Inequitable public financing has also been an issue. In 1998, Alaska had the smallest proportion of revenue from individual and commercial insurance payments; in turn, mental health programs typically receive a higher proportion of their funds from public coffers in Alaska, than any other state (Ford, 2000). With the decline in the production of oil in Alaska, the legislature has gradually reduced the state budget for social services which has lowered the size and number of mental health grants. At the same time Medicaid funding for mental health has increased. Rural service providers have not been able to take full advantage of these shifts in public funding for at least two reasons: The pool of rural clients is too small to justify the expense of applying for

Table VII. Mental Health Services in Alaska^

Alaska Region	Crisis/Emergency Services	Children & Youth Services	Adult Services	Justice Service	Senior Service	Staffing
North Slope Borough	Yes, only in Barrow	services & temporary	Outpatient Care Home-Barrow	Jail in Barrow	Out-reach	9 Staff pt. psy
Maniilaq/NW Arctic	In Kotzebue, suicide prog. villages	Kotzebue Some services in village	Shelter, residence Kotzebue	One Jail 14 beds	Respite Care	14 Staff 7 RHSW
Norton Sound	Acute Care Hospital Suicide Program in 8 Villages	Residential care & some services in Nome	Outpatient Care & 3 Apartments	Service in Nome	Respite, day care	8 Staff
Interior	Hospital Fairbanks Suicide Programs in 5 villages	Full Services Fairbanks only	Full care Fairbanks Outpatient care in a few villages	99 Beds MH Care	Day & Respite	138 in Fair-banks
Yukon-Kuskokwim	Crisis-5 beds Hospital-51 Beds Bethel Suicide Program 7 Villages	Residential care & services in Bethel	Residential Care in Bethel	Jail/MH Service Bethel	Out-reach & daycare	24 plus itinerant doctors
Southcentral	Full services in Anchorage Area	Full Services	Full Services	MH housing	Full	Com-plete
Copper River	Hospital Cordova Suicide Program in 3 Villages	Some services in Cordova, Valdez, & Copper Center	Residential Valdez Outpatient in a few villages	Jail in Cordova Valdez	Geriatric Out-reach	9 Staff
Bristol Bay	Crisis Care 6 Beds, Hospital-10 Beds in Dillingham	Some Services in Dillingham, Bristol Bay, 2 villages	Itinerant outpatient care in 32 villages	Jail	Respite in 4 villages	27 Staff 1.1 RHSW
Kenai Peninsula	Hospital, Emergency Services	Residential care, family services, Outreach	Residential, Homes, Outpatient	MH Care, Jail	Geriatric Out-reach	80 Staff
Kodiak	Hospital, Suicide Grants in 3 Villages	Family services, Outreach	Residential, Homes, Outpatient	Jail	None	15 plus 45 in school
Southeast	Hospital, Suicide Grants in 4 Villages	Residential care, family services, Outreach	Residential, Homes, Outpatient	Jail, MH Care	Geriatric Out-reach	Com-plete
Aleutians	Crisis Services, Suicide Grants in 3 Villages	Family services, Shelter	Outpatient, Itineran in 3 Villages	10 bed jail	Geriatric Out-reach	9 Staff

Table adapted from Alaska Mental Health Board, A Shared Vision II: A Strategic Plan for Mental Health Services in Alaska, 1999-2003. *Rural Human Service Workers

Table VIII. Alaska State Mental Health Expenditures FY 1999^

Mental Health Budget Allocations	Sub-Regional Communities		Regional Communities		Cities & Towns on Highway	
	Amount	Percent	Amount	Percent	Amount	Percent
Community Mental Health Grants	$68,000	8%	$4,300	1%	775,000	91%
Psychiatric Emergency Services	$474,900	8%	911,500	15%	4,702,099	77%
SED* Youth Services	$102,000	2%	523,000	12%	3,846,708	86%
Alaska Youth Initiative Services**	0		131,600	8%	1,459,560	92%
CMI***Adult Services	$177,200	2%	575,800	5%	9,856,074	93%
Total	$953,700	4%	2,146,200	8%	22,746,400	88%

Information from State of Alaska, Department of Health and Social Services, Fiscal Year 1999 Operating Grants. *Serious Emotional Disturbance. **Program to prevent emotionally disturbed youth from being placed outside the state. ***Chronic Mental Illness.

reimbursement, and rural administrators ". . . are reluctant to divert scant existing resources away from direct client services."[9]

By law, the Alaska Mental Health Board must periodically evaluate state mental health programs. The evaluations are carried out by site reviews, or what are called Integrated Quality Assurance Reviews. The reviews scrutinize the quality and fiscal responsibility of mental health programs. Three groups of indicators are assessed: outcome, performance, and satisfaction measures for services to children, adults, and families; administrative and personnel standards; and, client files and family service plans. Three value categories guide the outcome, performance, and satisfaction measures: **choice and self-determination**, **relationships**, and **community participation**.

Choice and self-determination refer to the family's ability to "develop goals and make decisions in all aspects of their children's lives. Children have opportunities to develop the attitudes and abilities that result in making goals and learning to attain them." For adults, it means people have the potential ". . . to make meaningful choices in all aspects of their lives." In this section reviewers ask questions about family and individual involvement in the planning and carrying out of treatment and care, the responsiveness of staff, the satisfaction of beneficiaries or consumers with

state services, the respect for each person's dignity and rights, and the health and security of everyone who is involved. In looking at relationships the concern is with the development of social skills, the maintenance of family and personal relations, and the opportunity to socialize with others outside the home. Community participation refers to opportunities for families and adults ". . . to participate in roles valued by citizens in the community." Here the criteria for desired outcomes and performance are involvement in school, work, cultural activities, clubs, and special events, contributions to the community, creative staff support and education for involvement in group and community activities, and consumer/client satisfaction with the chances they have to work and play with others.

The Integrated Assurance Reviews use an administrative and personnel standards checklist to inspect each program's mission statement, budgets, audits, governing board, policies and procedures, job descriptions, employee qualifications, methods of evaluation, consumer participation, and other factors that are part of any service organization. Finally, reviewers inspect randomly selected client files to insure they meet specific deadlines, documentation requirements, and the rights of individuals and families. For this report, the site reviews of eleven mental health programs[10]were examined to get a sense of the level and quality of services that are provided to Alaska Natives.

The responses to the review questions varied between each mental health agency, between each region, and between urban and rural clients. There were, however, a few points that were mentioned frequently enough, to permit some generalization. Most felt they were involved in the design of their treatment plan; that their preferences were acknowledged and formed a basis for the services they received. Others mentioned specific services for children, families, and elders which were particularly valuable. The Yukon Kuskokwim Health Corporation's provision for housing client and their families was one example that was cited (Northern Community Resources, 2000). All thought they were treated with dignity and respect. Personal privacy and confidentiality were observed and honored. Depending on the care they received, individuals sensed safety and security. If a crisis occurred appropriate action was taken, and those at risk were protected. A number of people thought the program helped them lead more independent and fulfilled lives. Clients' families and other "natural supports" were recognized by counselors and encouraged to be part of the healing process. The Yukon Kuskokwim Health Corporation was praised for its embrace of "Native support systems, including the use of Elders as counselors."[11] Many thought their social skills had improved and they had moved closer to friends and loved ones. Favorable comments about community participation stressed the value of support groups and renewed involvement in work and the life of the community.

The mental health program interviews referred to three weaknesses. First, are the complaints about limited psychological and psychiatric services in villages, the absence of family care, and the lack of useful employment and vocational training. Frequently there is little attention to "transition care," or communication with clients once they leave the treatment program. There is no "outreach" to isolated villages. A related grievance is the want of collaboration or understanding between providers and the courts, the police, the schools, and state social welfare agencies (especially the

Division of Youth and Family Services) involved in cases of mental illness or emotional disturbance.

Another area of concern is the mismatch between treatment and culture. Not many counselors speak a Native language or comprehend Native traditions or world views. There are objections to confrontational therapies and an exclusive emphasis on the individual client. There is little awareness of wider connections, and the importance of families and communities to the healing process. Lastly, many consumers did not feel part of the mental health program. A few were not consulted in the development of their treatment goals or in planning for transition services. Participation in advisory board meetings in some areas is limited to community and staff members. The consumer's voice is missing. Village workers complained that they are excluded from the regional policy making process.

The administrators of the programs too, are frustrated with budget reductions and the paucity of resources available to provide needed services. With restricted salaries and advancement opportunities staff turnover is high, which increases training costs and decreases morale. Clients are also baffled because the individual they are accustomed to working with, may not be there the following week. Whatever rapport or confidence existed is undermined. There is also a frequent rotation of directors which affects planning and the development of the organization.

These Integrated Quality Assurance Reviews are helpful to legislators who want to insure public money is being spent wisely. They are probably useful to officials in the Alaska Department of Mental Health and Disabilities in defending their annual budget requests and allocating their resources. They are also of some benefit to program administrators for accreditation and planning purposes. However, they do not alone, offer a full evaluation of mental health services in Alaska, particularly from a beneficiary perspective. In the eleven reports only 125 clients or consumers responded to the questions and just 29 persons attended one of the open forums. In some instances, the reviewers could not assess a service, because no one commented on it. In other cases, the individuals that were interviewed selected themselves, thus raising problems of reliability and validity (**See Table IX on Mental Health Site Reviews**).

Substance Abuse Programs in Alaska

There are 74 approved [12] substance abuse treatment programs in Alaska. Fifty-one are located in urban communities, 14 are in regional centers, and 9 are in rural villages.[13] This study has assembled information on 69 providers using formal surveys (32), personal interviews (43), and state site reviews (43). The survey sought information in seven areas: background and origins of the program, personnel administration, cultural competence, population served, the purpose(s) of the organization, treatment requirements, and program evaluations or accreditation reports. The Alaska site reviews furnish data on management and administration, support services (e.g., patient records, referrals, medication control), and service components (e.g., outpatient care, aftercare, intermediate care).

Table IX. Mental Health Site Reviews*

Programs	Services	Funds FY 2000	Source/Funds	Interviews	Forums
Bethel Community Services	Counseling, support, residential care	$422,400	State Grants, Medicaid, client	15 Staff, 15 Clients	10 people
4 Rivers Counseling Services	Outpatient, Crisis intervention, education outreach	$322,800	State Grants, Medicaid, client	8 Clients, 4 Staff, 13 other	0
Kuskokwim Native Association Community Counseling Center	Counseling, prevention, outreach	?	State Grants, BIA	4 Staff, 8 Clients, 9 others	0
Maniilaq Association	Psychotherapy, ounseling, family therapy	?	State, Medicaid	4 Clients, 10 Staff, 7 other	0
North Slope Borough Community Counseling Center	Emergency Services, Community Support, Outpatient Care	?	State, Medicaid	34	0
Norton Sound Health Corporation	Outpatient, youth program, behavioral health	?	State, Medicaid	7 Clients, 15 Staff, 15 others	4
Southcentral Foundation Counseling Services	Full Services	?	State, Medicaid, private	13 Clients, 6 Staff, 12 other	4
Southcentral Counseling	Full Services	$13,140.43	state, client	39 Clients, 13 staff, 50 others	13
Tanana Chiefs Conference, Inc.	Full Services	?	state, federal grants/contracts	24 Clients, 14 Staff, 12 others	0
Yukon-Kuskokwim Health Corporation	Full Services	$2,188,770	state, federal grants/contracts	7 Clients, 9 Staff, 11 other	2

*Information from Integrated Quality Assurance Reviews conducted in 1999 & 2000. **Includes staff from other service programs and board membe

Most (88%) substance abuse programs were established in response to alcohol abuse. Today, many address other problems including illicit drug abuse, child and sexual abuse, domestic violence, suicide, and general mental illness. Staff at the Bill Brady Healing Center in Sitka, for example, realize that depression, low-self esteem, physical and sexual abuse, criminality, anger, dysfunctional families, and other issues accompany the misuse of drugs and alcohol. Recognition of these difficulties is therefore built-in into a plan of treatment and care.

Forty-six programs offer outpatient care and 28 provide residential services. Six residences can house families; mostly women with children. Programs in Barrow, Nome, and Bethel illustrate the range of services open to rural residents in regional settings. The North Slope Borough Substance Abuse Treatment Center in Barrow is part of the North Slope Borough Health Department. It is funded by the Borough, the Division of Alcohol and Drug Abuse and the Division of Mental Health and Developmental Disabilities (state), the Alaska Department of Corrections, and the Indian Health Service. The Center affords emergency/crisis care, intermediate, outpatient, and after care, and outreach services in Barrow. There are five beds available for intermediate/detox use, 20 beds for patients in transition, and 10 beds for women and children. Outpatients are engaged in individual and group counseling, educational sessions, and vocational/skill development classes. Attendance at weekly Alcohol Anonymous (AA) meetings are mandatory. There are weekly group meetings, support circles, and twelve step assignments available for six to twelve months of treatment. There are two counselors assigned to each of the eight villages on the Arctic Slope. They spend a week in the village and then return to Barrow for a week. The counselors are trained in counseling, evaluation and referral, physical and sexual abuse reporting laws, crisis intervention, and community development. The villages choose their assigned counselors.

The Behavioral Health Services (BHS) division of the Norton Sound Health Corporation in Nome provides outpatient treatment and aftercare in Nome and counseling to villages in the Bering Straits region. The program is funded by the state (general fund), IHS, and other federal grants and contracts. They administer a Healthy Nations grant from the Robert Wood Johnson Foundation that supports the "integration of public awareness campaigns, prevention programs, and services for treatment, aftercare, and support." (Healthy Nations Initiative 2000) BHS also runs an inmate substance abuse program at the Anvil Mountain Correctional Center which is financed by the state Department of Corrections. Village services are provided by three itinerant social workers (in Savoogna, Koyuk, and Brevig Mission), one psychologist (itinerant care in Unalakleet and Diomede), and home based counselors (in twelve communities). The village counselors were trained through the Rural Human Services Programs at one of the rural campuses of the University of Alaska Fairbanks.

The Yukon Kuskokwim Health Corporation (YKHC) is a nonprofit tribal health corporation which combines mental health and substance abuse services. YKHC directs the substance abuse program (outpatient therapy, aftercare, Alcohol Safety Action Program) and the Phillips Ayagnirvik Treatment Center (Intermediate and aftercare, outreach or continuing care). Funds are derived from the state (general fund), IHS, Tribal Shares, and other state and federal grants and contracts.

The Department of Corrections supports one bed in intermediate care facility and the Corporation received a Community Action Against Substance Abuse Grant this year (FY 2000). Villages receive help through trained village based counselors and Community Holistic Development Services.

Substance abuse programs in Alaska serve an average of 208 patients every year. Of the facilities that were surveyed, there were 25 percent more males, and more than half (55%) were Alaska Natives. Over half(57 to 60%) of individuals in substance abuse care complete the program. Of those who do finish, 56% are Natives. Forty percent of those who dropout before a therapy plan is concluded are Native. The most frequently mentioned incentives for going through treatment are to avoid legal restrictions, (e.g., jail, probation, loss of drivers' license), and to regain custody of a child.

Alcohol treatment is carried out in either outpatient (62%) or residential/hospital facilities (38%) in Alaska. Of the 28 residential programs only 6 accommodate families. These are usually restricted to women and their children. The average length of treatment for outpatients is 5 ½ months; for residential care the average stay is 4 months. Outpatient programs vary in intensity and duration. A few engage individuals for a few hours several days a week. Others offer weekly counseling sessions for groups or individuals combined with home assignments. According to one study (B)ecause of escalating health care costs, the focus in recent years has shifted away from inpatient treatment and toward outpatient treatment for all stages of recovery. This shift has resulted in an emphasis on outpatient detoxification and intensive outpatient services for initial treatment, approaches that are less expensive than inpatient treatment."[14]

Most treatment programs in Alaska assume alcoholism is a disease. Individuals are encouraged to quit drinking and to attend Alcoholic Anonymous (AA) or other self-help group meetings, and follow a twelve-step recovery program. The approach of the Phillips Ayagnirvik Treatment center in Bethel is typical:

> Their "philosophy of treatment is based upon the understanding of alcoholism as a chronic, progressive, often fatal, and arrestable disease. It involves the physical, intellectual, emotional, spiritual, and social aspects of the whole person. Therefore, we believe that treatment must involve a holistic approach which includes the total person and his or her environment. We offer a multi-disciplinary team approach to treatment because of the nature of the disease. This approach intends to incorporate, whenever possible, the services of the various professional helpers and auxiliary agencies functioning in the community. Furthermore, we believe that recovery is more often than not accompanied by a tendency toward relapse. In order to provide continuity of care through the various stages of recovery, a flexible delivery system of treatment must be established." (YKHC 2000)

Patients begin the recovery process with detoxification and a clinical assessment of the presence and severity of their withdrawal symptoms. Based upon further assessments and consultations patients are referred to an intermediate care facility for 6 to 8 weeks, or outpatient care

for 10 weeks of treatment. Both programs are based on a twelve step facilitation process that opens with an admission that one is powerless over alcohol. In the residential center, patients engage in individual counseling sessions, visual and personal presentations, twelve step meetings, and alcohol-free social events. Assistance is provided by the staff and a variety of support, cultural, and parent groups. Outpatients attend two educational and therapeutic activities, a counseling session, and a local 12-step meeting every week. To reduce the incidences of relapse there is an aftercare regimen that lasts six to nine months beyond treatment. There is one group and a private counseling meeting each week. Seventeen villages in the Calista region have trained Village Alcohol Education Counselors which offer aftercare, preventive, and crisis services. There are also youth aftercare specialists that do both assessments and counseling with younger people suffering from alcohol abuse and dependence.

Some programs concentrate more on relapse care and cognitive-behavioral therapy in treating alcoholics. Patients are taught how to recognize and cope with situations or thoughts that lead to excessive drinking, e.g., depression, anxiety, social pressure, loss of job, death of loved one. Rational Insight Treatment Enterprises (R.I.T.E.) for example, emphasizes the importance of learned behavior and operant conditioning in understanding the misuse of alcohol and other drugs. Here clinicians look for determinants of substance abuse in three broad areas. First, is **cost**, which encompasses price, the effort required to obtain alcohol or drugs, the frequency and intensity of events that would detract one from abuse or treatment, and the identification of what is given up when misusing substances. Diverse **environmental contexts**, like unemployment, social or peer pressures, family or neighborhood circumstances, and individual deficiencies (other mental disorders, shortage of resources, coping skills) are also deemed important. Lastly, **individual variations** in sensitivity and susceptibility are considered in the development of a treatment plan. **Table X (Alaska Rural Substance Services)** provides a regional overview of substance services in rural Alaska.

The Evaluation of Substance Abuse Services

The intent of the treatment survey, for this study, was to discover the breadth of mental health and substance abuse services, who is served by these programs, and what gaps and disparities exist, if any. Representatives of each organization were also asked about the professional challenges they confronted. Problems related to funding, of course, were frequently mentioned. Facilities lack space, needed services are constrained or missing, and salaries are too low to attract and retain qualified personnel. Travel monies are scarce, a particularly difficult problem in Alaska where remote villages can only be reached by secondary bush air carriers, which are expensive. There was also a class of concerns about treatment models and methods. There appears to be a need for more family and community programs, and a preference for combining mental health and substance abuse therapies to more effectively treat patients with a dual diagnosis.

There is also a call by both mental health professionals and clients for more culturally appropriate services, the hiring of more Native counselors and health workers, and the incorporation of traditional healing practices into the process of treatment. These concerns fall under the general

Table X. Alaska Rural Substance Abuse Services (Regional)

Rural Service Provider	Village #	Village Services	Regional Services	Staff	Comments
Aleutian Pribilof Island Association	6	Outpatient, Aftercare Prevention	Primary service in St. Paul, Unalaska	2 in Anchorage, 7 in Villages	
North Slope Borough	8	Outpatient, Aftercare Outreach	Intermediate, Emergency Care	2 Counselors per village	Integration MH/SA Programs
Bristol Bay Native Association	32	Outpatient, Aftercare Outreach	Residential, Detox in Dillingham	26 (9 village workers)	Accredited Rural Program
Yukon-Kuskokwim Health Corporation	58	Outpatient, Aftercare Outreach	Intermediate Care Transitional-Bethel	18(?) Bethel, 20 VAECs#	Inmate counseling
Tanana Chiefs Conference	42	Outpatient, Aftercare Outreach	Family & Intermediate Care	?	Family Recovery Program
Maniilaq	9	Outpatient, Aftercare Outreach	Intermediate, Emergency Care	?	
Southeastern Alaska Regional Health Corporation	7	Outpatient, Aftercare Outreach	Intermediate Care & Transitional	13	Comprehensive Behavioral Services
Council of Athabascan Tribal Governments	9	Outpatient, Aftercare Prevention	Counselors in Fairbanks, clinician ir Ft. Yukon	1 clinician, 1 counselor, 3 VBCs*	Integration of Mental Health & Substance Abuse Programs
Eastern Aleutian Tribes, Inc.	6	Outpatient, Aftercare Outreach	Offices- Anchorage, Sandpoint	3 Village Therapists, 4 VBCs	Integration MH/SA Programs
Norton Sound Health Corporation		Outpatient, Aftercare Outreach	Inmate Services	4 Itierant, 9 Staff in Nome, 12 VBCs	Integration MH/SA Programs

Does not include Cooper River Native Association and a few sub-regional programs. #Village Alcohol Education Counselors. *Village Based Counselors.

issue of **cultural competence**, the ability of an organization to work effectively in different culturalsettings. The justifications for cultural competence, in regard to American Indians, are the diverse beliefs and perceptions that surround illness, disease, health, and well-being; the value and importance of empathetic and responsive providers; the significance of tradition; and, the prevalence of bias.[15] The survey looked at four areas that are germane to cultural competence: Native staffing, cultural awareness, the recruitment and promotion of Native staff, and specific traditional services,

e.g., ceremonial observances, use of herbal medicines, spiritual practices, traditional healers. **Table XI** on **Cultural Competence and Substance Abuse Services**, partially summarizes the responses of those who were interviewed. Almost half of these health agencies serve primarily Alaska Natives; however, many are small organizations with small staffs and usually a single counselor. About a quarter of total staff time is devoted to rural village services. Ten providers work in villages. Four exclusively serve village people. There are 21 (26% of the total)service providers in rural Alaska; eleven are in situated in villages.

Approximately 15 percent of the managerial staff is Alaska Native, 21 percent are in direct services, and 26 percent of all staffs are Native. When program administrators were asked whether they recruit, train, develop, promote, and retain successful Native employees, all but four said yes. Many said they would like to hire more Natives but that there were very few applicants, and those who did apply were usually not qualified. Unfortunately, beyond general statements of support for Native employment, there was very little useful evidence to determine whether organizations had an active plan of hiring, training, and promotion. Some are certainly making an effort. All the employees at the Minto Counseling Center and the Behavioral Health Services department at YKHC are Native. The Alcoholism and Drug Abuse Program (The Bristol Bay Native Association) in Dillingham, has evolved from an outpatient facility to an organization that has achieved some success in hiring Native counselors (Counselor's I and II) and administrators (field supervisor), training 9 village rural human service workers, and responding to a board of directors composed of representatives from the 32 villages in the Bristol Bay Region.

The question on specific cultural treatment services also produced disappointing results. There were a few programs that did include traditional rituals and ceremonies such potlatches, talking circles, smudging, spirit camps for youth, elder counseling, hunting and gathering outings, Native dancing and arts, powwows, or talking stick ceremonies. However, while the majority of those interviewed recognized the importance of traditions and spiritual practices, when pressed, admitted they did not actually offer services related to Native cultures. Rather, cultural beliefs and choices were a consideration, in the treatment of each individual.[16]

It is also important to assess the quality of mental health and substance abuse services. There are two types of performance evaluations of substance abuse programs in Alaska, accreditation studies and state certification reviews. Accreditation reviews in Alaska are conducted by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). There are five components of the CARF surveys: whether the organization is responsive to those it serves and committed to quality service (**Organizational Quality**); if the health organization collects and uses information from internal assessments of services, costs, and consumer preferences (**Quality Improvement System**); if mental health services are accessible, safe, and secure (**Accessibility, Health & Safety, Transportation**); if clients are involved in the process of decision-making and evaluation of the services they receive (**General Program Standards**); and, the effectiveness of behavioral health programs, whether it improves the quality of life and the functional abilities of those who are treated (**Behavioral Health Core Program Standards**).

Table XI. Cultural Competence and Substance Abuse Services*

Substance Abuse Programs	Natives Served in 1999	Native Staff/Mgr	Native Staff/Gen	Time in Villages (%)	Population Focus	Alaska Native (%)
Akeela	?	0	0	0	Adult/Inmates	25%
Alaska Human Services	156	0	0	0	Adult/Couples	5%
Booth Memorial	91	0	0	Some	Adolescent/Family	70%
Center for Drug Problems	?	0	0	0	Adult/Family	10%
Clitheroe Center	1458	0	3%	0	Adult/Family	30%
Ernie Turner Center	231	n/a	n/a	0	Native Adults/Fam.	75%
Providence Mental Health	476	0	14%	0	Age Twelve & Up	n/a
Rational Insight Treatment Enterprises	333	0	0	0	Teens, Adults, Families	5%
The ARC	9	0	0	0	Adult DD	70%
Volunteers of America-ARCH	58	n/a	n/a	0	12 to 18 & Family	34%
Volunteers of America-ASSIST	197	na	na	0	12 to 18 & Family	20%
YKHC Behavioral Health Services	?	100%	100%	100%	Native Adults & Community	99%
Gastineau Human Services	247	n/a	n/a	0	Adult	61%
CICADA-Kenai	0	100%	0	0	Adult, Youth, Fam.	7%
Four Rivers	160	0	n/a	50%	Individual, Family	85%
Minto Counseling Center-TCC	?	100%	100%	100%	Adult, Youth, Fam.	100%
Changing Tides	95	0	0	0	All	45%
Village Sobriety-Scammon Bay	5	100%	100%	100%	Native/All	100%
Seldovia Village Tribe	4	n/a	n/a	100%	Natives/community	75%
Bill Brady Healing Center	?	n/a	n/a	15%	Adult Natives	
Upper Tanana Alcoholism Program-TCC	25	n/a	n/a	62%	Adult & Teen Natives, Community	90%
Mat-Su Council Recovery Program	?	n/a	n/a	0	Adolescent/Family	14%
Nugen's Ranch	102	n/a	n/a	0	Adult Individuals	44%
COHO	0	0	0	17.50%	Age Two & Up	?
Fairbanks Memorial Hospital	60	0	0	0	Adult/Individual	17%
Women & Children's Residential Program	44	20%	47%	0	Adult Women with Children (0 to 9)	84%
Bristol Bay Area Health Corporation	175	50%	80%	60%	Individuals, couples, families	86%
Yukon Koyukuk Mental Health	?	0	0	100%	Individuals, couples, families, community	95%

***Information from Feasibility Study Survey administered Fall 1999 & Spring 2000.**

The Bill Brady Center in Sitka is the only CARF accredited program that directly serves rural residents. The CARF study favorably assessed the Brady Center for its competent and professional staff, its support of personnel education and training, its accessibility to rural individuals and families, its excellent screening and referral process, and its respect for "consumers and families." Reviewers were concerned about the absence of a formal line of communication between the Board of Directors and clients, a cultural diversity plan, and an accessibility standard that would deal with the problem of Native employee retention and promotion. Turnover is an endemic problem in all mental health organizations in rural Alaska.

Substance abuse providers are also evaluated and certified by the Division of Alcohol and Drug Abuse. These programs must comply with state standards in general and fiscal management, support services, and direct services. In the management area state reviewers look at the vitality of the governing board or committee, the rights of patients, the planning effort, financial records, environmental safety, personnel policies, and internal evaluation procedures. Support services criteria consist of orderly and updated patient records and assessments, the protection of confidentiality, adequate referral policies. Finally, the plans and records of each service activity, emergency/crisis intervention, intermediate and aftercare, and outpatient services are appraised based on accepted principles or standards. The most common criticisms of substance abuse organizations by state reviewers were failure to involve patients in the development of treatment plans, inadequate documentation, poor planning, insufficient record-keeping, faulty assessments and placement criteria, and unclear lines of authority and communication.

The use of indicators and performance measures to assess the value of substance abuse policies and services have been defended for planning and budgetary purposes, and attacked for being self-serving and impractical. Whatever their worth, numbers, by themselves, do not tell the full story of alcohol and drug abuse and treatment. It would be enlightening, therefore, to end this section with a few words from an experienced care giver who directs a dual mental health and substance abuse treatment program that serves an area in rural Alaska larger than the states of Connecticut, Massachusetts, Vermont, and New Hampshire combined, and a population of about 2500 people. It is a region that probably has more suicides and alcohol related problems than any location in the United States. In one month there were 17 "individual interventions of significant suicidality." Since April, 3 individuals have killed themselves and several have died from accidents tied to drinking. In one village, 4 young men, in two separate incidents, fell into the river drunk. Two died. After looking for the bodies for two weeks, a fund raiser was held for the search and rescue team. A beer walk was held in where the person who steps on a number that is called wins a case of beer, or a bottle. In another village, without a police officer, kids spent the summer breaking into elder's home for money to buy alcohol. Despite warnings, the local liquor store continues to sell to minors.

The staff of the program that serves this area, consists of a director, a part time administrative assistant, two village-based counselors, and one itinerant clinician responsible for 5 villages. The clinic is built on a "direct service model. It starts with the client and moves to the

community. When mental health ethics mandate, 'First do no harm,' providers must meet clients where they are. It is clear that the clinic model is an effective and ethical model in some areas-especially those that have a great and competitive range of service providers and a local culture that responds to direct influence. The clinic model does not meet our clients where they are-in traditional subsistence villages. Starting from a different perspective, in our villages, concerns begin from a community view and, eventually, may get to an individual. When we consider the clinic model within our region, it may best be explained this way-a good shoe is a good shoe but if it doesn't fit, it hurts." For example, expecting an elder Native woman to come to an office, talk about really bad things that happened to her as a child, and how they are exacerbated by current subsistence concerns-for an hour-and then go home, would not be considered a healing experience. (In fact, it could be damaging). Joining with a group of women for an afternoon, cutting fish and talking about how the community and (unnamed) families would be affected by the poor fish harvest would be a better start. Eventually, individual women might seek support for how their own families are affected by the shortfall. Here one can see that in traditional villages, understanding starts from a community perspective and only eventually may get to an individual. New programs need to respect this and they should be obligated to meet people where they are and be expected to be successful in providing services."

Here is a point where the epidemiological record of Native self-destructive behavior meets with Native thoughts of how best to conceptualize and treat the problems of mental illness and substance abuse. This is the subject of the next chapter.

Endnotes

1. Ford (2000)

2. Upheld by federal court in **U.S. v. Mazore** (1975) and Indian Solicitor in the Department of the Interior (1980). Case, D. (1984) **Alaska Natives and American Law**. Fairbanks: University of Alaska Press.

3. The fifth option was added in 1988 and amended in 1995 because of problems in enforcing the prohibition of selling and importing alcohol. (See Aiken 1995)

4. The Alaska Alcoholic Beverage Control Board maintains records of the status of local option communities. See Berman and Hull (1997).

5. Conclusions from Lonner, T. & Duff, J. (June 1983) **Village Alcohol Control and the Local Option Law**.

6. Lonner & Duff (1984)

7. Landen, M.G. et al (1997) Alcohol-Related Injury Death and Alcohol Availability in Remote Alaska. **Journal of the American Medical Association. Volume 278**, pages 1755-1758.

8. State officials cannot accurately say how many people are in treatment because of the difficulty in separating individuals receiving multiple services.

9. Alaska Native Mental Health Board (1998)

10. The eleven programs are: Bethel Community Services, 4Rivers Counseling Services (McGrath), Kuskokwim Native Association Community Counseling Center, Maniilaq Association (Kotzebue), North Slope Borough Community Counseling Center, Norton Sound Health Corporation, Southcentral Foundation Counseling Services, Southcentral Counseling, Tanana Chiefs Conference, Inc., Yukon Kuskokwim Health Corporation, and the Yukon-Koyukuk Mental Health Program.

11. Northern Community Resources (2000)

12. Meaning the programs have been certified by the Alaska Division of Alcohol and Drug Abuse.

13. In looking at programs in Alaska one could conclude that 71% are situated in urban areas. Urban is defined by the U.S. Bureau of the Census as a place with at least 2,500 people, or more. In Alaska, villages like Barrow, Kotzebue, and Bethel meet this criterion; however their character and orientation is obviously rural. A second consideration is that while programs may be in a city, it will have a clinic in a village, e.g., Eastern Aleutian Tribes, Inc. which has a facility in Sandpoint.

14. Fuller & Hiller-Sturmhofël 1999)

15. Georgetown University Child Development Center (1999)

16. In a study of rural substance abuse providers 49% wanted more cultural information, 50% complained about inadequate training, lack of an agenda, low wages, burnout, and job stress. See P. Cunningham (July,1999) Survey of Rural Paraprofessional Human Service Workers. Anchorage. School of Social Work.

Chapter 4
Community Perspectives

> Bigness, loss of community, organizations and society grown past the human scale- these are the besetting problem sins of the twentieth century, which threaten to paralyze our capacity to act. Therefore, the time has come . . . when we must actively fight bigness and over concentration, and seek instead to bring the engines of government, of technology, of the economy, fully under the control of our citizens. (Robert Kennedy, 1966)

Introduction

Representatives from three rural villages chose to participate in this project: Nulato, Quinhagak, and Unalakleet. Nulato is a Koyukon Indian community on the middle part of the Yukon River in Western Alaska. The Russians first entered the area in 1838 to gather more information about the river and the network of trade between interior and coastal peoples. A trading post was established to prevent the diversion of goods through intermediaries and away from the Russian American Company. At contact, it is estimated there were 300 to 400 Lower Koyukon people who lived near the intersection of the Nulato and Yukon Rivers. In 1999, Nulato was the second largest village in the Yukon-Koyukuk area. The population was 381, an increase of 6 percent since 1990.

The village of Unalakleet is southwest of Nulato on Norton Sound, just north of the mouth of the Unalakleet River. It is a point of transition between Iñupiat and Yu'pik peoples and an area, in the past, of intense conflict and trade between different aboriginal groups. As one student observed: local residents ". . . knew people from as far north as Kotzebue and Selawik, as far west as Wales and King Island, as far south as St. Lawrence Island, and as far inland as Nulato and Kaltag, who came to Unalakleet on a regular basis to exchange goods and ideas." (Correll 1972) With the passage of the Alaska Native Claims Settlement Act and improvements in village utilities and schools, the population has almost doubled in the last thirty years. Today there are approximately 805 residents.

Quinhagak, the third community in this study, is the largest of four villages on the southern coast of Kuskokwim Bay, 75 miles southwest of Bethel. The residents of Quinhagak are mostly Yup'ik, who have adapted to the southern coastal regions of the Bering Sea. The population has steadily grown from 83 people in 1880, the year of the first official census, to 427 in 1982, to 595 in 1999. Much of the growth can be attributed to the consolidation of smaller villages in the area after the Moravian Church established a school in 1891.

Interviews: Methodology

> First missionaries discounted ancient spirituality. Then teachers displaced elders as sources of knowledge. Social workers intervened in the traditional system of family care taking, police took justice out of the hands of the local community, and a plethora of local and regional boards subordinated every village need to political decisions made far away." (Sam Cleveland, Quinhagak. Anchorage Daily News, October 11, 1998)

We visited Quinhagak twice in March, Unalakleet in March and August, and Nulato in April. Most of the conversations in the villages were with small groups including elders, tribal and city council members, health care providers, students, ministers, public safety officers, judges (municipal and tribal), women, community wellness teams, and key leaders. This approach gave more emphasis to local concerns and encouraged more spontaneous and free commentary. It also minimized the researchers interference in the discussions. It is particularly important, in light of earlier findings, that villages define their problems, thus avoiding unfair labeling or erroneous classifications. One study of two Yup'ik communities, for example, found that villagers made a distinction between individuals who drink small amounts and "those who forget," or drink heavily. However, in contrast to predominant views about alcoholism, people were not permanently assigned to one category, or another. As the authors point out: ". . . people are not classified as problem drinkers indefinitely by local observers, even if they have a long history of drinking. If a person has not been drinking heavily in the recent past, which may be several months or years, he was classified . . . as a non-problem drinker." Thus, a ". . . habitual drinker can become a nondrinker in a short period of time, and furthermore can become a successful non-problem drinker."[1] Whenever possible, the first language of the community was used, particularly with elders.

The group consultations were organized around three general lines of inquiry. First, the extent and intensity of alcohol and drug use and their relation to mental illness and inappropriate or illegal behavior, e.g., sexual or child abuse, domestic violence, crime. Here questions were asked about what drugs were commonly used and how often, the history drug use, the meaning (or people's perception) about clinical terms like abuse or dependence, the seriousness of alcohol and drug problems, and the groups most affected.

A second area of investigation was the programs and services available to villagers suffering from alcohol and drug use. Discussions centered around programs for specific problems, effective rules and enforcement, alternative policies, the strengths and defects of current approaches to care and treatment, and the identification of gaps in services. Finally, we wanted to know whether people wanted a family treatment and prevention program in their village, and if so, how it could best be integrated into the life of the community. Important considerations were what the program would look like, who would it serve, where would it be located, and what would be its relation to other village programs, and nearby communities. We concluded by asking what were the assets, e.g., experienced leadership, capable organizations, individual talents, spiritual and healing traditions, local commitment and interest, popular agreement or consensus, in the village that would contribute to a successful program of care.

The inquiries were purposely open and broadly conceived. The intent was to discover the authentic needs of the villagers and their prescriptions for reform and change. This would not have been possible with a formal questionnaire or a standard needs assessment. Too often the chance to create the questions leads to the power to frame the issues and fashion the solutions.

Interviews: Living with Drugs and Alcohol

Everyone we interviewed agreed that alcohol, and to a lesser degree marijuana abuse were serious village problems and the source of many personal and family tragedies. No one is left untouched. In Unalakleet, it is estimated that 50 to 65 percent of residents drinks excessively. There is a perception too that alcohol consumption is increasing, particularly among children in school. Because liquor is not readily available, binge drinking is common. Though the sale of liquor is prohibited, there are at least 20 bootleggers who import large quantities of liquor from Anchorage or Fairbanks, and then sell it illegally for a substantial profit. Alcohol and drug abuse are implicated in crimes, nearly all of the state custody disputes, most of the emergency visits to the local clinic for traumatic injuries, and in cases of family abuse and domestic violence. According to police reports, there are 60 to 100 criminal incidents a year in the village; 95 percent of these involve alcohol. The tribal family services office handles 25 to 30 custody cases annually; all are tied to alcohol. Though there are fewer instances of family disputes, neglect, and violence than in smaller villages along the coast, it is nevertheless a serious problem.

Fewer people drink in Quinhagak. Perhaps 15 to 25 percent of the households have trouble with alcohol or drugs. "It is a narrow part of the population, they are repeat offenders." Though the village prohibits drinking, adults obtain what they want from bootleggers or home brew. There is also a problem with younger children, ages 10 to 15, who sniff (or huff) gasoline, Lysol, Pine Sol, solvents, or glue. A number of high school students and younger adults also drink and use marijuana. As one teacher mentioned: "There are some students who are physically in school, but mentally they are not. They come to school high on drugs or alcohol; mentally they are just not there." There have been several publicized instances of shootings, suicides, fatal "huffings" in the last ten years. All were connected to alcohol. Crime, abuse, and spousal violence are usually related to binge drinking. As one gentleman lamented: "People are dying you know, shooting each other. These young people using drugs. We have had cases like that in the past and those cases were under the influences of marijuana and alcohol, cases where there were killings and suicides. And it is still going on in the villages." [2] While these acts are rare, they impinge on the life of everyone in Quinhagak.

Nulato, the last of the three villages in this study, probably suffers most from alcohol and drug use. The testimony of villagers was chilling, powerful, and more revealing than a researcher's estimates or somber figures from the bureau of vital statistics. One elder, when asked about the depth of substance abuse problems in Nulato, replied:

I guess each and every family has to deal with something like that (disasters linked

with drinking). Even from my own experience, I have a daughter that lives in Fairbanks and I always worry about her because I know she is drinking. I don't know what else she is doing. And then in my immediate family at home, I know when they drink. I don't know what is worse, whether they are away from you or not and you have to deal with what is going on. It gets to where you cannot just come out and say, "can you please just quit drinking!" I have three boys and all three of them died of drunkenness. One in Germany, the oldest. My second boy drowned about two miles away when he was going up to get some booze at Last Chance, and my third committed suicide. So we all deal with it. And it hurts each and every family in different ways. And everybody hurts when someone loses their loved one that way. It is so painful. I think that is the hardest part is to deal with a family member that drinks. And I cannot get over this that some young people worry about their parents because they drink. And in some cases, we as elders, worry about our kids and grandchildren. It works both ways.

When asked to rate the gravity of alcohol and drug abuse problems in Nulato by choosing a number from one (not serious) to ten (complete saturation); most chose nine. High school students claim every family has at least one member struggling with drinking difficulties. At certain times of the year, the problems are more obvious and intense. "During Permanent Fund Dividend time (early October when the checks are mailed out or bank accounts are credited), it's worse. Sometimes none of it goes to bills. Somehow people are going to have to realize that there is something else besides drinking." (Elder)

The widespread use of drugs in Unalakleet is a recent phenomenon. One long-term resident explained:

> I was born and raised here. In my early childhood, you could count the inebriates on one hand. In my mother's time, she said there was very little (drinking). . . . Alcohol use began here when we got FAA and other outside employers. When new people moved in the 1950s and 1960s, they introduced alcohol. The youngsters seeing it now think it is a way of life, whereas we, the older (generation), know it is not a way of life. There was a community spirit and everybody took care of each other, and we never locked our doors, but now we have to lock our doors. Otherwise, things will walk out by themselves. When we have someone under the influence, it affects the neighborhood and everyone else around. Most of our accidents are caused by the use of these substances.

Many spoke of the loss of community in where people have lost their sense of fulfilment and purpose for something greater than themselves (spirituality?), where teachers no longer visit families or villagers call on each other, where elders are no longer listened to, or where attendance at the Covenant Church (whose authority in the past has been compared to a traditional *qasgiq*) has dwindled to only a few, to the drop in empathy and compassion between neighbors. One is reminded of an insightful comment of an Indian grandfather: "What has happened to the interdependence of

the family, the clan, and the tribe of earlier years? We have learned too much 'independence' from the 'uneg' (a white person), resulting in too much 'dependence' rather than having a life of sharing, and being 'helpers' for the greater benefit of the tribe as a whole." (Cameron, 1999)

Others felt individuals learned to drink from their parents or those they respect. "Kids that grew up have children, their parents drink, they grow up and have kids, and they drink. Some even drink with their parents." Students sometimes follow the example of upperclassmen and women who "go up river to party." Village leaders say they can predict the pattern of behavior of younger pupils from what the most prominent cliques are doing in high school. Some suggested too that students and adults drink out of boredom. There is little to do in Unalakleet if school is not in session, if jobs are unavailable, or if fishing and hunting is not required. "For many, there is nothing to look forward to."

Another tribal leader spoke of the frustration in trying to help children and families:

> We don't have the resources to help individuals who are crying for help. For example, there is a case that involves a child, that is alcohol related and also deals with mental health. Child is emotionally disturbed, not crazy, very bright, and very disruptive in class, has a lot of anger. Parents drink. One parent wants to help, the other doesn't. We tried to get her in a program that would help the family and the child; we have not been able to do that. We have been working on this case since December. We have not been able to place the child and the parent anywhere. Both want it. We are stuck. We have identified several agencies to help us, we have gone through the mill in contacting the school, the district office, with Norton Sound Health Corporation, and we are still at the same place we started. And so we really do need that aspect of treatment."

Elders in Quinhagak blame outsiders for the introduction of alcohol and drugs. "The origin of the problems came from the white man coming into the villages and essentially started out as playing cards and drinking alcohol at the same time . . . (I)ts never going to be stopped until the airlines stop bringing the stuff in." Another longtime resident added, ". . . the problem of alcohol did not originate in the village, it was brought in by other people . . . (I) can remember the old times, when the parents and the grandparents did not have alcohol."

The abuse of alcohol and drugs in Quinhagak is attributed to boredom, peer pressure, neglect, and personal problems. Some young people feel there is nothing to do except to get high. One police officer commented: "There's the alcoholics, people using it, some of them make homebrew pretty often, and for a lot of young people it's just to have fun." A few are insecure and drink to boost their confidence. Others want "to be cool, and fit in." One grandparent felt parents did not have time to talk to their children. "As I observe the villages there are parents who are working and their children have no one to look after them, because these days everything costs money. That has worsened the problem of alcohol abuse. It's easy to talk and we all advise people, but we don't talk to our children or tell them of what is to come in their future. One time, when I talked to one person,

he said that his father never talks to him like I did and that he was disappointed. When we speak in public, we (elders) try to speak the truth, but when we leave, we forget all about these things we have mentioned." Another elder agreed: ". . . children who are not counseled or spoken to about how to live life eventually tend to participate in criminal activities or activities that lead to criminal behavior . . . we basically are losing our chance to counsel the children on our way of life, or the facts of life. And people, even us, are tending to spend time watching television rather than doing counseling."

Others blame a state system which takes their young out of Quinhagak. Until the mid 1970s, for example, teenagers had to leave the village to attend high school. When the students returned, they lost a part of our way of life. They return rebellious and without respect for their parent's and their elder's way of life. " The criminal justice complex is also at fault. One villager argued:

> When young people commit crimes in the village, they are abruptly taken away by the police. This annoys me greatly when they're taken away. We don't see them. They have a program in Bethel, but I know that the state of Alaska tries to break the human spirit (even in the prison, I know). The state dictates how to fix the problems of the prisoner, and when they do this they work with the prisoner, by talking to them, until they become angry or until they get a point where they no longer listen to anyone. They do this because the person is a commodity from which the state benefits. If there are no prisoners or if they stop taking away people where the programs going to get their funding?

A friend agreed. "When our police take away our boys and girls, it is annoying when they return. They are worse off than before they left. They don't listen and they become worse as more offenses are committed until they can no longer be disciplined. That is the way it is when other programs are involved, even in Bethel. They may not intend harm, but things get worse."

Another elder criticized the rules and regulations that hamper tribal initiatives:

> In the early 50s and 60s the traditional council had its own set of rules where each tribal member would go in and discipline this individual according to somebody else's referral, some citizen's referral. He went and talked to the tribal people just recently if council members could discipline another individual like they used to a long time ago, but they said they don't do that any more because they have substance abuse workers.

Individuals blamed families and schools for the widespread abuse of drugs. One elder commented on life in Nulato years ago:

> About three or four months ago, there was about three of use, we were all talking about when we were growing up. We had a lot of things to do when we were growing up (in contrast to the complaints of youth today that there is nothing to do). Because we had no television, no lights, no telephone. We did a lot of outdoor play.

> Even married people used to play outdoors. They used to play with us. That all fell a part. I don't know what happened, maybe when the first television came out. . . . We used to be poor; we used to have to play with a crushed can. Smashed up can, we didn't even have a ball to play with. These women they were talking and they said, "kids don't have nothing to do." The thing we came up with was, everything used to be *hiclana*. Everything used to be taboo. We couldn't do a lot of things because we knew it was wrong. *Hiclana* is the word "thou shall not." I still keep it up in my house. My kids know what *hiclana* is, and I am working on my grand kids. That is our whole problem. Our whole problem is from home. It has got to start back from home (Elder).

The schools do little to close the gaps found at home. "In school, a lot of these children are not disciplined. Their parents were not disciplined. The young parents don't know how to discipline their kids. Like she said, *hiclana* this, *hiclana* that. That is how we were brought up to believe in our Native ways. Don't do this. Don't do that. Respect your elders; never answer old people back. And it is not like that anymore. You go to the school and the kids come up to you and say whatever is on their mind." (Elder). At times, parents seem indifferent to their children's behavior in school. "One of the teachers told me one day and she was so shocked. She called up a parent and told her the reason I am calling is because your daughter is not doing what she is supposed to be doing, she's not doing her work and she's not getting a good grade. And the parent said, "And you can't do nothing about it?" Just like that. That is the way the kids are growing up. The kids cannot help the way they are. They are growing up on their own." (Elder)

Interviews: Perspectives on Treatment

There was near universal condemnation of substance abuse treatment programs in Alaska. The criticisms were virtually the same in every village. In Unalakleet, one tribal leader thought about her family: "I would be very interested to see what the success rates of treatment programs are in Alaska. From my personal experience, my relatives have gone many times to treatment and, their problems have not gone away. They just went there to escape or because of court orders. I would like to see a success story and see what is out there. Treatment doesn't seem to open their eyes."Another individual pointed out a common problem after people return from outside programs: "They (those with alcohol or drug troubles) go out there, the ones that want to help themselves, and go to treatment centers. We had one individual go to three different treatment centers. One in Kotzebue, in Old Minto and, I think, Nome. Successfully passed every one of them and came back in the community where there was no support and went back to her own ways."

Others worried about children and the home when parents are spending time trying to find a treatment plan that works. "This individual or whoever it may be, in his or her quest to try to get treatment, and then the child is placed with a foster family, and then given back to the family. The parent messes up and the child goes back and forth. In the meantime, the child is growing from a

child to an adolescent with all these interruptions and no stable environment. They become grown. So what do we do?" One mother perceptively wondered about the family responsibility and the consequences of the parent's behavior, after the children are removed from the home: (T)hey should make them responsible. Because all they did to their parents was let them go ahead and be a free drunk. They have no more cares. He doesn't care to better himself; he has no kind of responsibility, nothing. Same as with the momma. Should make the parents suffer. Be there when she cries. Don't let it be easy. Follow them. They should drag them through all kinds of counseling, but don't separate them."

Quinhagak residents were deeply troubled about the separation of individuals, with substance abuse problems from their families and the community, and the failure of outsiders professionals to recognize the potential value of Yup'ik traditions and institutions to deal with the use and abuse of alcohol and drugs. "We worry about our own people who we do not see when they are away, but there is nothing we can do about it." Elders and the council used to be the source of wisdom and authority. When our leaders spoke everyone listened. Now we have counselors. (Paraphase from second meeting with elders) It is important ". . . not to abandon the Yup'ik ways. I would like to help people in Yup'ik ways. Presently, we use Caucasian ways to teach. . . . If we use the Yup'ik way to help a person we would take him or her hunting or talk while we berry pick that would work better."

A member of the village council felt there were few places for families for assistance or guidance. "With the existing programs, I don't know if there are people voluntarily going in to seek counseling from anybody except there are some people out there who do seek counseling from older people in the village. But as far as I know, it seems like the only clients that are referred through the tribal court."

One of the leaders of the Native Village of Kwinhagak wondered why social programs differed from other public measures that were under the control of the tribal council, and why village-based counselors were not more visible and involved in the community. "Since I began working at the IRA council here, we have begun taking most of the BIA programs onto our own business, let's say in the form of a compact. Where motions, or decisions are made by the council, not by BIA or the federal government. But what bothers me . . . are the programs that have to do with people. Such as alcoholism counseling programs and child welfare programs. Why do they say the program is offered to our village, when its doors are going to be closed to the people who are needy, the people it should be open to? Why isn't that person (a counselor) available to the village, who was hired to help out those people who are having that problem?"

In Nulato, people are as critical of outside care facilities as others, but they are also frustrated in their own efforts to control alcohol and drug abuse. They have tried educational programs, restrictions on consumption, and support groups, all to little avail. There is a counselor in the village but, because of fears of ridicule and condemnation, individuals seldom visit. Tribal authorities know who the bootleggers are, but no one will testify against them. There was a local safety officer but he was forced to resign. Residents realize a community-wide effort is required to

better the lives of their neighbors, but families are divided by residence,[3] television, and other preoccupations. One tribal leader has observed: "Families, extended families, used to be together more; would go to fish camps and spend time with each other. Now each family does their own thing. They have forgotten their responsibilities. Everyone used to watch out for one another. No longer." Another member of the village council added: "Many of our kids do not know who they are. They have not been educated in our traditions. We used to have survival education, but today young people do not know how to hunt, to trap, to survive in the woods.

Interviews: Envisioning Alternatives

> Treatment is best considered, not as the first line of response to addiction, but as a final safety net to help heal the community's most incapacitated members. The first avenue for problem resolution should be structures that are natural, local, non-hierarchical, and non-commercialized. (William L. White, 2000)

Alcohol and drug disorders are commonly attributed to either character defects (immorality, weakness) or disease. Proponents of the moral explanation look for solutions in the criminal justice system. Tighter law, more police, stricter enforcement, tougher courts, and certain punishment will do much to reduce the excessive use of legal and illegal substances. The advice of the Alaska Criminal Justice Assessment Commission is a good illustration of this approach. The Commission's Alcohol Policy Committee called for higher taxes and fees for enforcement (3 recommendations), organizational restructuring (3 recommendations), and the reform of courts and prisons (14 recommendations).[4]

Others, who believe alcoholism and alcohol abuse is a disease, recommend a public health approach. In this case "the goal is to apply comprehensive strategies and programs that reduce the rates of disease and early death among total groups and aggregates of individuals. . . . The focus therefore is on communities and particular geographic areas and not on individuals.[5] The emphasis is on secondary and tertiary prevention programs. Secondary policies seek to regulate the supply of alcohol (taxation, restrictions, prohibitions), encourage safer drinking practices through education and training, and decrease the risk of drinking. Tertiary prevention stresses treatment and rehabilitation. The assumption here is that current methods of treatment, e.g., pharmacotherapy, psychotherapy, interventions, group meetings, etc. will be transferred to communities where they presumably will be more responsive to local needs and ideas.[6]

Village suggestions for fighting substance abuse and dependence are thoughtful, creative, and assertive. They do not fit neatly into either the moral/character or the public health schools. There is much enthusiasm and support for a comprehensive village program or policy to combat the ills of substance abuse. A member of the Native Village of Kwinhagak tribal council said "(we) in Quinhagak can benefit from this (a local treatment program). Our young people, who have no money or jobs, could become employed . . . Our worker's minds would be more at ease. Our elders and church workers could stay in the (community) and talk with people. I would like to see

something like this in Quinhagak before I die." A young tribal police officer felt a village program would "help a lot of people. It would help them understand they (the abusers) are killing themselves and others. Fines and other restrictions are not working." A council leader in Unalakleet argued that "(W)e need a comprehensive prevention program. We need to have a comprehensive approach with the young people in the community." Another leader agreed that a family program would support parents and children in their efforts to lead more fulfilled and responsible lives. "We have lost some cases in the past, but a family center would provide the support we need." (A paraphrase) Others think a new approach is needed: "We have young men that are getting drunk every week . . . we need to show these men there are consequences for what they are doing, consequences for their families. Going to jail is not working. So we need to look at another way to do it." Tribal representatives in Nulato called for more alcohol awareness education, more family support services, more knowledge of traditional values, and more communication between elders and the young.

Self-determination or, more precisely, community determination would be the guiding principle of a village substance abuse program. True community or tribal determination requires reforms in four general areas:

> First, there must be a structural reform of tribal governing institutions that is fundamental but also permits a continuity between past and present. The search for such reform has been a constant theme in every period we have considered. Second, some kind of determined and lasting cultural renewal must take place to help resolve the question of Indian identity in the modern world; here emotional continuity must be recognized and considered seriously. Third, economic stability must be established and maintained if Indians are to survive as distinct and healthy communities; the (indigenous)economy must be recognized as uniquely Indian, but it must also be efficient in today's world. Finally, relations between the tribe and the federal and state government must be stabilized, and mutual respect and parity in political rights must be established (Deloria, Jr. & Lytle, 1998).

Village ideas about how to best treat alcohol and drug problems embrace the spirit of these reforms and offer practical recommendations to carry them out. First, local tribal governments must be accorded the authority to solve the problems of their communities. Here the State of Alaska must recognize the legitimacy and value of indigenous governments. The Governor did take a step in this direction when he issued an administrative order which said, in part, that the "State of Alaska recognizes and respects the governmental status of the federally recognized Tribes within the boundaries of Alaska" and pledges ". . . to work on a government-to-government basis with Alaska's sovereign tribes . . . and to enhance Tribal self-government, economic development, a clean and healthy environment, and social, cultural, spiritual, and racial diversity." (Administrative Order Number 186, September 29, 2000).

Aside from this general endorsement the state has not acknowledged the inherent powers or prerogatives (depending on the point of view) tribes need to counter the effects of alcohol and drug abuse. Among the most important is the power to control the sale and distribution of liquor, wine,

and beer in the village. Large quantities of alcohol are shipped every day to dry and damp villages. Meanwhile, the urban outlet stores and airlines earn substantial profits largely free of conscience or obligation. The elders in Quinhagak asked sensible questions about liability and responsibility. If states enforce dram shop laws, which allow persons injured by drunks to sue servers, why couldn't the legislature and tribes craft a social liability law, permitting communities to sue retail and transportation companies for damages?

Bootleggers, who import and resell the liquor, operate without fear of confiscation or penalty. Here, a few villages have taken corrective action. In Kipnuk, a Yup'ik village on the Bering Sea coast, tribal police began searching luggage and frisking visitors for drugs and alcohol. Their efforts have led to ". . . significant reduction of illegal sales and alcohol-related incidents." (Alaska Daily News, July 3, 1997).[7] In 1993, the state did pass a law that made bootleggers personally liable for injuries, death, or property damage resulting from the illegal sale of alcohol. Frequently though, the laws against use and sales are not enforced. One elder noted: "Perhaps

> in other villages the IRA Council and police keep an eye on people who sell and when they bring alcohol and drugs they arrest them. The IRA and the police follow the ordinance. In my observation, they don't enforce hard enough. Those who bring alcohol and drugs hide their substances and bring them into the village. This is a dry village and they are not supposed to bring substances. But they hide substances and are not caught and the laws are not enforced hard enough.

Another leader observed that ". . . the major airlines (are) bringing alcohol to the several regions, and from there it's essentially distributed to the villages who order the stuff . . . and that is part of the village problem. Is there a way that we can eliminate the shipping of drinking alcohol through the hub towns?"

Complaints about the states'[8] regulation of the alcohol industry are not new. Typically the laws are weak, and the agencies responsible for their enforcement, are underfunded. Public officials seem more concerned with the needs of the alcohol manufacturers and wholesalers, than consumers. This is a widespread problem in Alaska and throughout the United States. One study found, for example, that the concentration of liquor stores in poorer neighborhoods reflects "the relative power of alcohol producers and wholesalers who supply liquor outlets, banks who loan money to store owners, and state regulators whose activities are more oriented toward the interest of alcohol industry lobbying groups than the regulation of that industry and the relative powerlessness of the poor and unemployed individuals and groups who live in greater concentration in these areas of high outlet density." (Nash and Rebhun in DiIulio, Jr. 1996)

To effectively control the use and distribution of alcohol, tribes and other village organizations must have the support of the state. This support could take many forms. The Alcoholic Beverage Control Board and the Department of Public Safety could work more closely with village authorities to enforce laws against bootlegging and possession of alcohol and other drugs. For example, "a person who sends, transports, or bring alcoholic beverages into a

municipality or established village" is guilty of either a class A misdemeanor or a class C felony, depending on the amount of liquor, wine, or malted beverages that are imported. There is also a penalty (either fine or community service) for the possession of alcohol in a dry community. The success of these and other laws depends on public understanding and enforcement. One summary of the effects of prohibition cautioned: ". . . the effectiveness or ineffectiveness of any (strategy) that can affect alcohol availability is related to several interactive factors. These include public support and compliance, and the history of alcohol policy in that country. Without sufficient public support, enforcement and maintenance of any restriction is impeded . . . " (Edwards, G. et al, 1994)

To further control the illegal sale and possession of alcohol, the state could reduce the amount of alcohol one could possess that automatically leads to a presumption that the beverages are for sale,[9] and require package liquor stores close (within a 100 miles) to record sales that exceed the possession limit. The governor could urge the U.S. Postmaster to increase the surveillance of goods transported to rural communities and to cooperate with state, tribal, and other local enforcement agencies in intercepting illegal shipments of alcohol and other drugs. The law enforcement section of the Alcohol Beverage Board could be transferred from the Department of Revenue to the Department of Public Safety to aid in its investigations.

The legislature could increase wholesale license fees[10] and excise taxes to gain more revenue for governments to combat problems related to alcohol and drug abuse. In real dollars taxes have fallen from 47 cents in 1961 to 13 cents in 1997. Alcohol taxes have not increased since 1983. The state could also permit city governments to levy a higher sales tax on alcohol than on other items.[11] Higher prices usually result in reduced consumption.[12] The National Institute on Alcohol Abuse and Alcoholism's report to Congress ended by saying: "The conclusion supported overwhelming by the demand studies reviewed here is that the demand for alcoholic beverages is affected by price changes in the same way as are the demands for other products: Higher prices are associated with lower consumption levels.[13] Many studies have also found a relation between higher alcohol taxes and declines in accident fatalities and deaths from liver diseases.

Because of lackadaisical enforcement, inconsistency, and the urge to make a dollar, policies regulating the sale, use, and taxation of alcohol have had limited success. These policies also do not address the social, economic, educational, and cultural conditions that are directly tied that to substance abuse and dependence. Something more is needed. One researcher suggests: ". . . awareness is growing that solutions to social and health problems must be generated at the community level and those that have been imposed from outside will most likely be ineffective." (Beauvais, F., 1998)[14]

Certainly villagers are ready to confront their alcohol and drug problem. Though there were no substantive discussions, a general outline of a village treatment program did emerge. The principal elements include:

- A standard treatment program that would provide detoxification and assessment services, residential(inpatient) and outpatient (advice, counseling)care, relapse

prevention and aftercare, social and family interventions, and so on. A public safety officer observed that they now have to keep drunks in jail which "is not a good place to use. Better for people to be in a treatment center for intensive care; need a padded secure area for individuals to dry out." It should also house a library, according to one elder: "If we happen to have this facility, it should include a library, we should have books and pamphlets that concern our health and safety, for those who want to quit drinking, smoking, doing drugs, and other substances. There would be group sessions and a place to council individuals and families." A second elder thought the facility could "take referrals from the school system in order to discipline the student and talk about his problem." Another felt local counselors could more effectively deal with individual problems than police, who are not trained. "It is the wrong approach for the police to counsel someone[15]. Need people that are knowledgeable and work full time, not the police." One older gentleman remembered an earlier time: "I asked the council . . . remember when the council used to talk to people about the consequences of their actions? When I asked the council about this, they stated they no longer do this. The police, when they see the person in a situation, they make a decision regarding that person; that, to me, is disturbing. The councils don't talk to them first."

A village social worker felt a treatment center should address all of the issues that surround alcohol and drug abuse, domestic violence, sexual abuse, child abuse, and offer shelter to those who in need (particularly women and children). An elder in Nulato was impressed by group sessions: "I don't think that it (treatment program) should be something that is geared toward older people, but 20 to 40 year olds. And it should be something that should be available 24 hours. You can see alcohol coming on. If they had some place to go, something. I have a friend, he pretty much drank all his life. He is in AA right now. He calls me in the middle of the night, and they all do that. He is not the only one. The whole program does that. There any time they need them. It works for him. I think it would be something that would work here. I think it would take a long time to get started, it is not something that would work in two weeks. There would have to be money put into it to get somebody here. If we could get something started, it could take hold."

- A village program would also include traditional methods of caring for people who are suffering and advising those in need of guidance. One elder spoke for many: "If we get a counselors for the facility, let us not abandon the Yup'ik ways. I would like to know how to help a fellow person in the Yup'ik ways. Presently we use the Caucasian ways to teach people. If we revert to Yup'k ways, it is another matter. If we are going to help, our people are we going to use the Yup'ik ways or the Caucasian ways? This was discussed in the past. If we use the Yup'ik way to help a person we would take him or her hunting or talk while we pick berries-that would be better.

Another gentleman described his conception of care. "There was an orphanage facility in the village of Kwethluk and it was sponsored by a Moravian. It was mostly for orphans. They were all taken care of. They had counselors (matrons) working with them. That was working very well in those days. And it was good for the other villages because they sent young people there for bible study. Most were orphans and most were given responsibilities of their own, how to take care of themselves and do village kind of living, gathering wood and fishing, doing those things on their own. So that was working quite well in those days. According to these people (other elders), if we had those kind of facilities today, it would be very good, it would work well. Even if one person is attending that program, somehow it would work for that person that would eliminate most of the problems going on, what we are talking about right now. I may have missed some of what he was saying (what was translated), I think in general, the way I understood, he is saying that not only will it affect those who get in trouble with laws, but also serve as a place where people can come to learn and listen how to live a good life." Elders would relate what they know through traditional stories. "Embedded in these stories was how to live our lives. It basically started at when we were very small children. And you would hear about what so and so did with such and such and as you grow older, you would be told that this is what you do with this and that."

The Native Village of Kwinhagak is using two elders to counsel particular individuals. One of them discussed his ideas of how to help others. "Parents will ask me to talk to a person who is having trouble. I talk to the individual initially as church elder and listen and advise them. At the end of our talk I tell the person that if he or she gets into trouble later, I will approach them as a tribal judge. People have to come to us for help. Adults should be talking to children whenever we get the chance. If the person is being counseled and then gets into trouble, the situation should be presented to the village council for action; that is what the parents are told." An older woman then commented that counseling from a respected elder or a trusted friend or relative is preferable because their words are not threatening; one does not feel they are held in contempt. "Definite things have to be said, and certain actions have to be discouraged but not in such a way that the person is made to feel hated because of his or her actions."

- A treatment program would be founded on the culture and traditions of the people it serves. Two tribal leaders in Unalakleet argued that Iñupiat values, language, and traditions offer much hope in dealing with contemporary social problems. "There is a gradual movement (here) back to recognizing our culture and our history. We have a group of kids at the school who are going back to Native dances. I think that there has been a lack of pride that has created some of these social problems we have had in Unalakleet. I think with it gradually turning around, I think eventually, creating pride in culture and individuals will help a lot in eliminating most of the problems we have along with providing alternatives for kids to do." His friend added: We have

gone through a really tough era in being civilized. Quit speaking your language, quit doing your dances, and then now they said they made a mistake, and we have our children taking bi-lingual/bi-cultural courses, and the adults can't even speak our language. Just to build a treatment program would help." A third member concurred: "During the 60s they did something (for treatment), and in the 70s and 80s they did other things, now they have come full circle. They are finding out that going back to traditional and cultural ways are the only thing that has been working as far as cutting back on alcohol abuse. If we can create something for adults, going back to traditional/cultural ways would be the strongest approach."

There is great concern for children in all three villages. I elder related his worries: "I am more concerned about our youth (than adults). We are talking here about the welfare of our children. We already have what we need for adults. We have a church and church elders. Yet our children are lacking a great deal. When we go to play bingo, we leave our children behind. We need a place for the youth to gather. This way, they would not be running around at night so much and we would know where they are. Because we don't have a facility for our youth, they have a tendency to get into trouble at night; they inhale gas. They don't have a place for entertainment. We are torturing our youth. We don't allow them to have what they need."

Some feel a treatment program would benefit young people. "If we had a program like this it would help Quinhagak because it would help kids that are having difficulty and it would probably benefit other nearby villages to have a center here. During the fall meeting in Bethel, they had this kind of meeting where they talk about similar programs that would help the villages, our younger generation." Villagers were most enthusiastic about spirit camps that are organized every summer for young people. It is an opportunity for elders to talk with the young and impart their knowledge about hunting, fishing, survival, and many other activities. It is a chance, one leader in Nulato explained, for kids with a formal education to realize how little they know about living in the woods and appreciate the wisdom of their more experienced forebearers. In Unalakleet, the Covenant Church sponsors a subsistence camp for families every year which is well attended. The village corporation has also set aside 5 acres up river for younger people where they can learn more about Iñupiat subsistence and arts and crafts. Many village residents agree with one council member who said ". . . the real core of the problem is not having any real alternatives for kid, and even adults, to do. During the school year, it is okay. It is during the summer when the kids have more free time . . . We can minimize the problems associated with alcohol, drugs, and inhalants by providing alternative activities for everyone."

- It is assumed the treatment center will be managed and staffed by village residents. One elder in Quinhagak explained: "If such facilities or programs come into existence, it would be better if they were run by Yup'ik people, this is something

we(village council) discussed yesterday. We want certified people but it has to be someone from the village. Also realize that we will need some temporary assistance with individuals with experience and training." The council was then asked if they could foresee elders and village counselors working with therapists and psychiatrists each providing the other with support and guidance? The reply was yes, but only under the direction of the village council. The councils of all three villages insisted they want to develop their own program that is responsive to the general needs of the community, and the specific needs of families and individuals affected by alcohol and drug abuse. It is only through a local effort that involves everyone that people will realize that substance abuse is a community problem, not a particular or individual problem. As one elder told us, understanding and tolerance are the keys to a successful program: "I see a lot of recovering alcoholics trying to stay off the bottle. I think the real answer is to treat them like they are people, deserving of respect. I think a lot of people, because they have drunk in the past, are ostracized or ignored, looked down upon within the community. I think it is going to take social education and more personal responsibility to learn how to treat others. If you do not feel part of something, a culture or a community, you are not going to buy into this. You can create all the treatment programs you want, but if people do not buy into it, or they are not treated as worthy, it is not going to work."

The Value of a Village Treatment Program

> Whatever words are chosen to depict the situation of Alaska's Native people, there can be little doubt that an entire population is at risk. At risk of becoming permanently imprisoned in America's underclass, mired in both the physical and spiritual poverty that accompany such social standing. At risk of leading lives, generation to generation, characterized by violence, alcohol abuse and cycles of personal and social destruction. At risk of losing, irretrievably, cultural strengths and attributes essential for the building of a new and workable social and economic order. And at risk, inevitably, of permanently losing the capacity to self-govern-the capacity to make considered and appropriate decisions about how life in Native communities should be lived. (Alaska Natives Commission Volume I, 1994)

Too often discussions about rural Alaska begin with the problems that beset village residents, the poverty, the drinking, the violence, the absence of sewers, the abuse of children, the inadequacy of education, and so on. This emphasis on deficiencies and needs has several consequences. It leads to the multiplication of efforts to develop solutions, usually by well-meaning outsiders, which results in both the fragmentation of services and the deterioration of a community's ability to solve problems. Second, the resources behind these efforts, the money, power, and information, is usually given to the service providers, not local residents. In fact, service economies depend on the infinite

expansion of need.

There is also an assumption, many times unspoken, that only the experts, the social worker, the health care specialist, the educator, the attorney, can provide the required help and assistance. Natives are then designated consumers, clients, or patients. All three imply passivity, inequity, and isolation. Consumers take or buy from others, but produce nothing. They respond or react as individuals, but they don't initiate or collaborate with others. The appellation Client suggests protection or patronage. It is akin to a client state in which a weaker country is "dependent on a larger and more powerful country for its political, economic, or military welfare." (Webster's Encyclopedic Unabridged Dictionary of the English Language, 1996). The word patient is either an adjective signifying endurance with composure, or a noun meaning one who is under the care of another. The presumption is the client or the patient is ". . . the problem, the assumption is that *I*, the professional servicer, *am the answer*. *You* are not the answer. *Your peers* are not the answer. The *political, social, and economic environment* is not the answer. Nor is it possible that there is no answer. I, the professional, am the answer. The central assumption is that service is a unilateral process. I, the professional, produce. You, the client, consume."[16]

> In a report prepared for the Alaska Federation of Natives the authors concluded that (W)ithout real powers of self-determination, Native communities are condemned to be either wards or victims of other institutions trying to either improve or exploit the Native situation. This is unlikely to produce sustained positive change. Nowhere in the history of Indian policy has sustained, successful economic development or sustained improvement in Indian welfare been achieved by communities whose decisions, resources, and internal affairs are substantially controlled by outside decision-makers. In asserting governing powers today, Native communities argue a principle that has found confirmation around the world: we who bear the consequences of decisions about our fate should be the ones making those decisions. (Cornell et al, 1999)

The creation of a village mental health and substance abuse program could lead to many significant changes. It could strengthen tribal authority over health policies. It shifts responsibility and accountability to where the problems are. Village councils could use their knowledge of local history, traditions, people to decide what issues are important, what resources are available to work on these issues, and what programs have value. Local organizations are in a better position to answer such critical questions as what the possible negative affects of a proposed service? When is outside assistance necessary? How will a proposed social program enhance or detract what is already in place? What actions will increase the capacities and abilities of village residents and associations?

The devolution of health services could alter social and political relations in the community. In this arrangement individuals pool their ideas as citizens, not as clients, consumers, patients, or stakeholders. Through real and effective participation people develop more confidence, acquire

more information and understanding, and begin to cooperate in efforts to create something of common value. It would embolden the involvement of elders for they would be asked for their advice and counsel. It would renew the respect of the young for the sagacity and judgement of the old. Providing better health care for others becomes a shared endeavor. In this sense ". . . health care represents a commitment of the healthy to care for the more vulnerable. The political and moral will to support such a public work comes about not simply because people fear they one day may be sick, but because they sense their human connection to others. We engage in public works because we are a part of one another. Untreated disease, uncompensated disability, and untended suffering in a community diminishes not only the individuals who suffer, but the community as a whole."[17]

In a village centered health program the focus of health care would shift from deficiency to capability. Leaders could look inward for talent, wisdom, and experience of different people and what they can lend to the healing process. It would support village efforts to revitalize their cultural traditions and beliefs and apply them to the treatment and care of those around them. Some think, for example, that the use of traditional herbs, rituals, and healers would be of value in treating those suffering from alcohol abuse. Through acts of atonement, gift exchanges, ceremonial performances, and private consultations with elders, the individual is brought back into the ". . . good graces of family and tribe. New solutions to problems or new ways to see old problems becomes possible through interconnectedness, creativity, wisdom, and (ceremony)."[18] A local recovery program would complement other initiatives in Quinhagak and Unalakleet such as the organization of drug courts that will provide more supervision and direction to substance abusers. It could also provide more opportunities for employment in areas where jobs are scarce and incomes are inadequate.

A village health program would benefit the individuals and families who are crisis. Rather then separate a person from the village and subject them to external therapies and therapists, the goal is to bring the alienation or the distraught back into the social life of the community.[19] This approach could allay individual fears about moving to distant and unfamiliar places, and diminish feelings of exclusion. It could reduce the financial costs normally tied to treatment, e.g., airfare, restaurants, lodging, when traveling to distant cities for treatment. A residential family program would also be more compatible with proven methods of treatment for alcohol and drug problems.[20] Individuals are less likely to drink if prices are high, access to supplies is low, restrictions are enforced, and one is made aware on the consequences of one's behavior. Environmental factors like reinforcement, coping skills, education, and employment are also related to heavy consumption.[21] If learning and conditioning are instrumental to recovery, where are they more likely to occur? In a clinical setting or in the family and social context one normally lives in? Most villages would choose the latter.

One would expect the enthusiastic endorsement of a family health and recovery program in village Alaska by public authorities. The federal government has backed self-determination and self-government policies for more than 25 years. In passing the Indian Health Care Improvement Act Congress assured Indian people that would receive comprehensive and high quality health services and assistance in staffing and managing their own community health programs. The goal of the Indian Health Service is to insure "that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Natives people."

Therefore, there has been support for the participation of Indian tribes and organizations in the development and formulation of health policies and budgets. Unfortunately, while Congress has acknowledged responsibility for Indian health care, it ". . . has consistently failed to appropriate sufficient resources to support its otherwise impressive legislative mandates." (Pfefferbaum, et al, 1997) Occasionally too, there are differences in emphasis. For example, tribal and village residents talk about the importance of culture and tradition in combating health problems while federal officials may place more value in law enforcement, detention, and punishment. A recent report to the U.S. Attorney General referred both to the limited deterrent value of tribal law and the lack of ". . . detention facilities, intermediate sanctions, and substance abuse treatment programs" in explaining increased rates of alcohol and drug use in Indian country.[22]

An effective village behavioral health program would extend many benefits to the state of Alaska. It would provide more accurate, timely, and direct information from those who provide services and those who benefit from them. Currently, the Division of Alcohol and Drug Abuse and the Advisory Board of Alcoholism and Drug Abuse depends on a few statewide surveys and crude individual indicators, e.g., DUI, alcohol, and drug convictions, alcohol-related injuries, protective custody holds, for their data and information.[23] Villages could furnish social, cultural, technical knowledge about substance abuse and dependence that otherwise, would be unavailable, e.g., patterns of abuse and dependence, explanations for alcohol and drug use, appropriate treatment methods. This would lead not only to better communication and understanding, but to more cooperation and good will.

Too often public money and efforts is expended on the symptoms and alcohol and drug abuse, not on their foundations. In 1998, the state Alaska spent more than 16 million dollars on the prevention and treatment[24]of substance abuse, or one dollar for every 19 dollars spent on the effects of the misuse of drugs and alcohol. This is at least above the national average of $25.85 in expenditures for every dollar that support prevention and treatment programs. Per capita investment in treatment in Alaska $26.51, is two-and-a-half times the national average ($11.09) However, Alaska spends a smaller portion of its resources on substance abuse treatment (9.8%) than most other states (average is 13.1%). A recent study by the National Center on Addiction and Substance Abuse (CASA) found that states spend an average of 13 percent of their budgets on substance abuse problems. Most of the expenditures (96%) went to ". . . shoveling up the wreckage of addiction and substance abuse."[25] The state Division of Alcohol and Drug Abuse estimated that substance abuse cost Alaska $245,823,125 in 1999. The per capita burden on the State budget was the second highest in the United States.[26] More than half of this money is spent on imprisoning offenders and caring for abused or neglected children. More state, investment in village prevention and recovery programs could would In Bush Alaska there is a strong correlation between crime, violence, and alcohol. According to the Alaska Department of Health and Social Services 81 percent of all Division of Family and Youth Services reports of harm statewide involved substance abuse. (Alcohol) was a factor in 90 percent of the cases reviewed by the Citizens Foster Care Review Board."[27]

A viable village mental health and substance abuse program might enable the state and federal governments to reduce costs and to direct assistance where it is really needed. Villages could

begin to deal with individual and family difficulties before they become serious. Here guidance, conversation, education, and authority would be personal, compassionate, flexible, and spontaneous. There will be problems that villages cannot handle alone. State assistance might be needed in cases involving a violent crime, abuse, or psychosis. These exceptions though are usually the manifestation of a serious alcohol or drug issue. [28] The more important work has to done before the negligent or criminal behaviors surface. It is the local communities in Alaska that can best break the cycle of alcohol, despair, abuse, and violence.

Endnotes

1. Shinkwin, A. & Pete, M. (1982) Alaskan Villagers's Views on Problem Drinking: 'Those Who Forget.' **Human Organization**. (41) no. 4, page 318.

2. The most recent example was a teenager killed by his friend when he tried to stop him from killing himself. The friend was "highly intoxicated and volatile," according to state troopers (Anchorage Daily News, September 1999). Later two Quinhagak men were charged with providing alcohol to a minor and illegal importation (Anchorage Daily News, January 2000).

3. Three fourths of Nulato's residents live in the newer part of the village two miles from the old village on the Yukon River. According to the tribal council the division makes it more difficult for parents to look after their children.

4. The Commission sought to "review, develop, recommend, and implement strategies within the criminal justice system so that all offenders are held appropriately accountable for their conduct; promote responsible alternative options or community solutions for pretrial and post-conviction incarceration for misdemeanants and felons; work to make the criminal justice system more cost-effective to the extent this may be achieved without compromising public safety; and promote system efficiencies to relieve prison overcrowding. (Alaska Criminal Justice Assessment Commission, May 2000).

5. May, P. (1992) Alcohol Policy Considerations for Indian Reservations and Bordertown Communities. **American Indian and Alaska Native Mental Health Research**. Volume 4 (3) pp. 5-59.

6. Sowers, W.E. & Daley, D.C. (1993) Compulsory Treatment of Substance Abuse Disorders. **Criminal Behaviour and Mental Health**. Volume 3, pages 403-415.

7. Pat Hanley (1997) assesses the constitutionality of these searches in "Warrantless Searches for Alcohol by Native Alaskan Villages: A Permissible Exercise of Sovereign Rights or an Assault on Civil Liberties. Alaska Law Review (14) pp. 1-23.

8. Alcohol policies derive from the interplay of public organizations (state legislatures, Congress, courts, executives, agencies) and private interests (trade representatives, lobbying groups, e.g., National Council on Alcoholism and Drug Dependence, Mothers Against Drunk Driving, citizen, and other advisory groups). The regulation of alcohol is divided between federal, state, tribal, and local governments in the United States. The Department of the Treasury and the Federal Trade Commission oversee health warning labels. The Treasury Department also administers alcohol tax policies and revenues. Interstate transportation issues fall under the Department of Transportation (DOT). Alcohol research is the primary responsibility of the National Institute of Alcohol Abuse and Alcoholism. Prevention policies are developed by the Department of Health and Human Services, DOT, and the Department of Education. The states license the sale of alcohol, set age restrictions, regulate advertising, and allow communities to establish local standards for alcohol use (usually dry, wet, or damp ordinances). (See Gordis, 1996).

9. Currently, the limit is 12 liters of distilled spirits, 24 liters or more of wine, and 12 gallons or more of malted beverage (or a total of 24 points [a liter of spirits=4 points, a liter of wine=2 points, and liter of malted beverage=1 point]).

10. The present fee limit is $10,000 for wholesalers with sales of $1,000,000 or more a year.

11. Under state law a city sales tax on one item cannot be higher than the tax on other goods.

12. These recommendations are from the Alcohol Policy Committee, one of five committees that part of the Alaska Criminal Justice Assessment Commission. See the **Final Report: Alaska Criminal Justice Assessment Commission**, May 2000).

13. This conclusion is tempered by the differences between beer, wine, and distilled spirits in response to increases in price (beer is less responsive), and the insignificant response of very heavy drinkers (NIAAA, June 1997. See also Holder, H. & Edwards, G. 1995).

14. May also criticizes the legislative approach to substance abuse problems and calls for the development of a comprehensive community approach to alcohol use. (May, 1992)

15. In defense one village police officer complained that there is ". . . often no public support for helping others. Police are the only ones who will talk to someone who needs help. People have no place to turn. People that are involved in service can only do so much."

16. McKnight (1995)

17. McKnight & Kretzmann, J.P. (1993). **Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets**. Evanston, Ill.: Institute for Policy Research.

18. LaFromboise, T.D. & Trimble, J.E. (October, 1990) Counseling Intervention and American Indian Tradition: An Integrative Approach. Counseling Psychologist. Volume 18 (4) pages 628-655. See also Brady (1995), "Culture in Treatment, Culture as Treatment: A Critical Appraisal of Developments in Addictions Programs for Indigenous North Americans and Australians.

19. See the White Bison's "Circle of Recovery Program" which combines Native American methods with modern alcohol treatment and recovery programs. Its purpose is "to empower recovery communities on the development of substance abuse programs, policies, and quality assurance activities at state and local levels." (SAMSHA News (5) Spring, 1999). One might question whether an advocacy organization can effectively "empower a community." The dubious assumption is that communities cannot assert power themselves.

20. See Higgins discussion of operant conditioning and social learning in Galanter & Kleber, 1999.

21. One literature survey found that Indian ". . . youths most likely to abuse alcohol are those with close ties to alcohol-and drug-abusing peers. Also, those Indian youths who do not do well in school, who do not strongly identify with Indian culture, and those who come from families who also abuse alcohol are more likely to abuse alcohol and drugs." Moreover, abusers have poorer school records, weak religious and spiritual foundations, dysfunctional family and social relations, and not much hope in the future (May, March/April 1995).

22. The Executive Committee for Indian Country Law Enforcement Improvements (1997)

23. See the Advisory Board on Alcoholism and Drug Abuse, Results Within Our Reach: Alaska State Plan for Alcohol and Drug Abuse Services, 1999-2003.

24. No state money was spent for substance abuse research.

25. National Center on Addiction and Substance Abuse (January, 2001)

26. However, the proportional burden of substance abuse in Alaska was lower (9.4%) than the national average (12.6%). In the CASA study, the evaluation of costs was based on state programs in justice, education, health, child and family assistance, mental health and developmental disabilities, public safety and state workforce. The study underestimates costs in Alaska because the researchers were unable to gather information from public safety, the state department of labor, or regulatory agencies for 1998.

27. Alaska Criminal Justice Assessment Commission (August 2000)

28. As a reminder ". . . the Alaska Department of Health and Social Services disclosed that 81 percent of all Division of Family and Youth Service reports of harm statewide

involved substance abuse. Alcohol was a factor in 90 percent of the cases reviewed by the Citizens Foster Care Review Board." (Alaska Criminal Justice Assessment Commission).

Advisory Group Members

Jim Berner
Alaska Native Tribal Health Consortium
Community Health Service

Debbie (Aquilina) Bourdukofsky
St. Paul, Alaska

Pauline Harvey
Anchorage School District

Ed Krause
Copper River Native Association

Kimberly Martus
Tribal Justice Project

Chad Morse
University of Alaska Anchorage

Scott Prinz
Alaska Native Tribal Health Consortium

Elizabeth (Cookie) Rose
Fairbanks, Alaska

Susan Soule
Community Based Suicide Prevention Program

John Smith
Quinhagak, Alaska

Elizabeth Sunnyboy
Yukon-Kuskokwim Health Corporation

Deborah Vo
Alaska Inter-Tribal Council

Chaille Yasuda
Anchorage, Alaska

Ted Borbridge
Sitka Tribal Association

Sheri Buretta
Chugach Incorporated

Victor Joseph
Tanana Chiefs Conference

Susan LaBelle
Alaska Mental Trust Authority

Doug Modig
Anchorage, Alaska

Lori Namyniuk
Convenant House

Augusta Reimer
Alaska Mental Health Alliance

David Sam
Anchorage, Alaska

George Stone
Seward, Alaska

Tom Titus
Nenana, Alaska

Chris Walunga
Anchorage, Alaska

Bibliography (Condensed)

Alaska Advisory Board on Alcoholism and Drug Abuse (January, 1999) Results Within Our Reach. Juneau, AK.

Alaska Area Native Health Service. (2000) Alaska Area Native Health Summary. Anchorage, AK: Division of Planning, Evaluation Health Statistics.

Alaska Criminal Justice Assessment Commission (May, 2000) Final Report.

Alaska Department of Labor. (May, 2000) Population Overview. 1999 Estimates.

Alaska Mental Health Board. (October, 1998) Integrated Standards and Quality of Life Indicators. Juneau, Alaska.

Alaska Mental Health Board. (December, 1998) A Shared Vision II. A Strategic Plan for Mental Health Services in Alaska 1999-2003. Juneau, Alaska.

Anders, G. (1989, January) Social and Economic Consequences of Federal Indian Policy: A Case Study of the Alaska Natives. Economic Development and Cultural Change. Volume 37, pp. 285-303.

Andersen, T. (1988) Alaska Hooch: The History of Alcohol in Early Alaska. Fairbanks: Hoo-Che-Noo.

Anne E. Casey Foundation. (2000) Rebuilding Communities Initiative. www.aecf.org

Baldwin, J.A. (1999) Conducting Drug Abuse Prevention Research in Partnership with Native American Communities: Meeting Challenges Through Collaborative Approaches. Drugs and Society. Volume 14 (1,2) pp. 77-92.

Beauvais, F. (Fall, 1998) American Indians and Alcohol. Alcohol Health and Research World, Volume 22 (4) pp. 253-260.

_____ and Segal, B. (1992) Drug Use Patterns Among American Indian and Alaskan Native Youth: Special Rural Populations. In Edwards, R. (ed) Drug Use in Rural American Communities.

Berkowitz, Gale, et al. (Summer, 1998) Community and Treatment Program Challenges for Chemically Dependent American Indian and Alaska Native Women. Contemporary Drug Problems, 25 (2) pp. 347-371.

Berman, M. & Hull, T. (April,1997) Community Control of Alcohol in Alaska. Alaska Review of Social and Economic Conditions. Volume XXXI (1).

Conn, S. & Moras, A. (1986) No Need of Gold: Alcohol Control Laws and The Alaska Native Population. Anchorage, AK: School of Justice, University of Alaska Anchorage.

Cornell, S. et al (1999) Achieving Alaska Native Self-Governance. Economics Resource Group, Inc. and the Institute of Social and Economic Research. Cambridge, MA and Anchorage, AK.

DeLoria, V. & Lytle, C.(1998) The Nations Within. Austin: University of Texas Press. Second Edition.

Dilulio, Jr. J. (1996) Saving the Children: Crime and Social Policy. In Garfinkel, Hochschild, & McLanahan (eds) Social Policies for Children. Washington, D.C. The Brookings Institution.

Dinges, N, G. & Duong-Tran, Quang. (1993) Stressful Life Events and Co-Occurring Depression, Substance Abuse and Suicidality Among American Indian and Alaska Native Adolescents Culture, Medicine, and Psychiatry, 16 pp. 487-502.

Division of Family and Youth Services. (1999) Fiscal Years 1994 and 1995 Annual Report. Juneau: Department of Health and Social Services.

Fleming, C.M. (1996) Cultural Formulation of Psychiatric Diagnosis. Culture, Medicine, and Psychiatry. Volume 20. Pp.145-154.

Fleming, C.M. (1992) American Indians and Alaska Natives: Changing Societies Past and Present. In Orlandi (ed) Cultural Competence for Evaluators.

_____ (1992) The Next Twenty Years of Prevention in Indian Country: Visionary, Complex, and Practical. American Indian and Alaska Native Mental Health Research. Volume 4(3) pp. 85-88.

Ford, William, E. (June 2000) Understanding the Purchase of Outcome in Substance Abuse Treatment. Washington, D.C. National Council on Alcoholism and Drug Abuse.

Fortuine, R. (1989) Chills and Fever: Health and Disease in the Early History of Alaska. Fairbanks: University of Alaska Press.

Foulks, Edward, F. (1989) Misalliances in the Barrow Alcohol Study. American Indian and Native Mental Health Research. 2 (3) pp. 7-17.

Gordis, Enoch. (1996) Alcohol Research and Social Policy: An Overview. Alcohol Health and Research World. 20 (4) pages 208-212.

_____. (December 3, 1997) Alcohol Problems and Public Health Policy. Journal of the American Medical Association, 278, 1781-1782.

Hisnanick, J.J. and Erickson, P.M. (1993) Hospital Resource Utilization by American Indians/Alaska Natives for Alcoholism and Alcohol Abuse. American Journal of Drug and Alcohol Abuse. Volume 19(3) pp. 387-396.

Indian Health Service (February 18, 2000) FY 2001 Performance Plan and FY 1999 Performance Report. Washington, D.C. Indian Health Service.

_____ (1998) Office of Planning, Evaluation, and Research. Regional Differences in Indian Health, 1997. (Washington, D.C.: Division of Program Statistics)

Jorgensen, J. (1996) Comment: Recent Twists and Turns in American Indian Health Care. American Journal of Public Health. Volume 86. pp. 1362-1364.

Kelaher, M., Baigrie, N., & Manderson, L. (1998) Community Perceptions of Health, Illness and Care: Identifying Issues for Indigenous Communities. Women and Health. Volume 28 (1) pp. 41-61.

Kraus, F.B., & Buffler, P.A. (1979). Sociocultural Stress and the American Native in Alaska: An Analysis of Changing Patterns of Psychiatric Illness and Alcohol Abuse Among Alaska Natives. Culture, Medicine and Psychiatry, 3, 111-151.

Kretzmann, J. & McKnight, J.P. (1996) Assets-Based Community Development. National Civic Review. (1996, Winter) 85 (4) pp. 23-29.

Kunitz, Stephen, J. (1996) The History and Politics of U.S. Health Care Policy for American Indians and Alaskan Natives. American Journal of Public Health. Volume 86. Pages 1460 -?

Landen, M.G. et al. (1997) Alcohol-Related Injury Death and Alcohol Availability in Remote Alaska. Journal of the American Medical Association, 278, 1755-1758.

Legters, L. & Lyden. F. (1994) American Indian Policy: Self-Governance and Economic Development. Westport, CN: Greenwood Press.

Lester, David (1999) Crime and the Native American. Springfield, IL: Charles C. Thomas Publisher.

Lonner, T.D. & Duff, J.K. (1983) Village Alcohol Control and the Local Option Law. Anchorage, AK: Center for Alcohol and Addiction Studies, University of Alaska Anchorage.

Man, Anton & Labreche-Gauthier, L. (1998) American Indian Perspectives on Addiction and Recovery. Health and Social Work. Volume 23 (2) pp.127-135.

Manson, Spero, M. (1992) Depression and Related Mental Illnesses Among American Indians: The Current State of the Art in Treatment. In Haller & Aitken Old Medicine Nourishing the New. pp. 81-91.

_____. (1997 June) Ethnographic Methods, Cultural Context, and Mental Illness: Bridging Different Ways of Knowing and Experience. Ethos. 25 (2) pp. 249-258.

_____. et al. (1997) Assessing Psychopathology in American Indian and Alaska Native Children and Adolescents. Applied Developmental Science. I (3) pp. 135-144.

_____ et al. (1990) Alcohol Abuse and Dependence Among American Indians. In Alcoholism in North America, Europe, and Asia. Pages 113-130.

May, Philip, A. (1996) "Overview of Alcohol Abuse Epidemiology for American Indian Populations." In Sandefur, et al, Changing Numbers, Changing Needs.

_____. (1992) Alcohol Policy Considerations For Indian Reservations and Bordertown Communities. American Indian and Alaska Native Mental Health Research. Volume 4, Number 3, pages 5-59.

_____. (1995) "Prevention of Alcohol Misuse: A Review of Health Promotion Efforts Among American Indians." American Journal of Health Promotion, Volume 9, Number 4, pages 288-299.

McCormick, R.M. (2000) Aboriginal Traditions in the Treatment of Substance Abuse. Canadian Journal of Counselling. Volume 34 (1) pp. 25-32.

McKnight, John (1995) The Careless Society: Community and Its Counterfeits. New York. Basic Books.

Minton, B.A. & Soule, S. (1990) "Two Eskimo Villages Assess Mental Health Strengths and Needs." American Indian and Alaska Native Mental Health Research, Volume 4, Number 2, pages 8-24.

Mohatt, G.V., McDiarmid, G.W., & Montoya, V.C. (1988) "Societies, Families, and Change: The Alaskan Example." In Manson & Dinges, American Indian and Alaska Native Mental Health Research. (pp. 325-368.

Mueller, M.D. & Wyman. (1997) J.R. Study Sheds New Light on the State of Drug Abuse Treatment Nationwide. www.nida.nih.gov

Nader, et al. (editors), Honoring Our Differences: Cultural Issues in the Treatment of Trauma and Loss. (Philadelphia, PA: Taylor and Frances, 1999)

National Institute on Alcohol Abuse and Alcoholism. (June, 1997) Ninth Special Report to the U.S. Congress on Alcohol and Health. Washington, D.C.: Public Health Service, National Institutes of Health.

National Opinion Research Center (2000) The National Treatment Improvement Evaluation Study. http://www.health.org/govstudy/102

_____ & Manson, Spero M. (1996) "Research in American Indian and Alaska Native Communities: Navigating the Cultural Universe of Values and Process." Journal of Consulting and Clinical Psychology. Volume 64, Number 5, pages 856-860.

Namyniuk, L., Brems, C., & Clarson, S. (1997) "Southcentral Foundation-Dena A Coy: A Model Program for the Treatment of Pregnant Substance-Abusing Women." Journal of Substance Treatment, Volume 14 (3) pages 285-295.

National Academy of Public Administration. (1999) A Study of Management and Administration: The Bureau of Indian Affairs.

National Institute on Drug Abuse. (1999) Diagnosis and Treatment of Drug Abuse in Family Practice. [Definitions, Epidemiology, Pathophysiology, Prevention, Assessment, Final Comment] www.nida.nih.gov

Noren, J. et al. (1998, January-February) Challenges to Native American Health Care. Public Health Reports. 113 (1) pp. 22-33.

North Slope Borough (1999) 1998/1999 Economic Profile and Census Report. Barrow: Department of Planning and Community Services.

Northern Community Resources. (2000) A Report on the Outcomes of Supports and Services for Persons with Developmental Disabilities, Persons with Mental Illness, and Those Receiving Early Intervention Services. Ketchikan, AK.

Norton, I.N. (1999) American Indians and Mental Health: Issues in Psychiatric Assessment and Diagnosis. In Herrera, J.M., Lawson, W.B., & Sramek, J.J. (eds) Cross-Cultural Psychiatry. N.Y.: John Wiley and Sons, Ltd.

Penn, N. et al. (2000) Health Practices and Health Care Systems Among Cultural Groups. In Eisler, R.M. & Hersen (eds) Handbook of Gender, Culture, and Health. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Pfefferbaum, R.L. et al (1997) Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices. American Indian Law Review. Volume 21 (2) pp. 211-255.

_____, et al (1995-96) Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care. American Indian Law Review. Volume 20 (2) pp. 365-381.

Rodenhauser, Paul. "Cultural Barriers to Mental Health Care Delivery in Alaska." (Winter, 1994) Journal of Mental Health Administration, Volume 21, Issue 1, pages 60-71.

Ruthven, Lea. (1999) The Medical (Disease) Model vs. The Behavioral Model. Preferred Mental Health Management. http://www.pmhm.com

_____. (1999) What Data Does a Benefit Plan Need to Assess its Behavioral Health Costs? www.pmhm.com

SAMHSA, Office of Applied Studies. (September 2000) Treatment Episode Date Set (TEDS): 1993-1998. Washington, D.C. Department of Health and Human Services.

Segal, Bernard. (1998) Drinking and Drinking-Related Problems Among Alaska Natives. Alcohol World Health and Research, 22, 276-280.

Silk-Walker, P., Walker, D., & Kivlahan, D. Alcoholism, Alcohol Abuse, and Health in American Indians and Alaska Natives. American Indian and Alaska Native Mental Health Research, 1, 65-93.

Toomey, T.L. & Wagenaar, A.C. (1998?) Policy Options for Prevention: The Case of Alcohol. Journal of Public Health Policy. Volume 20 (2) pp. 192-213.

Trimble, J.E. (1996) Essential Cultural and Social Strategies for Counseling Native American Indians. In Petersen, P.B. et al, Counseling Across Cultures.

Trimble, J.E. (1984) Drug Abuse Prevention Research Needs Among American Indians and Alaska Natives. White Cloud Journal, 3 pp. 22-33.

Walker, D.R., Lambert, D.M., Walker, P.S., & Kivlahan, D.R. (1993) Treatment Implications of Comorbid Psychopathology in American Indians. Culture, Medicine, and Psychiatry, 16 pp. 555-572.

Webb, L.D. (1996, Fall) Suicide Among American Indian Youth: The Role of the Schools in Prevention." Journal of American Indian Education, pages 22-32.

Wiebe, J. & Huebert, K.M. (1996) Community Mobile Treatment: What it is and How it Works. Journal of Substance Abuse Treatment. Volume 13 (1) pp. 23-31.

Wilkins, David, E. (Fall, 1998) Tribal-State Affairs: American States as 'Disclaiming' Sovereigns. Publius: The Journal of Federalism. Volume 28 (4) pp. 55-81.

Yutrzenka, B.A., Todd-Bazemore, E., and Caraway, S.J. Four Winds. The Evolution of Culturally Inclusive Clinical Psychology Training for Native Americans. International Review of Psychiatry. 11 pp. 129-135.

Appendix A
Village Backgrounds

Nulato is a Koyukon Indian community on the middle part of the Yukon River in Western Alaska. The Russians first entered the area in 1838 to gather more information about the river and the network of trade between interior and coastal peoples. A trading post was established to prevent the diversion of goods through intermediaries and away from the Russian American Company. At contact, it is estimated there were 300 to 400 Lower Koyukon people who lived near the intersection of the Nulato and Yukon Rivers. In 1999, Nulato was the second largest village in the Yukon-Koyukuk area. The population was 381, an increase of 6 percent since 1990.

Salmon, pike, whitefish, and grayling were their most important foods, followed by caribou, bear, beaver, muskrats, rabbits, and birds (Loyens 1966). Every year Lower Koyukon family groups migrated from salmon fishing on the Yukon in the summer, to fall hunting and trapping further south, then to the creeks for beaver in mid winter, to the lakes for muskrats in the spring. Men from different families would periodically join together to hunt caribou and bear. In mid winter most people would gather for a celebration of the dead.

Hunting, fishing, trapping, and gathering continue to be of vital importance to people in Nulato. Fish, moose, bear, ducks, geese, and ptarmagain are supplemented with imported foods. Income from employment and public programs is essential. The only full-time jobs are with the local governments, the school, and the store. In the summer, seasonal work in construction, fishing, or fire fighting is sometimes available. Commercial fishing has suffered lately because of poor salmon runs and declining prices. In 1990, 33% of those over 16 were employed; the remainder of the labor force was either unemployed (26%) or no longer looking for work (56%). The median family income was $16,875; 36 percent of incomes were below the poverty line.

Families were generally monogamous, though shamans and wealthier men occasionally took a second wife. Children were cherished. They were generally raised by their biological parents. Adoptions, especially after the flu epidemics in the nineteenth and the twentieth centuries, were common. Through story telling and example Koyukon values of honesty, industriousness, respect for the old, obedience to shamans, generosity, sharing, and hospitality were imparted (Loyens 1966).

There was no formal leader or chief in Koyukon society. There were men who were accorded great respect for their wisdom, age, experience, and influence on others. Deference was shown to shamans because of their ties to the supernatural world. Behavior was restricted more by ritual, taboo, and popular sentiment than the exercise of authority. One ethnographer noted: "Group esteem and group approval was avidly sought after and acquired by the practice of generous hospitality and bountiful distributions at mortuary celebrations. To be esteemed by public opinion was a reward well worth the impoverishment which often accompanies a lavish

distribution of gifts. To be called 'stingy' was odious and to be avoided at all costs." (Loyens, 1966) Upon the insistence of an official from the U.S. Bureau of Education, the federal agency responsible for Native welfare until 1932, the Nulato Koyukon elected a chief (toyon). Later, three councilmen were added. Their duties were limited to ceremonies and occasionally, the mediation of disputes. After the withdrawal of the U.S. marshal in 1951 the Nulato council began to exercise greater authority. Currently, Nulato is governed by a city and a tribal government.

Spiritual beliefs were an integral part of Koyukon life. There were the spirits of cold, heat, and wind; the human souls which lived on after death; evil spirits; and, yegas, which were the protective spirits possessed by all humans and animals. The spirits were guides to living life, avoiding dangers, and searching for food. Some were good. Others were evil. Shamans were thought to directly communicate with spirits. Thus, people depended on them for their curative and interpretative powers. With the spread of disease and the gospel, the power of the shaman steadily deteriorated. More of his responsibilities were taken over by priest who, after some time, gained considerable influence. According to one ethnographer:

> "The eighty years of Catholic teaching have all but obliterated the body of aboriginal religious and supernatural beliefs by which the Lower Koyukon related himself to the food quest for the realities of the spirit world. As stated earlier, it is an area of former culture of which the older informants are noticeably ignorant. The new Catholic supernaturalism has definitely supplanted the old, and thus emptied most of the remaining ceremonials of ideological content." (Loyens, 1966)

Kokyukon has been classified as a dying language. Only a few elders in Nulato and Galena still speak the original dialect. The youngest speakers are in their 40s.

Nulato was featured in the People in Peril series as a village earnestly trying to stop the flow of alcohol. In 1986, Elmer Manook, a former resident of Nulato living in Anchorage, applied to the state Alcoholic Beverage Control Board (ABC) for a license to open a liquor store just outside the village. The mayor was outraged when the state approved the application, and the directors of Gana-a'Yoo, the village corporation for the five communities in the area, leased the land for the store. In defense, the members of the ABC board argued that they should not be involved in policy issues in rural Alaska. "We're not legislators." The chief executive of the village corporation replied, when asked about the lease sale: "We didn't get into the right or wrong of the alcohol issue. Be it right or wrong, our intent was to lease it, whatever he (Manook)wanted it for." (ADN 1988)
In 1988, two residents died in alcohol-related incidents. Eventually, the state refused to renew Mr. Manook's license, after receiving a sheaf of letters and a petition signed by most of the registered voters in Nulato (ADN 1989)

The village of Unalakleet is southwest of Nulato on Norton Sound, just north of the mouth of the Unalakleet River. It is a point of transition between Iñupiat and Yu'pik peoples and an area, in the past, of intense conflict and trade between different aboriginal groups. As one student observed: local residents ". . . knew people from as far north as Kotzebue and Selawik, as far west as Wales and King Island, as far south as St. Lawrence Island, and as far inland as Nulato and

Kaltag, who came to Unalakleet on a regular basis to exchange goods and ideas." (Correll 1972)

Before the arrival of Europeans, three peoples or demes occupied the Unalakleet region, the Maalimiut, Qauviaramiut, and the Unaalilrmiut. The first were Yu'pik speakers who depended on fish, seal, and trade with other coastal families, interior Indians, and Siberians. The latter two are Iñupiat groups which were migrating south hunting caribou and trading. The majority of residents today are Iñupiat. Subsistence continues to be an important part of everyday life. Winter finds people ice fishing for tom cod, smelt, or trout, hunting for caribou and moose, and trapping for lynx, wolf, wolverine, foxes and other fur bearing animals. In the spring, migrating birds, seals, and greens are the favorite foods; during the summer, fishing and berry gathering are the predominate activities. The fall months of September and October are a time for upriver camping to fish, hunt for moose, and pick cranberries. Cranes, ducks, and geese along the rivers and seals and clams in the sea are also available (Jorgensen 1984).

During the nineteenth century missionaries and gold prospectors profoundly altered aboriginal beliefs and practices. The first prelate, representing the Swedish Evangelical Mission Church (later the Swedish Covenant Mission), arrived in 1887. Two years later a school and a home for children were built and services for the aged and sick were offered. In some ways, according to an ethnographer of the region, the church supplanted the **qasgi**, (men's house) a place where information was shared, rituals held, and important economic and political questions were answered (Correll 1972). The discovery of gold in Alaska near the end of the century led to a stream of fortune seekers through Unalakleet on their way to Nome. Many Natives found jobs as guides, translators, laborers, and occasionally, prospectors. The fever for gold even spread to the Covenant missionaries, who fled their offices and responsibilities for personal gain and wealth. This led to strained relations between Iñupiat and Yu'pik parishioners and the church. (Correll 1972)

The population of the area has been affected by disease, changes in the local economy, and fluctuations in government spending. In 1836, after an epidemic had swept through the region, only 13 people survived. In the first official census in 1880 there were 100 residents; by 1910 there were 247. There was little change in the next few decades because of Native fatalities from a worldwide influenza virus; but, after World War II, migrants from outlying villages almost doubled the size of Unalakleet (469 in 1950). During the 1950s and 60s different federal policies moved individuals and families in and out of the village. The Korean and Vietnam wars drafted eligible young men; the BIA's Relocation Program, and its replacement, the Employment Assistance Program, relocated people in cities for purposes of training and assimilation; and children, after completing elementary school, were encouraged to attend boarding schools in Sitka (Mt. Edgecumbe) and elsewhere. However, with the passage of the ANCSA and the physical improvements in village utilities and schools, the local population grew from 469 in 1970 to 805 in 1999.

The political economy of Unalakleet revolves around subsistence, active local governments, and private initiative. The Native Village of Unalakleet, formed under the Indian Reorganization Act in 1939, has been responsible for obtaining more than 11 million dollars in funds in the last ten years for housing improvements, road construction, fish processing, and tribal courts. Frank Degnan, a leader of the Native claims movement and a former state legislator from Unalakleet, was able to attract state and federal support for the construction of homes, public utilities, and a

secondary school. The Unalakleet Native Corporation manages more than 160,000 acres and a number of local businesses and joint ventures. There are also regional associations in the Bering Straits that prefer to locate in Unalakleet, because many Natives distrust the "European power structure" in Nome (National Research Council, 1999). The Bering Straits School District and the Norton Sound Economic Development Corporation[1] are both located in the city.

Incomes are higher and unemployment rates are lower in Unalakleet than in other rural communities in Western Alaska. The median family income in 1990 was $40,347. Just under twelve percent of the residents were considered poor by federal standards. Fifty-six percent of those over 16 are employed. Almost half (44%) work for private organizations or they are self-employed (2%). Formally, the rate of unemployment was 19.2%. However, a third of the labor force was no longer searching for work.

Quinhagak, the third community in this study, is the largest of four villages on the southern coast of Kuskokwim Bay, 75 miles southwest of Bethel. The population has steadily grown from 83 people in 1880, the year of the first official census, to 427 in 1982, to 595 in 1999. Much of the growth can be attributed to the consolidation of smaller villages in the area after the Moravian Church established a school in 1891. In the 1950s, school attendance became mandatory, which forced many families to relocate from smaller settlements in the area.

The residents of Quinhagak are mostly Yup'ik, who have adapted to the southern coastal regions of the Bering Sea. In the past, they divided their time between larger communities in the winter, and smaller camps for seal harvesting in the spring, and fishing in the summer. Traditional communities were built around men's houses (*qasgiq*, or *kashim*, *kasgee*, or *casine*) and smaller dwellings for women and children. The *qasgiq* was ". . . as much an institution as a physical place

> of residence. Within it, two to twenty men resided. Although they would visit their families on occasion, it was in the *qasgiq* that they took their meals, slept, worked, told stories, gossiped, took sweat baths, and made and repaired tools and equipment. Women only entered to bring food to their male relatives or to join them on the numerous ritual land ceremonial occasions when together they danced in gifts for a distribution (Fienup-Riordan, 1982).

Boys left the families to live in the *qasgiq* when they were five. They would wait on the elders and learn from their stories, their counsel, and their example. The elders, who were the head of each family line, together (*tegganeq*) had broad authority. Their word, in matters of social conflict, ritual, and custom, was definitive.

Though families live in permanent homes today, the seasonal round of subsistence continues. Seal hunting begins in January after the shore ice is completely frozen. From February through April, walruses along with seals, are taken; smelt are also jigged from the Kanektok River, which flows by the village. In the early spring arctic char, whitefish, grayling, and trout netted in the ice free parts of the river. As the ice on the bay recedes, seals are hunted along the coast in a skiff. At the end of April migratory waterfowl return to the Kuskokwim Delta. Near the end of May, families move to their fish camps for the annual run of salmon, which lasts until July. Toward the end of

summer, berry picking starts and extends through the first snowfall. From September to the end of October, small groups of hunters to up the Kanetok and Eek rivers to hunt moose, bear, squirrels, and beaver. Once the river ice is solid people drive their snowmachines, with a sled in tow, upriver for fishing, trapping, wood cutting, and hunting. (Wolfe et al, 1984)

Values like sharing, cooperation, reciprocity, and generosity continue to sustain the lifestyle of Yup'ik people. Food and resources are voluntarily shared and surpluses are widely distributed. Gifts are presented to elders out of respect for their experience and wisdom. The exchange of goods between individuals, households, and sometimes communities, is ". . . ultimately tied to the system of mutual hospitality embodied in the relationship between men and the natural world. What comes freely must be given freely in order to ensure that it will return. With the upset of this relationship, the essential egalitarianism and cooperation between hunters is threatened." (Fienup-Riordan 1982)

The impact of Russian imperialism on southwestern Alaska was weakened by remoteness, climate, and Yup'ik hostility; however, it was not without effect. The spread of smallpox in the nineteenth century killed many. The epidemic also hardened indigenous resistance to explorers, traders, and missionaries. In 1818, a Russian trading post was erected at the entrance to the Nushagak River (Alexandruouski Redoubt). Russian trade items were then added to the already active exchange of goods between Native peoples in Alaska and Siberia. The post also served as a base for occasional forays into the interior. The effect of Orthodox missionaries was superficial because of the paucity of priests and the limited demands of the church. The first American missionaries to arrive after the Treaty of Cession were Catholics and Moravians. In 1885, the Moravians selected Bethel as the original site for their first mission. In 1891, the church added a station in Quinhagak. Like the Jesuits, the Moravians first learned the aboriginal language. They then attached Yu'pik rituals and ceremonies in congregational gatherings, and in their schools and orphanages. The missionary's intent was the "establishment of an indigenous church, that was both self-governing and self supportive." (Fienup-Riordan) According to one student, they were only partially successful:

> "Although social life was significantly redirected (premarital sex and adultery denounced, marriage made into a formal contractual arrangement, divorce made difficult, and the traditional men's house abandoned), the Yup'ik retained their language, traditional standards of childbearing and adult behavioral norms, learning patterns, curing techniques, and subsistence patterns, as well as many of the components of their traditional subsistence ideology." (Fienup-Riordan 1982)

In some respects Quinhagak is a typical village in western Alaska. Incomes are low, poverty estimates are high, jobs are scarce, and employment prospects are confined to schools and government service. Despite these difficulties, or perhaps in spite of them, Quinhagak leaders are endeavoring to directly confront the communities economic and social problems. First, they revived their tribal government, the Native Village of Kwinhagak, in 1993. Then in 1996, the city and the tribe signed a Memorandum of Agreement that formally joined the two governments. Under the Agreement, the tribe administers the operations and services of the municipality. There is one unified budget which draws from state and federal sources. The two councils meet together

periodically to discuss their respective (and common) agendas. The tribe and the city carry out, equally, their policy, planning, and executive responsibilities. Disputes between the two councils are settled by the tribal court (Cornell et al, 1999).

The governing councils of Quinhagak have achieved some success. They replaced a moribund and underfunded state justice program with an active tribal police force and a tribal court. In the last three years, the village has obtained more than 12 million dollars for improvements in housing and transportation and the construction of a community center. The tribe now employs over 60 people, almost half of the local workforce. Community leaders also work closely with staff and teachers at Kuinerrarmiut Elitnaurviat ("school of the people of Quinhagak") to integrate Yup'ik beliefs and language with instruction in English. According to a recent assessment, these efforts have led to improved language skills, increased parental involvement, the certification of Yup'ik teachers, more opportunities to learn about Yup'ik values and traditions, and better standardized test scores. (Kushman & Barnhardt, October 1999)

The village has also sought more of a voice in the management and protection of their subsistence resources. Here, the tribe encountered opposition. Faced with an increasing number of commercial guiding and sportfishing along the Kanetok River, the tribe began to post warning signs and impose fines on anglers. In 1997, the Quinhagak government proposed a contract with the state where they would enforce trespassing and sanitation rules. The following year the governor announced that ". . . it will not delegate police authority over sportfishing tourists to the tribal government of Quinhagak. Instead, the state plans to enlarge its own official presence in the area by sending extra money and personnel to the Southwest Alaska community." (Anchorage Daily News, July 1998).

Appendix B
Funding Community Mental Health/Substance Abuse Programs

Introduction

The search for sources of funds for a village mental health and substance abuse center is bounded by two considerations, compatibility and relevance. The conditions and requirements of a grant must be consistent with village recommendations, i.e., devolution of substance abuse prevention and treatment services, support for traditional and culturally sensitive care, the training and employment of local residents. Secondly, it is assumed that the preference for more effective and responsive community health program is part of a larger effort to achieve self-government and self-determination. Therefore, many of the funding alternatives that are considered don't normally assist health care projects, but do support efforts to increase the capacity of tribes, local governments, and other organizations.

The search was confined to the Catalog for Federal Domestic Assistance, resources of the Foundation Center (FC Search), the National Institutes of Health, the state Division of Alcohol and Drug Abuse, Science Wise (Minority On-Line Information service), an electronic information service, and discussions with representatives of three Alaska donors.

Local Sources of Funds: The Denali Commission

The Denali Commission[1] was created in 1998 to work on economic development projects in isolated rural communities in Alaska. According to the Denali Commission Act of 1998 the purposes of the Commission are: "(1) To deliver the services of the Federal Government in the most cost-effective manner practicable by reducing administrative and overhead costs; (2) To provide job training and other economic development services in rural communities, particularly distressed communities; (3) To promote rural development, provide power generation and transmission facilities, modern communication systems, bulk fuel storage tanks, water and sewer systems, and other infrastructure needs." (Denali Commission, November 1999). Senator Ted Stevens, the primary sponsor of the legislation, envisions the Commission as a mini Appalachian Regional Commission, which was organized in 1964 to assist poorer communities in thirteen states.

The Commission first supported rural energy projects like the repair of leaky bulk fuel storage tanks. Near the end of 1999 Congress ". . . authorized demonstration projects between the Commission and the U.S. Department of Health and Human Services (DHHS) that can extend beyond primary care facilities, e.g., into hospitals, mental health facilities, elder care and child care facilities." (Denali Commission, October 2000). In January, 2000 rural health care and services were selected as a second area of concentration. A steering committee was created to carry out a needs assessment of rural health facilities and services and develop a methodology of distributing funds to eligible villages.

The Commission completed the initial assessment of rural primary health care in October of

last year. Village representatives were asked to fill out a 27 page questionnaire that summarized local physical health facilities and program services. The survey indicated that 305,316 square feet of space and over 200 million dollars was required to meet the health needs of village residents. The criteria that will be used to determine which villages are eligible to receive financial aid are **facility deficiency** (space available, age and condition of facilities), **health status** (fertility, teenage births, mortality, suicide rate, injuries, homicides, heart disease, cancer), **isolation of community**, **dependency ratio** (number of elderly and youth divided by working age population), **economic status** (per capita income), **trauma registry**, and **seasonal population fluctuation** (demands on local services).

Funding proposals will be evaluated based on the following standards:

	Points
• **local support for the projects**	**0**
• **site availability and control**	**0**
• **utility extension plan**	0
• **cost sharing**	**20**
• **service delivery plan**	**10**
• **business plan**	**10**
• **facility related deficiencies**	**45**
• **consistency with overall community development plan**	**5**
• **multi-use components of project**	**5**
• **project management plan**	**5**
Total	**100**

Clinics or other facilities supported by the Denali Commission must be managed by a non-profit organization, and the services must be accessible to everyone in the area. Projects funds are limited to one million dollars. Funds may be used for planning, designing, repair or renovation of older structures, new construction, permanent medical equipment.

According to the director of the Commission's Health Committee, Karen Pearson,[2] there will be a Request for Proposal (RFP) issued soon for small communities to apply for funding a clinic health facility. A second RFP for a larger clinic will be published sometime later. There will be rooms available in the clinic for mental health and family counseling. The director personally feels "it would be quite a stretch to use these dollars now for residential mental health and substance abuse facilities." However, she encourages villages to see if such proposals might fit into what the Denali Commission wants to accomplish. According to her letter: "I wouldn't necessarily put Denali Commission funding out as a source for these types of facilities because it could create false hope, but I also wouldn't exclude the possibility it might in the future be a possibility. Right now, the focus is on ensuring basic physical health services are available in every community in the State, as a foundation from which to build more comprehensive services over time." (Personal Communication, March 19, 2001)

Local source of funds: The Alaska Mental Health Trust Authority.

The Alaska Mental Health Trust Authority was created in 1956 to insure that a comprehensive and integrated mental health program would be available for individuals suffering from mental illness, mental retardation or similar disabilities, chronic alcoholism with psychosis, or Alzheimer's disease or related dementia. Each group is represented by one of the following boards: the Alaska Mental Health Board, the Governor's Advisory Board on Alcoholism and Drug Abuse, the Commission on Aging, and the Governor's Council on Disabilities and Special Education. The responsibilities of the Trust include: enhancement and protection of the Trust's land and financial assets; leadership in the advocacy, planning, implementing, and funding of mental health programs; coordination with state agencies that work with the beneficiaries of the Trust; the review and consideration of recommendations from program advisory boards, e.g., Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Board; prepare reports for the legislature, the governor, and the Alaska public; and, propose a budget for the state's mental health program.

Originally the state was allowed to select one million acres of federal land for the Trust. Unfortunately, over half the land was distributed to parks, local governments, and private individuals. In 1985 a lawsuit was filed demanding that the Trust be restored. In 1994 the Trust was reestablished with 500,000 acres of original lands, 500,000 acres of replacement lands, and $200 million dollars. The Trustees are obligated to manage these assets in a way that funds services to those in need. The Trust contracts with the Alaska Department of Natural Resources (the Mental Health Trust Land Office) to administer the 1,000,000 acres. The Alaska Permanent Fund Corporation manages the Trust's money and invests annual revenues.

The Alaska Mental Health Trust Authority makes recommendations to the state for the funding of mental health program services and funds operating budget and capital projects, and small undertakings (under $5,000) every year. The Trust could be an important source of funds for a village mental health program. By law programs funded by the Trust must be provided as close to the beneficiary's home and family as possible. There is also increasing support for bypassing institutions and providing services directly to individuals and groups in the community.

To apply for funding a village must first submit a conceptual letter or outline of the proposed residential treatment facility and program to either the Governor's Advisory Board on Alcoholism and Drug Abuse[3] or the Alaska Mental Health Board.[4] The advisory board then forwards its recommendation to the Board of Trustees who oversee the Alaska Mental Health Trust Authority.[5] Initially, the staff and board look at how well the proposal fits into the Trust "guiding principles"[6] and current funding initiatives, whether it meet the Trust's criteria, the degree of support from planning board and advocate groups, and if alternative sources of funding have been explored. For fiscal year 2002, the Trust did recommend funding for two rural substance abuse programs, Substance Abuse Treatment for Rural Women and Children ($750,000) and Family Wellness Camps ($243,000).

Local Sources of Funds: The Rasmuson Foundation

The Rasmuson Foundation, founded in 1955, supports non-profit organizations "that are focused and effective in the pursuit of their goals, with special consideration for those organizations that demonstrate strong leadership, clarity of purpose, and cautious use of resources. The Foundation

trustees believe successful organizations can sustain their basic operations through other means of support and prefer to assist organizations with specific needs, focusing on requests which allow the organizations to become more efficient and effective. The trustees look favorably on organizations which demonstrate broad community support, superior fiscal management, and matching project support." (From Foundation's website: http://www.rasmuson.org).

The Foundation will support Tier 1 proposals(for under $25,000) for capital expenditures, e.g. refurbishing office, purchase of equipment (copiers, computers), updating technology. Funds are also available for Tier 2 projects in excess of $25,000, for capital costs, new initiatives, or the enhancement of existing programs. In 2000, the average Tier 2 award was $123,000. The awards ranged from $700,000 (to United Way in Anchorage for Shared Services Initiative) to $25,000 (Calista Elder's Council to preserve and share Yup'ik 'Way of Being'). Ninety-three percent of the grant monies($2,496,000) were dedicated to organizations in Anchorage and Fairbanks.

I spoke with the administrator of the Rasmuson Foundation, Diane Kaplan, about this study. They would be interested in the project if it were connected to other regional or state organizations with more experience and expertise, e.g., the relevant regional health corporations (Yukon-Kuskokwim Health Corporation, Norton Sound Health Corporation), the tribal health initiative (Denali Commission), or the rural providers training program at the University of Alaska Fairbanks. Interested organizations should submit a cover sheet (available at website) and letter of inquiry by September 30th. The letter should include **background** (brief history of the organization, the services that are provided, the area that is served, and the number of beneficiaries), **project** (description of project, need, timeline, value), **estimated costs** (total cost, amount raised thus far, amount requested from Rasmuson, how project will be sustained). Send the cover sheet and letter to The Rasmuson Foundation, 301 West Northern Lights Blvd., Suite 443, Anchorage, AK 99503. Fax: 907-279-2870. E-mail: rasmusonfdn@ak.net

Local sources of funds: The Division of Alcoholism and Drug Abuse (Alaska Department of Health and Social Services).

The Division is soliciting proposals to provide substance abuse prevention services, particularly if they ". . . arise out of community and statewide initiatives to address local problems."According to the program description:

> "Successful applicants must develop a project based upon an accurate assessment of community need, including data on the characteristics of individuals, families, schools, and other institutions; a resource assessment, including data on the community assets that are or could be used for prevention services; and, an assessment of community readiness, including data on community attitudes and the strengths of the applicant organization. This assessment should logically lead to an identification of what strategies are likely to be successful in a particular community, what changes a community needs to make to improve prevention success, and what additional local organizations need to be involved as partners in the service delivery."

As part of the Child Abuse Prevention and Treatment Act amendments passed by Congress

in 1996 the state offers Community Based Resource and Support Grant Family programs. According to the Request for Proposal "(T)hese programs must be responsive to the unique and diverse strengths of the whole community. It is hoped these funds will foster the development of a continuum of preventive services for families that are family-centered and culturally competent." There is also a requirement that communities must form a partnership with state agencies "coordination and responsibility."

There are also state funds for substance abuse treatment services for rural women and children. Residential and/or outpatient care and after/continuing care must be provided. "Successful applicants must present a system of care, either directly or through partnership with other resources, that meets the individual needs of women and children."

National Sources: Private Foundations

The Robert Wood Johnson Foundation is the largest foundation dedicated to improving American health and health care. Their financial support is concentrated in three areas: increasing access to basic health care at a reasonable cost; improving care and support for people with chronic health problems; and promoting health and the prevention of disease by reducing the harm caused by the abuse of tobacco, alcohol, and illicit drugs.

Three of the foundations grant making priorities in the in substance abuse field are relevant to an Alaska rural village health program: reducing the negative health and social consequences of alcohol and illegal drug abuse; understanding how social isolation contributes to poor health and strengthening social support and connectedness; and, promoting leadership and tool development for population-wide approaches to health improvement. Awards range from $2,000 to $14 million. The average grant amount is $275,000.

The Foundation now funds a dozen Healthy Nations initiatives to help reduce substance abuse among Native Americans. The Central Council of the Tlingit and Haida Indian Tribes ($899,915) and the Norton Sound Health Corporation ($677,556) receive support from this program. In the current Calls for Proposal, the **Local Initiative Funding Partners Program (LIFP) 2002** might cover a proposal for a village treatment program. The Initiative seeks to establish partnerships between the Foundation and local grantees in support of innovative, community-based projects that improve health and health care for under served and at risk populations. The program provides 36 to 48 month grants of $100,000 to $500,000. Local organizations must match these funds. "In special circumstances-when it can be demonstrated that no other philanthropic support is accessible in the region-city, county, or state funds may be considered as a source of matching dollars." The applicant must prepare a concept paper describing the project. The paper must be typewritten, double-spaced, and succinct (not to exceed 6 pages). The paper must include a one page budget and an explanation of the need for the project, population served, goals, intervention strategy, and measurable outcomes; the project's consistency with the mission of the Foundation; the distinctiveness of the project; the integration of the project with existing services; the degree of community support; and the long-term plan for maintaining the program.

Inquiries and applications should be sent to Pauline M. Seitz [Director] or Orrin

Hardgrove [Deputy Director], Local Initiative Funding Partners Program, c/o Health Research and Educational Trust of New Jersey, 760 Alexander Road, Princeton, N.J. 08543-0001. Telephone: 609-275-4128. E-mail: thardgrove@njha.com Web Site: www.lifp.org **Deadline for the initial concept letter is August 1, 2001.**

The Foundation also considers proposals that match their areas of interest (accessibility, improved care, and reduction of substance abuse). General letters of inquiry should (in five pages or less) briefly describe the projects and the principal objectives, the proposed intervention, the rationale for the project, the expected outcome(s), the qualifications of the applicant, the project's timetable, the estimated budget, the evaluation plan, the plan for keeping the project going after funding is ended, the name of the local contact person. Letters should be addressed to Richard Toth, Director, Office of Proposal Management, The Robert Wood Johnson Foundation, Route 1 and College Road, P.O. Box 2316, Princeton, NJ 08543-2316.

The Anne E. Casey Foundation

The Anne E. Casey Foundation supports efforts to build better futures for disadvantaged children and families through the reform of public systems, the promotion of accountability and innovation, and the transformation of communities. The Foundation works with neighborhoods and state and local governments with grants to public and non-profit organizations to strengthen services, social networks, physical facilities, employment, self-determination, and the economic vitality of distressed neighborhoods.

The Foundation assumes that in many distressed areas public and private services are expensive, fragmented, and physically and culturally removed from supposed beneficiaries. The Foundation's investments "reflect a resolve to refashion human service systems in ways that will make them more relevant, respectful, and rooted in the communities they serve." The Foundation seeks to influence policy-making through the dissemination of accurate information and support for constructive action on behalf of families and neglected communities. The working premise of the Foundation is that "(K)ids do better when their families do better, and families do better when they live in supportive communities."(Anne E. Casey Foundation, 2001)

These ideas have led to a new direction in grant making for the Foundation, the Neighborhood Transformation/Family Development initiative. It "encompasses a broad range of activities designed to advance policies, programs, and practices that contribute to strong families and vital neighborhoods. These activities, on a national scale, include building public will; supporting system reforms; promoting policies that recognize the central role of family and neighborhood in child outcomes; and connecting and strengthening institutions, organizations, research, and practice in the field." Through the **Making Connections** program, the Foundation hopes to "improve neighborhood conditions in ways that give families the best possible opportunity for success. Our goal is to engage residents, civic groups, political leaders, grassroots groups, public and private sector leadership, and faith-based organizations in an all-out effort to help transform tough neighborhoods into family supporting environments." The intent is to support efforts that offer opportunities for families to work and earn a decent living, to foster and protect social relations between families, friends, neighbors, and community organizations, and to fund ". . . services that

are accessible, responsive, and culturally appropriate." (Anne E. Casey Foundation, 2001).

Villages applying to the Foundation for funds should submit a three page typewritten letter outlining their proposal, the goals of the project, the population served, the amount of the funds requested, and a brief history of the organization. Inquiries should be addressed to the Anne E. Casey Foundation, Attention: Office of the President, 701 St. Paul Street, Baltimore, MD 21202.

The W.K. Kellogg Foundation

The focus of the Kellogg Foundation is ". . . building the capacity of individuals, communities, and institutions to solve their own problems." Many of the values and principles that guide the work of the Foundation are consistent with village ideas. They include the assumption that all communities have assets, including history, knowledge, and the power to define and solve their problems; support for the development of individuals and families leads the growth of healthy communities; the belief that the richness and energy of life are determined by the synergy of the mind, body, and the spirit; and, that healthy people emphasize prevention over treatment

The Foundation is familiar with rural Alaska and Alaska Natives. For years Kellogg supported an Alaska Native leadership program. The Foundation does assist both health and rural community initiatives. The preference is for comprehensive health care proposals organized around public health, prevention, and primary health care; and, comprehensive approaches to rural development that stress problem solving, the cultivation of leaders, more effective human services, and the training of local government officials.

Kellogg encourages applicants to submit funding requests on line. Alternatively, a brief (5 pages and under) pre-proposal letter should be addressed to: Supervisor of Proposal Processing, W.K. Kellogg Foundation, One Michigan Avenue, Battle Creek, Michigan 49017-4058. The letter should include the contact name, the organization, mailing address, phone numbers and e-mail addresses, grant purpose statement (40 to 50 words), dollar amount requested, project activities (who will be served, operational procedures, time schedules), outcomes, and personnel and financial resources available and needed.

National Sources: Federal Funds

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the major federal source of funds for alcohol and drug programs in Alaska. Over 23 million dollars was appropriated for substance abuse and mental health services in 2000. Twenty-one percent ($4,751,294) of the funds supported formula based programs;[7] the remainder were discretionary monies for mental health ($$1,811,061), substance abuse prevention ($3,174,143), and substance abuse treatment ($13,409,752). Table I summarizes the rural programs funded by SAMSHA last year. SAMHSA will sponsor three programs that might aid village organizations and behavioral health initiatives. First, is the **Strengthening Minority Communities Program**[8] which encourages racial and ethnic minorities to enter into cooperative agreements to improve the quality and

Table I. SAMSHA Funds for Rural Alaska FY2000 (a)		
Program	Grantee	Level of Funding
Yuut Ikaiyuquulluteng/People Working Together Program	Yukon Kuskokwim Health Corporation	$1,250.00
Circles of Care	Fairbanks Native Association	$292,481
Expansion for Substance Abuse Treatment (Inhalant Intervention)	Yukon Kuskokwim Health Corporation	$1,500,000
Expansion for Substance Abuse Treatment-Village Sobriety Project	Yukon Kuskokwim Health Corporation	$701,584
Residential Treatment Camp for 15 men and women in cultural setting	Copper River Native Association	$416,973
Enhanced Treatment for young adults with substance abuse and emotional problems	Norton Sound Health Corporation	$749,083
Expanded substance abuse services for women & children in rural southeast	Search	$475,000
a: The first two programs are funded through the Center for Mental Health Services (SAMSHA) for serious emotion disorders. The rests are funded through the Center for Substance Prevention or Treatment.		

efficiency of the treatment of substance abuse. The donor assumes that better organized services leads to more effective treatment. This grant may not directly fund a new village mental health program for it stipulates that providers involved in the agreement "must have been providing

substance abuse treatment services for a minimum of two years prior to the date of this application. SAMSHA believes that only existing, experienced providers have the infrastructure and expertise to provide services and to address emerging and unmet needs as quickly as possible."

Approximately $2.5 million dollars($300,000 to $600,000 per year in indirect and direct costs) will be available to fund five to eight cooperative agreements for three years. Tribal and local governments are eligible to apply. Applications should be sent to SAMSHA Programs, Center for Scientific Review, National Institutes of Health, Suite 1040, 6701 Rockledge Drive MSC-7710, Bethesda, MD 20892-7710. Applications are due May 21, 2001. For program issues contact Ali Manwar at (301) 443-0816 or amanwar@samhsa.gov; management questions contact Kathleen Sample at (301) 443-9667 or ksample@samhsa.gov.

The **Circles of Care** project[9] is for tribal and urban Indian communities plagued with high rates of depression, substance abuse, child abuse, and related family problems. While the program is primarily designed for mental health services for children and adolescents (under 22 and their families) the intentions of the project are compatible with what was said in village meetings in Quinhagak, Unalakleet, and Nulato. The goals of Circles of Care are: (1) to support the development systems of care that are designed by American Indian/Alaska Native community

members; (2) to put tribal and Indians organizations in a good position to secure funding; (3) to develop a body of knowledge to assist organizations in improving care for American Indians and Alaska Natives; and, (4) to reduce the rate of suicide and increase the proportion of children with mental health problems.

The **Recovery Community Development and Community Mobilization** program, or Recovery Community Support Program for short, provides assistance for the development of recovery community organizations[10] or facilitating organizations that enable the formation of recovery movements.[11] In this section (Track I) two million dollars is available to fund up to eleven grants ranging in amounts from $175,000 to $200,000 per year (both direct and indirect costs). The grant period is for five years. There is also a second section of the program (Track II) that supports the enhancement and replication of successful recovery community organizations. There will be two million dollars available for eight grants over a three year period.

Proposals must be submitted by May 16, 2001. Applications should be sent to Center for Scientific Review, National Institutes of Health, Suite 1040, 6701 Rockledge Drive MSC-7710, Bethesda, MD 20892-7710. For questions about the program contact Catherine Nugent at (301) 443-2662 or enugent@samhsa.gov; for questions about management issues contact Kathleen Sample at 301-443-9667 or ksample@samsha.gov.

There are also various federal grants which may tie in with a village behavioral health program. They have not been evaluated but are included for purposes of discussion. Many of these are familiar to village leaders.

SAMHSA: Center for Substance Abuse Treatment. **Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth.** Funds cooperative agreements to encourage communities to strengthen their drug and alcohol identification, referral, and treatment system for younger people 21 and under. Requires the participation of experience and licensed providers because SAMHSA believes only they have the "infrastructure and expertise to provide services and to address emerging and unmet needs of youth and their families in a timely fashion, with state-of-the-art treatment interventions." For program issues contact Randolph Muck, (301) 443-6574 or rmuch@samhsa.gov for grants management questions Kathleen Sample at 301-443-9667 or ksample@samhsa.gov

Office of Justice Programs, Department of Justice. **Violence Against Women Discretionary Grants for Indian Tribal Governments.** Assistance for Indian governments to develop and strengthen effective law enforcement and prosecution strategies to combat violent crimes against women, and to develop and strengthen victim services in cases involving crimes against women. Contact Office of Justice Programs, Violence Against Women Office, Department of Justice, 810 Seventh Street, NW Washington, D.C. 20531. 202-307-6026.

Office of Justice Programs. **Children's Justice Act Partnerships for Indian Communities.** Funds are available specifically for the purpose of assisting Indian tribes in developing, establishing, and operating programs designed to improve (a) the handling of child abuse cases, particularly cases

of child sexual abuse, in a manner which limits additional trauma to the victim, and (b) the investigation and prosecution of cases of child abuse, particularly child sexual abuse. Contact Cathy Sanders, Deputy Director, Federal Crime Victims Division, Office of Justice programs at 202-616-3578 or cathy@ojp.usdoj.gov

Public and Indian Housing (HUD). **Indian Community Development Block Grant Program**. Indian tribes and Alaska Native villages may use block grants to improve the housing stock, provide community facilities, make infrastructure improvements, and expand job opportunities by supporting the economic development of their communities. Web address: http://www.hud.gov/progdesc/pihindx.html or National Office of Native American Programs, 303-675-1600.

Indian Health Service. **Health Management Development Program**. To improve the quality of the health of American Indians and Alaska Natives by providing a full range of health services; and to improve the management capability of American Indians and Alaska Natives to assume operation of all or part of an existing IHS direct-operated health program. National contact: Deanna Dick, Office of Management Support, IHS. 301-443-6290. Web address: http://www.ihs.gov

SAMSHSA. **Demonstration Grants for Residential Treatment for Women and Their Children**. Funds for alcohol and other drug treatment services delivered in a residential setting, coupled with primary health, mental health, and social services for women, their infants and children that can improve overall treatment outcomes for the woman, here children, and her family. Contact Clifton Mitchell, at 301-443-8802.

Indian Health Service. **Tribal Self-Governance Demonstration Program: Planning and Negotiation Cooperative Agreements and IHS Compacts**. Financial assistance to enable Indian tribes to assume management of IHS and DHHS services. Contact Paula Williams, Director, Office of Tribal Self-Governance at 301-443-7821.

Office of Justice Programs. **Rural Domestic Violence and Child Victimization Enforcement Grant Program**. To implement, expand, and establish cooperative efforts and projects between law enforcement officers, prosecutors, victim advocacy groups, and others to investigate and prosecute incidents of domestic violence and child abuse. Contact Violence Against Women Office at 202-307-6026.

Health Resources and Services Administration (DHHS). **Rural Health Outreach and Rural Network Development Program**. To expand access to, coordinate, restrain the costs of, and to improve the quality of essential health services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions. Contact Eileen Holloran, Grant Programs Coordinator at 301-443-7529.

Administration for Children and Families (DHHS). **Native American Programs**. To provide assistance to public and private non-profit organizations including Indian tribes and Alaska Native villages, for the development and implementation of social and economic development

strategies that promote self-sufficiency. Contact Leon McKoy, Program Operations, at 202-690-6320.

Office of the Secretary, DHHS. **Project Grants for Facilities to Improve the Health Status of Minority Populations**. To construct, renovate, expand, repair, or modernize facilities designed to promote the improvement of the health status of minority underserved communities and populations including American Indians and Alaska Natives. **No funding for 2000 or 2001.** Contact Tuei Doong, Deputy Director, Office of Minority Health at 301-443-5084.

Office of the Secretary, DHHS. **Cooperative Agreements to Improve the Health Status of Minority Populations**. To support activities why may improve health and quality of life of racial/ethnic minorities. Contact Cynthia H. Amis, Director, Division of Program Operations, Office of Minority Health at 301-594-0769.

Rural Housing Service, Department of Agriculture. **Community Facilities and Loans**. Funds to construct, enlarge, extend, or otherwise improve community facilities providing essential services to rural residents. Contact Deputy Administrator, Community Programs, Rural Housing Service at 202-720-1490.

SAMHSA. **Demonstration Grants for the Prevention of Alcohol and Drug Abuse Among High-Risk Populations**. Funds for projects to demonstrate effective community-based models for the prevention and early intervention of alcohol and drug abuse among high-risk youth. **No funds for 2000 or 2001.** Contact Stephen Gardner, Division of Knowledge Development and Evaluation at 301-443-9110.

Office of Public and Indian Housing (HUD). **Public and Indian Housing Drug Elimination Program.** Assist public housing agencies and tribally designated housing entities to develop a plan to deal with problem of drug related crime around Indian housing developments. Contact Office of Public and Indian Housing, Public and Assisted Housing Delivery, Community and Safety and Conservation Division at 202-708-1197.

End Notes

1. Commission members include Fran Ulmer (Lt. Governor and state co-chair), Jeffrey Staser (Federal co-chair), Mark Hamilton (President of the University of Alaska), Julie Kitka (President of AFN), Mano Frey (Executive President, Alaska State AFL-CIO), Kevin Ritchie (Executive Director of Alaska Municipal League), and Henry Springer (Executive Director [ret], Associated General Contractors of Alaska).

2. E-mail is: Karen_Pearson@health.state.us and phone number in Juneau 907-465-8615.

3. Pam Watts is the executive director. The address is: Advisory Board on Alcoholism and Drug Abuse, P.O. Box 110608, Juneau, Alaska 99811-0608. Phone numbers: 907-464-8920; FAX 464-4410. E-mail: pam_watts@health.state.ak.us

4. Richard Rainery is the acting executive director. The address is: Alaska Mental Health Board, 431 N. Franklin Street, Suite 200. Juneau, AK 99801-1121. Phone numbers: 907-465-3071, FAX 465-3079. E-mail: rainery@pobox.alaska.net

5. Currently the members are: Caren Robinson [chair], John Pugh [Vice Chair], Tom Hawkins [Chair of Asset Management Committee], John Malone [Chair of Program and Planning Committee], Nelson Page [Chair of Budget Committee], Susan LaBelle [Secretary/Treasurer, Chair of Rural Outreach Ad Hoc Committee].

6. The Trust's guiding principles for creating a comprehensive integrated mental health plan are: is the plan oriented toward change? Is the plan inclusive (wide range of participants)? Is the plan directed by certain preferred practices, e.g., services should be close to home, support for individual and community initiatives? Does the programs direct benefit the consumer? Are measurable indicators (for performance) and accurate date included in the plan?

7. Formula grants make funds available automatically based on state and local conditions related to mental health and substance abuse. The two largest block grants for Substance Abuse and Treatment ($3,440,623) and Community Mental Health Services ($715,829).

8. Longer title is Cooperative Agreement for Strengthening Comprehensive Substance Abuse Treatment Systems for Racial/Ethnic Minority Communities.

9. Full title: Circle of Care: Planning, Designing, and Assessing Mental Health Service System Models for American Indian and Alaska Native Children and their Families.

10. Recovery Community Organizations are comprised of and led by people in recovery and their family members and allies. Facilitating Organizations may not necessarily include people in recovery; however, people in recovery and their families must be involved in all aspects of application development, program design and implementation, and evaluation.

11. For the relevance and value of recovery movements see the work of William A. White (2000) that portrays alcoholism and addictions as problems, for which there are solutions. The accent is on the possibility of recovery and the importance of supporting a variety of accessible, worthy treatment and recovery programs, and the removal of legal, social, and political impediments to recovery.

PROPERTY OF
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000