COMPREHENSIVE TREATMENT PROGRAM

FOR

INDIAN PROBLEM DRINKERS

Conducted by

Office of the Governor,

State of Iowa

In Cooperation with

State Office of Economic Opportunity

and

Division of Vocational Rehabilitation Education & Services

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Significant Findings for Rehabilitation and Social Service Workers

The complexities of problem drinking, alcoholism, and alcoholism abuse in relation to the limited knowledge about cause and treatment makes it very difficult and almost impossible to state a solution or some solutions. The many ambiguities of problem drinking makes this illness the nation's number one medical-social problem among American Indians.

Anthropologists suggest that the problem drinking Indian appears to be using alcohol largely for euphoric purposes as a means of socializing and less for the reasons of reducing tension. These occasions in which Indians drink are euphoric, such as, return from several weeks of absences, a large gathering for some event, or the arrival of a subsistence payment.

The drinking attitudes and differential drinking patterns present a special kind of alcoholism problem for this group. These appear to be definable problem drinkers of a special nature. It is a behavioral pattern of use in which drinking is periodic, explosive, and centered around fellowship and peer group interaction.

The changing of a cultural supported activity concerning an individual or group, therapeutically not motivated, that has some personality factors which tend to reinforce a very different type or unique pattern of drinking behavior are several of the complexities of this rehabilitation program.

Aside from this cultural difference and unique pattern of drinking is that the American Indian is no longer vanishing, but probably the nation's fastest growing minority. Recent statistics on the birth rates of Indians claim they are increasing two and one-half times that of whites with the majority of them under twenty years of age. In 1910, the Indian population was at an all time low of 220,000 but has since increased to a recent reported figure of 791,839.

The comprehensive rehabilitation program of these problem drinkers must be approached from the standpoint of a health problem with additional emphasis placed on motivation and acculturation. This starting point would begin to develop a moderation of drinking in their culture, thus have them overcome their apathy, define their problem drinking themselves and attempt to manage it.

Indian specialists trained in alcoholism at all counseling or functional levels are utilized to provide services to the problem drinker and develop change within the community. This personal empathy and concern of these workers is the basic element that may motivate the client to do something about his destructive drinking. The specialist identifies more closely with the group, can overcome communication barriers and cultural values that are not understood or misunderstood by others.

After significant management of this deviate drinking behavior, vocational planning and training should be phased in according to the readiness and feasibility of each client. But despite all this planning and individual progress there still will be a high recidivism rate among this group. Progress and change in this specific type of rehabilitation program is exceptionally slow.

The Indian problem drinking rehabilitation services should be continued as a coordinated treatment program. The process of referral to the caregiving agencies should be strengthened, expanded and utilized to an even greater extent.

Training and employing Indian subprofessional counselors can help overcome complex attitudes, cultural variants, general feelings and language barriers of this group.

Usually in the past clients have been incarcerated for a drinking related incident. Generally this punitive approach tends to solidify the Indian drinking group rather than creating a confrontation of this destructive drinking. A cooperative effort should be continued to develop alternate techniques and methods for handling public intoxication.

The Alcoholics Anonymous program should be strengthened and made more meaningful to the Indian problem drinker. The educational efforts and printed material must be based on situations that are familiar and important to these people.

More use should be made of the Disulfiram (antabuse) program as it becomes accepted by the problem drinker and the caregiving agencies. For certain inebriates this is the only alternate to counter the drinking group pressure.

The treatment methods used by the project are to utilize a variety of approaches, non-medical as well as medical. In this type of program every agency, resource and method is an important contribution to the client's rehabilitation and to the development of an alcoholism program.

In coordinating all the community resources estimates from the base line material, follow-up information and staff evaluation indicated a significantly higher percentage of employment, less absenteeism from work, a relative decrease in arrests for drunkenness, and higher self-esteem in these Indian problem drinkers.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

After centuries of injustice and inequity, the American Indians are still the most deprived and most isolated group in the United States. References to these conditions in a recent two volume publication by the Senate-House Economics Committee states, "By virtually every available measure of economic and social well-being-family, income, employment opportunity, educational opportunity, housing quality-the American Indian continues to be the most poverty stricken and disadvantaged group in the American society."[1] As a group of people, the Indians are clearly the most neglected, misunderstood, and repressed minority of our time.

Other references in magazines and news articles illustrate the Indian's deprivation and poverty at a time of an affluent society with a high standard of living. Recently statistics quoted by the executive director, National Indian Council, cites these deplorable conditions: family income, around $1,500; 80 percent of all dwellings are substandard; 70 percent of the Indian children do not finish high school, and only one percent of the Indian population go on to college, and of that one percent, 60 percent drop out.[2]

Similar conditions exist on the Navajo Reservation, according to a school administrator from the Many Farms Community College. This reservation, the largest Indian territory in the United States, with 25,000 square miles of land in Arizona, New Mexico, Colorado, and Utah, has 60 percent of its population unemployed; 70 percent of the adult population cannot read or write English; half the population is under 25 years of age; the average number of years of schooling for the adults is three years; the average income is less than $700 annually per family.[3]

Other indications of the Indian's condition and suffering are staggering and appalling. The Indian's life is relatively short, his infants are more likely to die, his own bad health contributes to his unemployability, suicide, or suicide attempts. His life expectancy is 44 years, compared with 71 for the parent society. Unemployment ranges from a low of 20 percent on the more affluent reservations, to 80 percent on the poorest.[4]

Previous government commitments, excessive paternalism, special pilot projects confined to the reservation, or programsof assimilation into the mainstream of society all have one thing in common--they have failed.

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[1]"Study Shows Indian Most Disadvantaged," Sioux City Journal, 1970.

[2]Wilkinson, Gerald T., "Notable & Quotables," Wall Street Journal, August 8, 1970.

[3]England, Mike, "Education Key to Indians' Future," Cedar Rapids Gazette, November 6, 1970.

[4]"The Angry American Indian: Starting Down," Time, February 9, 1970.

Citing these conditions of deprivation and poverty, administration officials are calling "for a new era in which the Indian's future is determined by Indian acts and decisions." This policy is to strike a common middle ground between a federal hand-off policy towards the Indian on the one hand, and excessive paternalism on the other.[5]

Any plan of action, such as economic development among the Indian tribes and their people, must be compatible with the Indians' own sense of value if it is to succeed. It should be apparent that the American Indian, in many cases, does not want to abandon his identity and his traditional cultural and social values. This culture places a high value on preservation of the natural environment, on sharing, on maintaining a life style which allows time for quiet and contemplation. Many Indian people have no wish to abandon these cultural values for an industrial society's emphasis on competitive acheivement or a frenetic activity stressing individual competition for jobs and status.

Other anthropologists' research indicates that the Indian people are quick to share with fellow tribesmen whatever they have, placing little importance on saving for the future or a needy day. The use of the term "Indian time" is usually followed with little or no emphasis on clock watching or stress on punctuality, "just when they get there." Others lack job skills or proficiency in English, making the search for work and a means of livelihood all the more difficult. Many interested in working are channeled to nonskilled or spot jobs and others into day labor where they can draw pay at the end of each working day. However, others do fare a little better, but still work basically in nonskilled occupations.[6]

These cultural values, massive paternalism, language barriers, problems in semantics, nondirection and identification outline a struggle with several complexities that are demanding, sometimes unchangeable, and in many cases, irresolvable so constitute one of the greatest social challenges of our time.

PROBLEM DRINKING AMONG INDIANS

The struggle with the complexities of problem drinking, alcoholism, and alcoholism abuse in relation to the limited knowledge about cause and treatment makes it nearly impossible to state a solution or solutions to this social-medical type of illness. This philosophy is applicable to all cultures and civilizations that have a population with drinking problems. Thus, the Indian drinker has a few added elements and a very different

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[5]"Nixon Bids Congress: Give Indians Control of Their Programs and Boost Tribal Aid," Wall Street Journal, July 9, 1970.

[6]Isenberg, Barbara, "Red Man's Plight, Driven to Cities by Poverty, Find Harsh Existence, Many Drift, Turn to Drink as Search for Jobs Fail; Activist Groups Spring Up," Wall Street Journal, March 9, 1970.

dimension that must be understood and reckoned with in working this type of rehabilitation program.

In the past, writers have expressed the concept that the Indians use alcohol as a means of escape from boredom and pressure. A recent magazine article, describing one midwest reservation containing 4,600 adults, claim 44 percent of all the men and 21 percent of the women were arrested at least once for drunkenness in a span of three years.[7] Bill Pensoneau, President of the National Indian Youth Council, in a much repeated statement, clearly explains the dilemma: "We drown ourselves in wine and smother ourselves in glue--because the only time we are free is when we are drunk."[8]

Others describe the Indians' plight as, "Driven to the cities by a harsh existence, many drift, turn to drinking as the search for jobs fail." It continues, "For an appalling number of Indians, alcohol is preferable to accommodate the white world."[9] So, many of these migrants seem to find their way to the Indian bars in cities such as Los Angeles, Gallup, Denver, and Chicago.

The city of Gallup, New Mexico, often referred to as the "Indian Capital of the World," is consistently plagued with a high arrest rate for drinking-related problems. Many drunken reservation inhabitants can be seen in the streets on Saturday night, especially since a judicial ruling recently limits incarceration to a maximum of 60 people in the local center of detention. Prior to this time, over 200 had been arrested and detained on weekend nights. Since then, other provisions have been made to handle these inebriates under a different concept and a more humane approach.

Many claim that the pressures of urban life in a strange new society intensifies and contributes to an extraordinary rate of alcoholism. A recent survey during the daytime through an Indian neighborhood in Los Angeles reveals many cases of drunkenness. According to the local Indian leaders, these are not isolated cases or just a small segment of the Indian population.[10]

Sociological studies have substantiated that individuals will experience difficulties in moving from a highly integrated rural community to a massive urban center. Adjustment depends upon such factors as occupational training, education, social class position, attitude, and personal aspiration. Many rural migrants in all cultures and societies have evidenced signs of inability to adapt to the highly complex system and a time-clock-culture. The migrants from rural to urban are attempting to narrow or overcome a gap between two very different cultures similar to the migration of the rural South and urban North.

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[7]"The Angry American Indian," op. cit.

[8]Ibid.

[9]Isenberg, loc. cit.

[10]Ibid.

Sioux City Area

The Indian population of Sioux City, Iowa is arbitrary but usually maintains a level of approximately 1,500 - 2,000 people. Over the years, these individuals and families have migrated from the surrounding states into the Sioux City metropolitan area, seeking opportunities and employment. The lack of occupational skills, training, and problem drinking has become the present and future challenge, not only of Sioux City, but also of many other midwestern cities.

This population represents the many tribes located throughout the midwestern states. Geographically within a thirty mile radius of Sioux City are located two reservations: the Winnebago Tribe at Winnebago, Nebraska, population 745; and the Omaha Tribe at Macy, Nebraska, population 1,367. Further west is the location of the Santee-Sioux at Niobrara, Nebraska, population 317, and some members of the Ponca Tribe.

Going northwest into the Dakotas are reservations of many other tribes which include: Cheyenne River Sioux, Crow Creek Sioux, Devils Lake Sioux, Flandreau Santee Sioux, Lower Brule Sioux, Oglala Sioux, Rosebud Sioux, Sisseton-Wahpeton Sioux, Standing Rock Sioux, Yankton Sioux, Turtle Mountain Band of Chippewa and three affiliated tribes known as: Ventre, Mandan, and Arikara.[11]

Generally, most of the Indian people residing in the Sioux City area can trace their heritage to one of these tribes. Many have made this urban area their permanent residence, while others float between the city and reservation staying with relatives.

The statistics on record in the Sioux City Police Department indicate that in the year 1966 there were 2,762 arrests for drunkenness. Breaking this total down, it indicates: 1,213 American Indians, 27 Negroes, and 1,522 whites arrested during the calendar year. Later statistics in 1970 indicated 2,729 arrests for drunkenness. Of this total 1,138 were American Indians, 45 Negroes, and 1,546 whites. Although Indians make up less than 2 percent of the permanent population of this city, they account for over 42 percent of the arrests for drunkenness.[12] It should be pointed out that these statistics include repeaters, the same individual arrested several times.

Tama Area

Near Tama, Iowa, in the middle of the state, is the location of Sac and Fox Tribe, or Mesquakies. Approximately 450 Indian people live on this settlement, sometimes referred to as a reservation.

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[11]Directory of Tribal Officials, Aberdeen Area, December, 1969.

[12]Sioux City Police Department, Statistical Section, Sioux City, Iowa.

The major problems facing many of these individuals is lack of skills, problem drinking, and loss of self-esteem. At the start of the project, a survey revealed that about 15 Indian people were arrested weekly for problem-drinking-related offenses. Of the recent 120 intoxication arrests, 81 were Indian and 39 were non-Indian offenders. Twenty-one of the 28 Indian clients were given jail sentences; here again, some of those arrested were repeaters, committed by the same individual. The Indians from the settlement are less than two percent of the population of the entire county of Tama, however, the arrests and jailing for intoxication involved over 68 percent Indians during this reported period.[13]

THE INDIAN'S DRINKING PATTERN AND BEHAVIOR

Previous cross-cultural studies among Indian problem drinkers characterized and illustrate behavioral patterns which are significant and important in helping understand these people. The drinking patterns show a marked difference between the characteristics of the non-Indian drinking groups compared to the Indian drinking group. The Indian's drinking pattern and behavior is closely aligned with fellowship--buying or receiving of drinks from friends and relatives. This fellowship and interaction with the drinking peer group is highly valued and a significant part of this culture.[14]

Contrary to many views, recent observations of drinking behavior does not indicate that the Indian is just anxiety-pressured into drinking as an escape. Anthropologists tend to suggest that today, Indians who regularly live in their own communities or on a reservation appear to be using alcohol largely for euphoric purposes, as a means of socializing and less for the reasons of reducing tension. These occasions on which Indians drink are a time of elation; such as, a friend returned from several months of absence, a large gathering for some event, payday, or the arrival of a subsistence payment in the form of social security, dole, or land payment.[15]

Empirical findings in alcohol and alcoholism abuse research substantiate these values or patterns of values in cultures, and individuals are a crucial factor in the social control of alcohol use. Alcohol metabolism promotes symbolic associations among human beings. These symbolic associations of alcohol derive from its function as a behavior modifier. Various stages of intoxication promotes the expression of a variety of different

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[13]Canfield, David, "Tama's Indians and the Law," Des Moines Register, 1967.

[14]Sears, William F., and Ferguson, Francis S., "Community Treatment Plan for Navajo Problem Drinkers," National Institute of Mental Health Grant (MH 01389), 1968, p. 2.

[15]Dailey, R.C., "Alcohol and the North American Indian: Implications for the Management of Problems," The North American Association of Alcoholism Programs, October 1966, pp. 22-27.

values in the individual along with a large measure of socially-shared and communicable values. The social value in the consumption of alcohol functions in diminishing social distance and strengthening group ties. These values concern fellowship, social amity, and group morale.

The social importance which alcohol seems to have for the Indian is characteristic in other similar behavioral patterns. Alcohol is always shared, drinking remains a community-wide activity, no cultural controls appear to regulate its use, and little shame or guilt is associated with intoxication. Anthropologists feel that getting drunk is highly valued to this group, with gross intoxication expected, as it is noncompetitive, and very little value is placed on capacity.

In these cultures, there is little or no social control over the consumption of alcoholic beverages; it has become a laissez-faire type of condition. Thus, no organized public opinion has been formulated unfavorably to drinking or drunkenness by the group. Most of the efforts are directed to avoiding the costly consequence of drunkenness, rather than controlling it. This apparent tolerance and lack of direct control of the inebriated person in a culture is associated with the high value placed upon intoxication by individual members.

Also, the ambivalence towards alcohol as a behavior modifier has some important significances and implications. The modifications in human behavior brought by intoxication are socially and personally destructive, as well as socially accepted and integrative. The same ingredient which makes human pleasure also makes human pain and unhappiness. This can happen by many other things used by human beings, however, alcohol is different in that it is difficult to predict the consequence of its consumption.

In cultures organized into clans, as one of the groups in this study was structured, a drunken person may be a specially distressing problem because attempts to restrain him may be disruptive, or they may trigger conflict. This combination, with a diffused authority in leaders and the absence of supra-clan or supreme ruling organizations, minimizes the control over the drunken person. The group maintains a ruling organization, however, it has displayed an unmistakable indifference to insobriety. In some cases the anti-social acts of drunkenness are excused and generally there is a failure to recognize the kinds of damage which result from overuse or misuse.

The importance in knowing some of the complexities and cultural values is important to the understanding of alcoholism and alcohol abuse among Indian groups and tribes. The various cultures studied in this project put a great deal of social meaning into drinking. At times, it was highly valued, and no activity seemed rewarding without it.

Many problems arise from the drinking; however, the Indians accept it, and in many cases, they feel unmistakable indifferent. Drinking, the problems that arise from it, and its damages are taken for granted. Many writers pointed out that the Indian's way of life provides neither the elements for control, nor the guidelines for treatment. Even if the Indians were motivated to seek help, the chances of success would be marginal because

our treatment methods and processes are based upon feelings and values which the Indian does not have.

There can be very little doubt that one of the major problems for the Indian people today is problem drinking. It is directly or indirectly involved in almost all their difficulties. Never before have so many private and public agencies been concerned with improving or changing the conditions of the American Indian; however, the Indian seems further than ever from taking a place in this society that is not almost totally dependent.

The Indian's participation in the white culture and society is limited because of his second-class status. Most of the contact with the white population is usually channeled and restricted to the streets, taverns, and jails.

The drinking attitudes and differential drinking patterns present a special kind of alcoholism problem concerning Indian people, especially those closely associated with reservation life. These characteristics appear to be a definable problem or a type drinker of a special nature. This excessive use of alcohol does cause sociological and economical damage identified as instances of binge drinking. It is a behavioral pattern of use in which drinking is periodic, explosive and centered around fellowship or peer group interaction.

This pattern of Indian drinking does produce a definable problem drinker, but of a special type. If one uses Jellinek's classification, the problem drinking Indian may not necessarily be included with this grouping or identification. Jellinek proposed that alcoholism is best understood as a disease. In this type of illness the various body systems are progressively involved, and the etiology varies depending on the alcohol use symptoms,as they exist in the alcoholic. These symptoms, sometimes being a prime diagnosis, are associated with this etiology and prognosis often referred to by Jellinek as "species." The classifications or species are put into subtypes or groupings called alpha, beta, delta, gamma, and epsilon.[16]

The alpha alcoholism is characterized by a psychological, continual dependence to relieve body or emotional pain. This type of drinking is not associated with loss of control, nor is there any progressive process. The beta type of alcoholism occurs when there is organic complications such as cirrhosis of the liver or polyneuritis, but where dependency is either physical or psychological. The gamma alcoholism involves tolerance to alcohol so there is a need for increasing dosages. There are withdrawal symptoms, craving, and a loss of control over the amount of drinking. It is a progressive disorder moving from psychological to physical dependency.

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[16]Jellinek, E.M., The Disease Concept of Alcoholism, College and University Press, New Haven, Connecticut, in association with Hillhouse Press, New Brunswick, New Jersey, 1960.

Delta alcoholism is similar to gamma, but instead a loss of control by the amount of intake on any given occasion, there is an inability to abstain even for a day or two without some withdrawal symptoms appearing. Epsilon alcoholism is a periodic alcohol overuse as in dipsomania.

The Jellinek classification covering drinking patterns, progression, and affect, however, doesn't explain the pattern of Indian drinking especially those who regularly live in their own communities or on a reservation. Later writers added to this classification a term called "zeta", a unique pattern of alcohol use in which drinking is periodic and explosive, community-wide, but nonaddictive. These people appear to be culturally prone to the affects of alcohol rather than constitutionally prone.[17]

Most of the well-documented research on Indian alcoholism and alcoholism abuse substantiate that this group of people have a cohesiveness or basis of personality factors that use alcohol more for euphoric reasons and less as a means of reducing tension or anxiety.

This study in Iowa, similar to other studies, substantiates the theories that there is great social value in the fellowship drinking pattern. This was reflected many times in working with the clients as they were referred to the various service agencies. It seemed almost as if the agencies and the project staff members were more concerned about the client's inability to understand and manage his drinking problem, than the client was himself. The direction and emphasis was to overcome the lack of motivation and apathy; thus, have the client define and understand his drinking problem and take steps, with our help, to manage it and do something about it. This type of change by the individual has to come about within a culture that supports or condones permissiveness along with a high degree of expectation from the use of alcohol.

The rehabilitation process must change or modify a cultural-supported activity concerning an individual or group therapeutically not motivated for change, that has some personality factors which tend to reinforce a very different type or unique pattern of drinking behavior. Added to this cultural difference is that the Indian is no longer vanishing; however, they are probably the nation's fastest growing minority. Recent statistics on the birth rate of the Indian claim they are two and one-half times that of whites, with the majority of the Indian people under twenty years old.[18] Time reports these statistics of the Indian population:

> At the time of Columbus, the native population of what is now the U.S. was probably between 1,000,000 and 3,000,000. By 1860, that had dropped to about 340,000, and by 1910 to an all-time low of 220,000. No longer vanishing, the Indians are now the nation's fastest growing minority.[19] The 1970 Census Bureau states there is a total Indian population of 791,839, a jump of more than 50 percent over the 1960 census.

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[17] Dailey, loc, cit.

[18] Time, loc. cit.

[19] Ibid.

With this thought, it appears that we are reaching a crucial point in the acceptability of drinking behavior. Alcoholic beverages are more readily available with the younger generation drinking in a permissive atmosphere that is becoming the main source of socialization among the group.

C H A P T E R II

PURPOSE AND RATIONALE OF THE PROJECT

General Vocational Rehabilitation Problem

The general problem studied in this research-demonstration project was to determine the effects of a coordination of community resources in reducing problem drinking among members of Indian tribes located in the Tama and Sioux City areas of Iowa.

Specific Objectives

The specific objectives in the study were to determine if Indian problem drinkers who accept treatment will show:

1. Higher percentage of increased employment;
2. Less absenteeism from work;
3. Relative decrease in arrests for drunkenness;
4. More stable family relationship; and
5. Higher self-esteem.

Rationale of the Study

The pattern of Indian drinking does produce a special kind of definable problem drinker. This type of drinking is a common problem facing the American Indian. Incidences of alcoholism run considerably higher among Indian people than in almost any other ethnic group in the United States.

While traditional attitudes regard alcoholism as a morale and legal problem, the modern approach views it as a illness. In the present investigation alcoholism is viewed as a cultural and socio-medical problem. It is characterized by periodic and explosive consumption of alcoholic beverages, by loss of control and dependence on alcohol, and by interference with the drinker's functioning in one or more major areas of life.

At the present time the Indian problem drinker is an undesirable or neglected individual for most private and public agencies. A possible reason for this attitude is that the agencies often lack personnel trained to understand and work with this type of client. The project is designed to create an understanding of the Indians afflicted with problem drinking.

This project is expected to support the point of view that problem drinking among Indians is a treatable condition, and that the course of this condition can be arrested by appropriate treatment. The project will support the thesis that Indian problem drinkers who receive treatment can be rehabilitated vocationally to the same extent as can other disabled

persons. The project is expected to show that treatment of problem drinking has positive bearing on the employment records, family relationships, respect for law, self-worth and community relations of those receiving treatment.

Economically it is more feasible to check the problem drinker prior to complete disintegration. As the Indian problem drinker deteriorates the resulting cost to the public increases through relief checks to the family, institutional care of children, frequent incarceration or other institutionalization and the probability of long-term care.

If the care-giving services are not provided early enough, in proper sequence and to a sufficient degree, secondary disabilities may cause more problems. As the problem drinker progresses to the extreme stages, rehabilitation tends to become obstructed and requires much greater investment of time and money.

CHAPTER III

METHOD OF STUDY

General Philosophy:

A recently completed five year research study and report by the Co-operative Commission on the Study of Alcoholism provides the philosophy and general direction of the alcoholism rehabilitation movement in this country. This report, "Alcohol Problems: A Report to the Nation,"[20] stresses the use of varied approaches, emphasizing that psychiatric personnel and agencies should mobilize their own resources and those of other agencies to deal more effectively with alcohol problems.

Utilizing this report and implementing the individualized comprehensive approach within the traditional care-giving services has been the main emphasis of the Iowa Indian Project and its assigned staff. The treatment methods used by the project were mainly to utilize a variety of approaches, non-medical as well as medical. In this type of program every agency, resource, and method is an important contribution to the client's rehabilitation and to the development of an alcoholism program.

There are some related but distinct approaches to providing services to the Indian problem drinker and also in developing change within the community. The first stresses a continuous ongoing community-based service for the individual, centered around the local mental health program. The second approach deals with developing more services for the unmet needs and overcoming resistance to needed action on all alcohol-related problems.

Local Office in the Community:

The local field office is community-based so that the patients do not have to go long distances to obtain counseling and referral services. Much of the work and effort consists of insuring that the problem drinkers receive the needed or appropriate attention from the community helping agencies.

Tama Center

In the Tama area, a rural oriented settlement, (settlement is usually referred to rather than reservation) office space is rented and housed in a building just off mainstreet. Special consideration was given to locating this office in a town nearest the Indian population.

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[20]Plaut, Thomas F.A., Alcohol Problems: A Report to the Nation, by the Cooperative Commission on the Study of Alcoholism. New York: Oxford University Press, 1967.

This office then was selected especially to gain the maximum effectiveness in working with the study group, and also provides a liaison with other community resources who work with problem drinkers. At other times, this center developed into a regular group meeting place, information center, and counseling station.

Along with the importance of the program location is the design and layout of the office itself. Special consideration and emphasis was placed on separate staff offices with an adjoining lounge or conference room. Generally, this office has the dual function of being both a treatment and referral center. This lounge provided a setting for the group dynamics and ongoing buzz sessions similar to an informal AA meeting. Coffee and rolls are served as an encouragement to have the problem drinkers stop in and periodically discuss problems, either individually or in ongoing group therapy sessions.

A significant feature of this type of program is the staff's ability and willingness to make at least some provisional counseling with the patient right away. This type of "crisis-oriented intervention" is particularly important to the Indians who are not appointment and schedule conscious, as other treatment clinics may require.

Under this structure, the center staff provides the support and guides the discussion, interaction and dynamics of the therapy sessions. The "talking out" of everyday problems and conflicts is the main theme of this ongoing treatment process.

Sioux City Center

The field office in Sioux City is located in the Goodwill Industries facility near the downtown area. This is an excellent location for the staff office as many of the Indian people are employed at this plant, it is accessible to contact clients, and it provides a comfortable setting in working with this group.

Goodwill Industries provides the project staff with rent-free office space, employment opportunities for the clients, staff administrative support, evaluation, and training. This is one of the ideal resources to start a client on the long road to recovery. It gives the individual a chance to gain stability and confidence, earn some money, and establish positive work patterns. For the client returning from the in-patient treatment unit, or just released from jail and recently off a drinking spree, this type of start in rehabilitation is less costly and more practical.

An approach of first utilizing temporary employment and a work adjustment program has proven more practical than rushing a client into a formalized training program. However, as the client progresses satisfactorily, some type of training can be initiated at a later date. These training plans are contingent upon the continued success of the client as recommended by a series of staff conferences in each individual case.

SELECTION OF CLIENTS: Elimination of the Control Group

Originally research plans were developed to have all clients referred to an Employment Intake Filter and then select a treatment and non-treatment grouping at random for the research sample. This approach seemed to cause complications in working with the group in each location. For example, when a man and his wife came to be selected into a treatment or non-treatment category, we would have to provide services for one but not the other. Also, it was very difficult and could cause resentment to select a few for services and rehabilitation in a community or reservation while neglecting the other part of the family, some of the group or tribe from that area.

Special permission granted from the National Advisory Council on Vocational Rehabilitation allowed us to proceed without a control group being selected or assigned. The total group was treated in the same manner with all available resources from each community. Thus, no specific criteria was used for screening and selecting the study group.

POPULATION AND SAMPLE

This study of Indian problem drinkers was conducted at two locations, Tama and Sioux City, Iowa, during a period of two and a half years from October 1968 through June 1971. The sampling consisted of all the referrals during this period. These referrals, 195 Indian and 36 non-Indian totaled 231 cases. (However, little or no reference is made to the non-Indian population in the study.)

Table 1

Tribe and gender classification

Tama Center

Indian	MALE	FEMALE	N
Sac Fox	47	6	53
Sac and Fox-Winnebago	1	1	2
Sac and Fox-Kickapoo	1		1
Sac and Fox-Potawatomi	2		2
Sac Fox - other	1		1
Omaha	1		1
			60

Tama Center	MALE	FEMALE	N
Non-Indian	35	1	36

Sioux City Center

	MALE	FEMALE	N
Omaha	13	6	19
Ponca	2	1	3
Winnebago	21	19	40
Sioux	23	17	40
Sioux Winnebago	3	2	5
Winnebago Kickapoo	3		3
Navajo	1		1
Omaha Winnebago	2		2
Winnebago Sac Fox	1	1	2
Chippewa Sioux		1	1
Chippewa	2		2
Sac Fox	1		1
Other	15	1	16
	87	48	135

Referral:

Generally, problem-drinking clients were referred to the project staff from a variety of sources. These included: probation, or parole services, law enforcement agencies, state mental health units, social services, Division of Rehabilitation, Education and Services, doctors, judicial systems, community, friends, Alcoholics Anonymous, and family. Still others just walked in and requested assistance on their own.

The staff makes an assessment of the patient's needs and then guides him to that treatment program or service which is appropriate to his state of recovery. The subprofessional counselor in the centralized office makes the direct contact with the service in the community for action. This staff member is the linkage mechanism between the problem drinker and the agency which helps with the treatment needs. At various stages of the planning, an intake form is filled out and a long-range rehabilitation program is developed, with the client's help, to determine what resources are needed.*

Treatment:

In planning the rehabilitation program of the Indian problem drinker, a variety of operational methods and techniques are suggested and utilized. A special concentrated emphasis is placed on a highly individualized process stressing each client's condition, personality, family, and community background. It is felt that the many pressures or forces brought to bear on this individual may help or hinder the recovery process and long-term rehabilitation program.

*See appendix D for copy of Social History Form
See appendix E for descriptive Narrative and Follow-up History Forms

Many times the recovery of the individual includes working with the family and friends. The patient's social environment, employment, friends and fellow workers are all significant factors in the recovery process. Similar to many other problem drinkers, we are dealing not only with the illness of a person, but also with the individual in relationship to his environment. Thus, a variety of approaches, non-medical as well as medical, are coordinated, using every agency, resource, and method that seem important to the recovery process.

Inpatient Treatment:

The patients who are mentally or physically ill and need care are transferred to the state-supported inpatient treatment unit. In this institutional approach to treatment, emphasis is placed upon the use of medical and psychiatric treatment in a controlled environmental structure.

By starting a patient with this process, an attempt is made to begin effective intervention into the destructive drinking behavior of the individual. Various treatment techniques are used, such as: case conferences, group therapy, role playing, evaluation, vocational counseling, self-government, didactic lectures, work therapy, training or employment. The emphasis of this unit is to help the problem drinker to be rehabilitated and self-supporting.

After release from the treatment unit, the recovered problem drinker is provided with close follow-up and living facilities structured to reduce the chances for a relapse. This continuous treatment by the staff in the local community is to support or reinforce the institutional progress.

Community Treatment:

For the majority of the clients, treatment was provided by the local community's broad spectrum of services as an alternate to institutionalizing him. This method represented a departure from just providing inpatient care. Services were provided as a community endeavor in which the problem drinker receives necessary care in a local setting or home environment. These services might include any or all of the following:

1. Employment Services: If the patient is jobless, a referral for vocational assessment and/or placement will be made through the Division of Vocational Rehabilitation and the Employment Security Commission. For the employed patient, with his approval, contact will be made with his employer and/or labor representative to enlist their aid in the rehabilitation program.

2. Welfare Services: If the patient is in need of welfare services such as food, clothing, shelter, etc., a referral to the appropriate agency will be made, e.g. County Welfare, Soldiers and Sailors Relief, Catholic Charities, Salvation Army, Goodwill Industries, other religious and/or civic groups or organizations.

3. Family Services: Service needs for the family may be numerous and varied. Dependent upon the needs, referral may be made to an agency offering counseling services such as Family Service Association; to an agency offering direct assistance such as the Welfare or Health Departments; or, one offering supportive help such as Alanon, etc.

4. Psychological Needs: In some cases there may be need for psychological care and/or support for the alcoholic and/or his family. Referrals for this may be to the Mental Health Institute or a private practitioner.

5. Financial Needs: Referral for services in this category may be for budget counseling, consolidation or legal adjustment of debts, etc. Referral may be made to Family Service Association, a bank or credit union, the Legal Aid Society, etc.

6. Social Needs: This would include referrals for such things as recreational activities, educational opportunities, or any other activity designed to assist the Indian alcoholic and/or his family in the resocialization process. This may include referral to AA and Alanon, religious or civic groups, YMCA, Boys Scouts and Indian Club.

7. Residential Care: Should the client be homeless or if it would be therapeutic to delay return to the home environment, arrangements shall be made prior to discharge for residential care. Such care may be obtained with the assistance of the Welfare Department, Soldiers and Sailors Relief, Division of Vocational Rehabilitation, Veterans Administration, etc. in such places as Men's Residence (Halfway House), private boarding home, hotels, Salvation Army Men's Social Service Centers, etc.

Flow Charts illustrating the referral sources and service agencies at the local centers are presented in Table 2 and 3 for the Sioux City and Tama areas, respectively.

DISULFIRAM TREATMENT (ANTABUSE)

Disulfiram is a drug taken orally in pill form, which interferes with the normal metabolic degradation of alcohol in the body, resulting in an increased acetaldehyde concentration in the blood. A person is unable to drink alcohol in any form without adverse symptoms for four or five days after he has taken the last dose of the drug.

Under medical supervision each client is encouraged to participate in the antabuse program. All the treatment units have prescribed its use on a voluntary basis. Halfway house managers and some families are using it successfully.

The local judicial system and law enforcement officials were approached on implementing the involuntary antabuse program for resistant alcoholics. In this type of program, the client is paroled under court order to take this disulfiram pill at specified times or be in violation of his parole and returned to the center of detention. Interest and cooperation in this type of treatment method is very positive, however, there is some reservation on forcing an individual to take the medication, although it is readily used on a volunteer basis. Appendix B illustrates the procedure in using this type of program.

There is a great pressure exerted on each patient to drink with friends or his peer group upon returning to the local community. This camaraderie or fellowship drinking acts as a deterrent in part of the recovery and rehabilitation process of the problem drinker. All the therapy, inpatient treatment and detoxification frequently breaks down as a result of this fellowship drinking pressure. A recent study completed at the Navajo Indian Reservation, Fort Defiance Indian Hospital demonstrated the "successful disulfiram treatment" approach to alcoholism with this group.[21]

LOCAL OFFICE ACTIVITIES

The community-based office performs a variety of functions and activities which in most cases help and support the client in a total rehabilitation program. The activities vary almost continuously as clients come and go from the local center. Some of the tasks are simple, while others require a great deal of planning and agency coordination. An indication of some activities are clearly illustrated by these varied tasks.

A tribal council member visits the staff about the prospects of starting an electronics plant to be located near the reservation employing several Indian people.

A staff member talks to the community action director on the pay and work progress of an individual assigned to our program.

Staff time is set aside for daily planning on each employees work assignment for the day.

The area vocational school is contacted concerning a client's absence. This client had been drinking so a staff member provides the necessary counseling and follow-up service.

A client who has been drinking is transported from the downtown area to his home.

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[21] Savard, Robert J., PhD, Effects of Disulfiram Therapy on Relationships Within the Navajo Drinking Group. Quarterly Journal of Studies on Alcohol, Vol. 28, No. 4: 909-916, 1968.

A staff member provides information by telephone to the regional employment office for a client who has been laid off and is filing for unemployment compensation.

Arrangements are made for marriage counseling sessions concerning a client and his wife to be held at the inpatient treatment unit. The transportation, a trip of sixty miles one way, is provided by the staff as the client does not have a car. Also, this allows the staff time to confer with professional workers at the inpatient treatment unit and visit some of the Indian patients.

A staff member calls social welfare to see why a client hasn't received her monthly subsistence payment.

The staff is asked to participate in a court hearing involving a client and his wife to determine if the children are to be placed in a foster home.

A client stopped in and asked one of the staff members to call his employer in the next town to advise them he needed some time off for personal reasons. Client is to appear in court that morning on an intoxication charge. Counseling provided the client and his wife to attend some AA meetings and group counseling sessions. Also, by working with the employer it was hoped to retain the client's employment.

A representative from the Iowa State Employment Office stopped to pick up client referrals for job openings and post a list of employment positions.

During the spare moments a staff member contacts several people and encourgaged them to attend the next AA meeting to be held in the office.

The regularly scheduled visits to the jail allows the staff time to talk with clients incarcerated for intoxication.

A special counseling session is held with a client on the probability of attending the inpatient treatment program. This coordinated effort involves motivating the patient to accept treatment, making the necessary financial arrangments with the agencies to pay for this treatment, and also lining up some friends or relatives to care for the children while she is gone.

A staff member visits with parents on a teen-age drinking problem.

One member of the staff visits with a client on his progress and helps him write a report to his parole officer.

A staff member attends mayor's court concerning a client's damage to the city hall and other public property. The staff worked with the Bureau of Indian Affairs, law enforcement personnel, social welfare, and a member of the treatment unit staff designing the necessary direction and rehabilitation in this case.

Contact is made with an interested citizen concerning the posting of a bond for a client charged with assault and battery. The staff is working with this youth and his family to get him released from jail so he can continue attending high school classes.

A telephone conversation with a counselor from the inpatient treatment unit helps the staff up-date client's progress and reveal some past history pertinent to his recovery program.

The staff coordinates with a parole officer regarding client's progress and educational plans. This particular individual desires to continue his education by getting a general education development test completed.

The school psychologist is contacted to determine the requirements for a client's graduation from high school as he never participated in physical education.

Direct staff contact by telephone to an employer is made inquiring about the employment of a client for a welding position.

The Veteran's Administration is contacted by telephone for information concerning a client's interests in receiving an enrollment certificate for training.

In a nearby large city a client was picked up for drinking and is incarcerated for thirty days. A staff member talks to the client's aunt and sister to determine the course of action to be taken. We picked up his personal things from his apartment and tried to arrange for a release from the jail.

A potential client stopped in and complained that another individual had taken her baby and refused to return him. The staff member provides counseling and an attorney is contacted to determine the legal recourse.

A staff member talks to the local minister and Bureau of Indian Affairs official regarding a trip to the state reformatories. Usually these trips are scheduled monthly in order to start planning with clients scheduled for a release.

Counseling provided to a client and his wife concerning a charge by the highway patrol of illegally operating a motor vehicle upon a public highway while his license was under revocation. Client has had several previous charges of operating a motor vehicle while intoxicated.

A staff member visits with the mayor concerning the client being held in jail for problem drinking.

Contact is made with the vocational rehabilitation counselor at the inpatient treatment unit on a client about to be released. Planning at this recovery point involved halfway house residency, AA attendance, and training.

Coordination by the staff with the county attorney concerning a client's intoxication charge and up-coming court trial. A staff member visits with the client and relatives on the seriousness of these pending charges for a problem drinking offense and their responsibilities prior to the trial.

A staff member works with the vocational rehabilitation counselor regarding a clients' interruption in the training program. This client left work after one week, he was passive and didn't seem to be well motivated in this type of work. More information was provided on limitations of the client as he is also epileptic and already limited in many areas of training. The planning will continue to consider other alternates in training or employment.

The staff worker attends each scheduled staff meeting at the inpatient treatment unit. A multidisciplinary team plans the necessary recovery and rehabilitation program for the patient. Present at these staff meetings is a social worker, a vocational rehabilitation counselor, alcoholism specialist, nurse, medical doctor or a psychiatrist.

A member of the local tribe visited the office and discussed the problem of their grandson as he does not want to go into the Job Corp. Counseling provided and a meeting set up with the Job Corp representatives and social services to work out these details.

After a court hearing on a charge of operating a motor vehicle while intoxicated a client is paroled to the staff in the local office for one year, with a loss of his drivers license for 120 days. Under this suspended sentence he is required to take antabuse and will attend each AA meeting and educational program on alcoholism. The staff encouraged his wife to also attend the AA meetings and gave her some literature to read on alcoholism.

Staff counseling provided for client's wife concerning marriage problems and conflict. The daughter was in the hospital as a result of this client's excessive problem drinking. Also a telephone conversation with the social welfare department regarding the family ADC monthly payment.

Some arrangements are made with social services to pay the financial charges for a one day observation evaluation on a client at the state psychopathic hospital. This client has been charged with assault in a drinking related incident so an evaluation is requested prior to the court trial. The project staff is coordinating all the agencies involved in working with this young man.

F L O W C H A R T

REFERRAL SOURCE

Self

Courts

Police

Welfare

DRES

Community

Family

AA

Client Referred To Project Staff →

SERVICE AGENCIES

Alcoholics Anonymous
Winnebago Public Health
Woodbury County Home
Sioux City Mission
St. Joseph Hospital

County Welfare
Goodwill Industries Training & Evaluation Center
Iowa Vocational Rehabilitation, Education & Services
Judge - Municipal Court
Judge - District Court

Jewish Foundation
Iowa State Employment
Catholic Charities
Siouxland Opportunity (OEO)
Mental Health Service

Traveler's Aid Society
Men's Social Center
Salvation Army
Sheriff's Department
Halfway House (Western Iowa Men's Residence)

Sioux City Police
American Indian Center
Mental Health Institute
Soldiers Relief
Medical Center

Siouxland Council on Alcoholism

→ Follow-up By Project Staff → Evaluation By Project Staff

Table 2

FLOW CHART

REFERRAL SOURCES		SERVICE AGENCIES			
County Attorney Self Police Sheriff Welfare Employer Project Staff Alcoholics Anonymous	Client Referred To Project Staff →	County Welfare Soldiers Relief Community Action Program (OEO) Alcoholics Anonymous Sheriff Department In-patient Treatment Unit Bureau of Indian Affairs Physician Mental Health Clinic (out-patient) Iowa State Employment Service Manpower Training Act Division of Rehabilitation, Education & Services University Hospital Halfway House Court - Judge Mayor Legal Aid Society Police Department Detoxification Center (out-patient) Probation Officer Veterans Hospital Public Health Service Minister Attorney Cedar Rapids Service Center	→ Follow-up By Project Staff	→ Evaluation By Project Staff

Table 3

C H A P T E R IV

THE SUBPROFESSIONAL COUNSELOR

The field or operational staff consisted mainly of Indian specialists trained in alcoholism at all counseling or functional levels. Special emphasis and guidelines were used to select a staff almost entirely of Indian people that could relate to the study group. It was intended to use these workers in all direct lines of contact or person-to-person activities.

The descriptive narrative on the staff personnel pertains to the areas of the effectiveness of the subprofessional Indian counselor as he works in different settings, structures or situations. These varied approaches document the workers strength and limitations in modifying the problem drinkers behavior and in developing the treatment services in each community.

In this part of the study, an attempt was made to answer questions on: How effective is the trained subprofessional Indian counselor working with the study group? What pressures must the subprofessional counselor overcome to be effective in changing the client's drinking behavior? What characteristics and recommendations are important to select the subprofessional working in the field of alcoholism? Can the Indian subprofessional counselor work with non-Indians or other tribes? What are some of the limitations of the subprofessional worker functioning in this field?

EFFECTIVENESS OF THE TRAINED SUBPROFESSIONAL INDIAN COUNSELOR

The significance of training and employing the subprofessional is important in many respects. They are likely to have more knowledge of the complex attitudes, cultural variants, general feelings and needs of Indian problem drinkers than some outsider. These workers have the awareness to know what is going on in the community, in the various families, and can be in the forefront of such activities.

The personal empathy and concern of these workers is the basic element that may motivate the client to do something about his destructive drinking. The specialist has a general understanding of alcoholism, identifies more closely with the group, can overcome communication barriers and cultural values that are not understood or many times misunderstood.

The behavioral change within the group or an individual client may be as a result of this peer group subprofessional counselor's efforts. These workers can overcome the feelings of isolation and to some degree understand the demands and irresolvable conflicts that must be worked thru. In a few instances, these workers gained rapport and enough confidence that the client often proved to be suitable for treatment and spectacular success was achieved within the group.

To develop a good client working relationship and attitude of trust and cooperation the worker many times would go to them. Arrangements are usually made to contact and assist these people in the areas where they live or work. Until this time the client's contact in their day to day life many times involved those associated with either exploitation or punishment. By this type of direct contact, it was hoped to introduce these problem drinking individuals to some type of treatment and rehabilitation.

PRESSURES THE SUBPROFESSIONAL COUNSELOR MUST OVERCOME TO BE EFFECTIVE

The role of the subprofessional counselor is inherently turbulent, demanding, and full of conflict by the very nature of the problem drinking and at other times, as a result of the client's secondary status. These types of client problems many times create bafflement, disorder and other muddled thoughts, not only in those with whom he is closely associated, but also in those who have some opportunity and responsibility to help.

As in other alcoholism-concentrated studies, these subprofessionals will have to handle similar behavioral and personality patterns. In the daily work load and ongoing counseling process, the worker will be subjected to working with individuals that are sensitive with a high level of apprehension and emotion. Similar characteristics include a very low tolerance of frustration, with tremendous anxiety, anger and depression. Other patterns show a poor capacity to accept failure with an inability to do insignificant accomplishments without a great deal of anxiety.

These characteristics can perhaps be best illustrated by the brief case histories of two men in the study:

> Case B-23* Fred Hare, 38 years old was referred to the staff by a friend for help in arresting his problem drinking. Fred states, "he has had a drinking problem for at least ten years or longer and usually drinks heavy every time he gets a chance." He likes to drink with friends, socialize with people and generally has a good time. As a disabled veteran he receives a large monthly pension which no doubt reduces his motivation or desire to control his drinking. His rehabilitation program involves voluntary commitment to State Mental Health Treatment Unit, AA counseling, and subsequent planning of future activities to change his destructive drinking.
>
> During his first hospitalization Fred showed considerable depression and hostility but did cooperate with the treatment staff. He talked readily of his difficulties, resented being told what to do and had a very poor insight and judgment into his problems. Many of these difficulties can be traced to his being partially paralyzed in the left arm and leg due to a Army or service connected disability.

* All names of individuals are fictional

During the second week of treatment Fred began feeling better so pressed for discharge. After a stay of 14 days he was released in his mother's custody, planning to live with her, and regularly attend AA meetings. Prognosis was guarded upon release.

However, he continued to drink very heavy interrupted only by a series of incarcerations in the city jail. Again he was transported to the treatment unit which lasted this time for 2 months. He showed initial suspicion, resentment and hostility, but generally cooperated with the staff. He had an occasional temper outburst and during one of these walked off the grounds so had to be returned by the local police. Upon release again his prognosis was guarded due to his continuing relapse into hostility and resentment at the slightest frustration.

Shortly after his release the second time Fred continued to drink so heavily that emergency hospitalization was required at the Indian Public Health Service and later he was transferred to the Veterans Hospital.

In another case the deviant behavioral characteristics of the client coupled with the low educational attainment from a disadvantaged social group, lacking in occupational skills reduces the adaptation of the individual to almost a marginal level in our society. The following case history illustrates the project worker's efforts to maintain the client's sobriety and some occupational stability.

Case A-30 Al James a 26 year old single man has accumulated over 25 arrests for intoxication, bad checks, and other drinking related incidents. Since our contact and referral Al has made remarkable progress in controlling his destructive drinking and thus reduced his arrest rate to one in 1969 and none in 1970.

Al's background reveals that he has had very few family ties. His mother is confined to a nursing home, his father is unknown so was raised by a grandfather until his recent death. Due to Al's indifference in school work he dropped out at the sixth grade. Later he was disqualified from the Army because of low general classification test scores. Most of his previous employment history has been day labor of an unskilled nature.

After referral to the staff counselor, Al was transferred to the State Inpatient Treatment Unit for detoxification and psychotherapy. Upon discharge from this unit he moved into the halfway house for some structured residential living and later was employed by the manager of a local automatic car wash company.

After a short time he left the car washing employment and worked briefly as a janitor at a nearby college for a couple of weeks and then remained unemployed for the next four months. He was then referred to the Iowa State Employment Service and enrolled in the MDTA Vocational Evaluation Assessment Course to determine his occupational skills. After attending one weeks evaluation and training he became lonely so started to drink. Leaving the training program he did day labor on a construction project, in a foundry, and as a brick tender for a mason. He left this work and was readmitted to the halfway house and employed again at the

Automatic Car Wash Company. Later he was accepted for three months training to qualify as an outreach alcoholism aide. After completion of this training he was employed at the state penitentiary as a sub-professional counselor working with Indian problem drinkers. Shortly thereafter he became dissatisfied with this employment and returned to the halfway house and was employed in an OJT training position with the local community action program. Later he was reassigned to a counseling position at the nearby reservation working with Indian problem drinkers. Again he was reassigned to another community action program to help develop a four county alcoholism program.

A chronological history of Al's employment from November 1968 until July 1971 indicates he had been trained and employed at least thirteen different times. Although he has maintained his sobriety and reduced his destructive drinking to an occasional binge his employment history hasn't stabilized to any degree.

In addition to the client-centered problems, the worker has to function within a peer group and community geared to stress and dissension. In-group loyalties, tribal rivalry, or multi-clan structured groups have a considerable influence on the worker's efforts and a direct bearing on the client and total rehabilitation program. An understanding of the psychodynamics of this group and a management of the environmental stresses is important to the workers' overall functioning in this field.

Another major area of stress to the worker is in developing and coordinating the major care-giving services in each community. The police-penal system of handling public intoxication, inadequate medical care for the patient, and the negative reaction to problem drinking are possible areas of disappointment and apprehension for the workers.

Individuals within the non-Indian community, particularly in a higher socio-economic group, either through the encouragement of their family, friends, or on their own are likely to seek out an agency for help with their drinking problem. This is not true with the Indian client we worked with because many shun confrontations. Discussions of personal problems are painful. For many the meeting of eyes and firm handshakes are long avoided. Also, it is difficult for them to conceive that they have any benefits to gain from sobriety when all those around them drink.

At times the workers will experience some persuasiveness and pressure from the group to drink with them. This pressure to drink with friends is very great and the person who refuses is ridiculed and constantly pursued. This can be exceptionally difficult for the worker if he is a recovered problem drinker, thus he may return to the original inebriate status becoming ineffective and unproductive.

On the one hand, they must have the ability to handle the drinking group pressure, manage their own sobriety, and effectively function in a culture not oriented to any type of restraint or moderation. The worker will have to cope with personality conflicts, prejudice, and biases among the people, and many times in the community that often negates or reduces his effectiveness. Generally speaking, many of these feelings and conflicts can be overcome, however, it will be difficult. By having two or three workers on the staff at the local community office, one member from this team should be able to function in a positive manner with a particular client, agency, or problem drinker.

SELECTION OF THE SUBPROFESSIONAL

One of the most important factors in the success of this type of rehabilitation program is the selection, employment and training of the subprofessional working with this group of problem drinkers. Ideally there are certain advantages in selecting a staff member that can act as part of a team in handling the various problems. In this approach emphasis is placed on selecting one staff member that represents the local tribe. Thus, we have a person that speaks the tribal language, and understands the various tribal customs and culture.

The Alcoholics Anonymous movement is an important part in this type of rehabilitation program and as a technique will be used more often with the Indian problem drinker in the future. It would seem appropriate to employ one member of the staff that is a recovered problem drinker indoctrinated with the AA philosophy and concept. Use of this technique of group therapy is a combination of both prevention and recovery. This approach is especially useful in working with a clientele that has a high recidivism rate.

As is often the case in a long term program the overall success is dependent upon a highly technical or semi-skilled staff having the ability, training, and personality factors to adjust to varying situations. Special importance is placed on employment of one staff member that can generate enthusiasm for the patient to change or modify his drinking habits and also function in a positive manner with the various care-giving services within the community.

These workers will need to be trained in all phases of inpatient treatment, etiology of alcoholism, and the many functions of the various agencies concerned with aftercare services. It is very unlikely that the worker can develop a knowledge and insight of all these requirements over a short period of a few months. Some type of training that spans over two or three years should be initiated to give the worker the required experience and necessary operational background in this field.

LIMITATIONS OF THE SUBPROFESSIONAL COUNSELOR

It is highly presumptuous and probably unrealistic to conclude that a problem drinker or chronic inebriate will change a life pattern of drinking after only a few months of progress in a comprehensive treatment program. It is imperative that the subprofessional counselor be orientated or "tooled up" to adjust to various behavioral changes and a high recidivism rate in dealing with maladjusted personalities requiring a continuous treatment program.

Some individuals arrested for public intoxication who are in need of treatment suffer primarily from a serious mental aberration, thus alcoholism is a secondary personality defect. Other cases are terminal in nature requiring custodial care due to an acute stage of alcoholism and impaired judgment. The futility of trying to rehabilitate this type of individual is a management problem for the worker as the client is shuffled from agency to agency with very little available assistances for him. This custodial

type client either refuses to participate in a structured after-treatment program or many of the community care-giving agencies just decline service for one reason or another. Periodically, this individual reverts back to the worker for some type of rescue service.

Another major hurdle confronting the worker is a developing or strengthening of community treatment services for the problem drinker. This concept and change in philosophy maybe a bit ahead of just what the helping agencies are equipped to do and they may not be ready for this change of responsibility. Generally, however, this is a management problem faced by all types of alcoholism related programs.

The following statement by an official from the public health agency clearly illustrates this type of problem the worker encounters.

> "With regard to the problem of alcoholism, I don't know whether Indian alcoholism is a bigger disease, a health matter or just another failure. Certainly there is not a question in my mind that alcoholism is a disease. The Bureau of Indian Affairs considers it a disease and considers the problem of doing something about, alcoholism itself not within its scope, except through the social workers of which we don't have enough of, to prevent another victim of alcoholism. To my knowledge there is no present plan to get the ...."[22]

Another common problem encountered by the subprofessional is establishing a positive working relationship with the professional staff. The differing attitudes, privileged information and rigid views of many in both groups, does not encourage the development of a meaningful or harmonious relationship. The trained subprofessional using a positive approach, achieving results, and working closely with the professional worker can overcome this barrier. At one of the treatment units plans were formed to use sensitivity training for the entire staff to improve attitudes toward each other and thus resolve common problems. As needed this would create more openness among all staff members and bridge the gap between the subprofessional and professional team.

Although the worker has an increasing awareness of the adverse problems related to drinking, it is probably doubtful to suggest that he could make judgments, or be assigned responsibility to manage a specific number of cases, similar to a Vocational Rehabilitation Counselor. However, it is possible to have a qualified team leader or a professional staff member consult with these workers regularly concerning the client's needs, readiness and feasibility. A completely structured type of staffing, daily assignments and recommended action will be needed to give the subprofessional the direction required for progress.

This daily guidance and operational direction is especially important in the urban areas where there is a concentration of individuals from many tribes with identification fragmentated into several cultures. In order to manage these conflicts, in-group loyalties, and tribal rivalry, a team approach seems

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[22]Dialogue from the American Indian Research Project at the University of South Dakota, KAIYOWAZA, the Echo, Vermillion, South Dakota, October, 1970.

the most appropriate functional administrative structure.

As in other programs the worker will be required to keep detailed "activity logs" or accounts of each client's treatment, progress, and rehabilitation plan. It is intended to use this material as a reference to make some future judgments and also as an informational source for other care-giving community services. Some workers are not trained or "well grounded" in the necessary required writing to tabulate patterns of what has happened in the past to determine future direction. This documentation is necessary in avoiding approaches that have been tried and proven unsuccessful.

Some workers in this project kept very good follow-up information and descriptive narratives while others did very little, so the decisions many times had to be made on what the client wanted at that time of contact, rather than on what has happened, what to avoid or what worked and what didn't work.

The following case history illustrated the need for background information:

> Case A-45 Pal a 26 year old, eighth grade drop-out, was referred to the project staff by the court. The client relates that he has been drinking for around 11 years, since the age of 15. He does feel, he is a heavy drinker and usually gets into trouble as a result of his destructive drinking.
>
> His previous history indicates that in 1960 he was sentenced to 1 year in the Boys State Training School for auto theft while intoxicated. Also, in 1963, he was involved in another auto theft while drinking, and was sentenced to 6 years in the Colorado Detention Center. He was released on good behavior in September, 1964, however, he violated his parole in 1965 and was returned to prison for 2 more years. Since this time he has been incarcerated locally several times for drinking related incidents.
>
> Once Pal was hospitalized at the State Mental Health Treatment Unit for 3 days for detoxification and therapy. This treatment staff stated that he was uncooperative, unmotivated and disinterested in any treatment program. He was discharged against medical advice as unimproved and not to be readmitted as a voluntary patient. The client's plans were uncertain at the time of discharge and his prognosis was poor. He refused to become involved in any treatment program or therapy during his short stay at this unit.
>
> While in prison, Pal received training as a spray painter and decorator. Later he started a retraining program through the United Tribes of North Dakota and dropped out. Again under the MDTA program from the Iowa State Employment Service he enrolled in an auto-body and fender course and dropped after a couple of months. None of the training plans were completed during the time we worked with him.
>
> During the two and a half years working with Pal, we utilized 14 referral agencies, the antabuse treatment program and structured living in a halfway house with close follow-up and counseling. Along with starting various training programs, he worked off and on for eight different

employers.

Pal, maintained periods of sobriety up to three months, and then would go on short explosive binges. After a series of parole violations he was returned to the State Prison to serve his remaining sentence.

Using almost every treatment method available, a structured living, disulfram, court order and intensive counseling, we were able only to succeed in keeping him sober up to three months at a time, with little or no change in his work habits or deviant behavior.

SUBPROFESSIONAL COUNSELOR WORKING WITH NON-INDIANS OR OTHER TRIBES

The comprehensive services at the Tama location are provided to all Indian and non-Indian problem drinkers on an equal basis. This consisted of referral to the center staff, completion of the intake form, counseling and long range vocational planning. The care-giving services are phased in as needed for each individual depending on the stage of progress.

After working several months in this community it was evident that the project staff could function effectively in almost any combination if the proper rapport, trust and confidence is first established with each group and service agencies. The staff worked in various combinations such as Indian staff members working with non-Indian people, Indian staff members from one tribe working with another tribe, and non-Indians from service agencies working with Indian referrals. Generally this approach helped overcome a feeling of isolation and thus develops a more harmonious atmosphere in both communities.

There were no other similar counseling services, AA meetings, and direct services available to the non-Indian so naturally the project staff became the operational base focusing on all drinking related problems. This is probably the only concentrated special project where we have the majority being directly served by a minority staff.

Such a collaboration between the two groups can help to insure future cooperation on programs to deal effectively with alcohol problems. Also it is apparent that the Indian clientele accepted the project more readily as a result of these services being made available to all problem drinkers on an equal basis.

CHAPTER V

PROBLEMS OF EVALUATION IN ALCOHOLISM

Questions commonly addressed to those working in the alcoholism field are: How many people did you cure? What is your recovery rate? How many alcoholics have you rehabilitated? What is the criteria for recovery? What constitutes rehabilitation? What is success? How do you define success?

How does the program measure success? One author says, "tell me what success is in alcoholism treatment and I'll tell you how successful we are."[23] This may sound like an evasive answer, but it is an example of the ambiguity in this field. The standards of success in assessing alcoholism rehabilitation are largely lacking.

Should the goal of treatment be described as immediate, complete or lasting sobriety? What does lasting sobriety mean? How essential is success to immediate recovery? Is complete sobriety the only result which could be called successful.

A good success rate is difficult to measure and often is hidden. Success sometimes is the rapport the individual counselor establishes with each patient; the alcoholic is an uncomfortable person, and if his counselor makes him comfortable for one hour even though he never returns to the center- this is a part of success.[24]

In establishing the measurements of success John Saltman, Director of the Alcoholic Recovery Foundation, Vancouver, Washington recommended the following points to be considered: 1) There must be some recognition of the phase of the illness prior to treatment. Certainly there is a difference between the very young problem drinker and the 65 year old chronic inebriate, 2) The record of drinking after treatment must be completed in detail not just drunk or sober, 3) The primary measurement of effectiveness must be improvement in the patient's ability to handle his life.[25]

In addition to the measurements of success are the methods of collecting, tabulating and disseminating this information. These guidelines recommended are: information and evaluation should be first hand if at all possibly, statistical results must be valid and the reporting of this information be in categories of standard measurements established by a responsible agency.[26]

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[23]Saltman John, "How does a Program Measure Success?" Inventory, Vol. 19, No. 3, (Raleigh, North Carolina, Winter issue, 1970), p. 30.

[24]Editorial, "What is success?" Alcoholism Review: June-July 1970, Vol. 1X, No. 5, Vancouver 10, British Columbia, pp. 1-5.

[25]Saltman, op. cit.

[26]Ibid.

Another author, Dr. Reginald G. Smart, Associate Research Director at the Addiction Research Foundation stresses the use of "evaluative research" on alcoholism problems. In this article he suggests using scientific methods of collecting and analyzing information about the results of a particular program. He would want to know in what way the patient's behavior has changed as a result of the therapy. How many patients in a particular program have actually been improved and in what ways and to what extent.[27]

These elements of meaningful evaluation should have a good design and proper research standards. A control group and treatment group would be assigned on a random basis. The change that therapy is expected to produce must be measured in a reliable and valid way. Also some type of base line behavior data needs to be compiled prior to starting the therapy. These same measurements that were taken before treatment must be taken during and immediately after the therapy. Close follow-up is to be provided for a year or more.

Comments on Psychotherapy

In Dr. Smarts' article, a review is made of various other studies concerned with research on alcoholism. He writes, that the Voegtlin and Lemere studies between 1909 and 1941 reached the conclusion that there was no evidence that psychotherapeutic methods were of value in the treatment of alcoholism. Also in 1967, Hill and Blane published a paper called "Evaluation of Psychotherapy with Alcoholics: A Critical Review, thus they reached the same conclusion. These suggest that the scientific case for the use of psychotherapy has not improved in 25 years. Insight therapy of various types is the most widely used method of treating alcoholics; and still nobody has proved if it works or not or what makes the difference between therapy that works and therapy that does not.

Psychotherapy has not been established as an effective method of treatment for alcoholics. Dr. Smart felt that there is evidence substantiating that psychotherapy in general may not be effective in a variety of mental illnesses. He cites the papers by Bergin (1966) which reviews all controlled studies of individual psychotherapy mainly with Schizophrenics and Neurotics. These studies indicated that people who received psychotherapy got no better than the comparable people who did not. Psychotherapy did cause some people to get better and some to get worse than the comparable people who did not receive therapy. The average amount of change for "treatment" and control groups" did not differ, but the variability was much greater in the treatment groups.[28]

These studies indicate that as a method psychotherapy can at least make some people better off than they were before. The point is not to eliminate psychotherapy but to find out why some people get better while others do not.

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[27]Smart, Reginald G., "The Evaluation of Alcoholism Treatment Programs," Addictions, Vol. 17, No. 1, (Toronto 179, Ontario, Canada, Spring issue, 1970). pp. 41-51.

[28]Ibid.

In Bergins' studies many of the "control" group who do not get clinical treatment do get help from non-professional sources such as friends, family, clergymen and others. The supposedly "untreated" groups may be getting just as adequate therapy as those in a clinic, thus the concept "spontaneous remission" could be improper.[29]

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[29]Ibid.

C H A P T E R VI

RESULTS

HYPOTHESIS 1

HIGHER PERCENTAGE OF INCREASED EMPLOYMENT.

Discussion:

In utilizing all the local resources in each community employment was increased to various levels and for different periods of time. The follow-up documentation indicates some type of employment at Tama in 54 out of 60 individuals for 90 percent and at Sioux City in 89 out of 135 individuals for 66 percent.

Training to increase skills and employability.

The planned training used to upgrade individuals skills serves as a major index illustrating not only the level of personal aspiration, but also the enormous task of motivating the recovered problem drinker.

Table 4 indicates that 23 of the 33 referrals about 70 percent dropped out of training and evaluation. Two people are still enrolled in the Work Incentive Program (WIN), a on-the-job training concept sponsored by Social Services. Three individuals had completed the eight weeks evaluation and training program at Goodwill Industries.

Table 4 Sioux City Center

Occupational Training, College and Evaluation

Occupation Training	Started	Dropped	Completed	Still in Training
Meat Cutting	2	1	1	
OJT-Social Serv. (WIN)	2			2
Goodwill Industries Eval. & Trng.	12	9	3	
Welding	3	2		1
Auto body & fender repair	2	2		
Job Corp.	3	3		
College	1	1		
Art	1			1
Relocation & trng for United Tribes	2	2		
Office Machines Repair	2	1		1
Band Instrument Repair	1	1		
NYC	2	1	1	
	33	23	5	5

In table 5 eighteen individuals were referred for occupational training, MDTA evaluation, or college. Significantly of this total, three are still in a college program, however, two did drop out but reenrolled later. Of the eight that completed training six are unemployed, only one is working in his trained skill as a welder and another is employed as a fabric worker in a factory.

Table 5 Tama Center

Occupational Training	Applied	Never Started	Started	Dropped	Still in Training	Completed
College	3		3		3	
Welding	10	2	8	2		6
Machinest	3	1	2	1		1
Meat Cutting	1		1			1
Evaluation	1		1	1		
	18	3	15	4	3	8

Limitations:

The occupational skills of the Indian problem drinker are skewed toward the lower end of the economic structure. As a result of the low educational attainment, lack of occupational skills, and personal aspiration many individuals are limited to day labor, piece work or spot jobs.

Thus, it is extremely difficult to tabulate the employment pattern of this type worker and compile it into meaningful statistics. A review of the follow-up information from the descriptive narratives and the evaluation by the project staff reveals that these individuals are constantly revolving in a circle around starting a spot job, drinking, incarceration, released from jail, loss of employment, changing employment, or moving to a different location.

The reporting efforts and progress required of the helping services, and the condensing of this information into a single statistic based on a systematic accounting process working with a cultural deprived individual can be very misleading and often penalize the services. In reporting the success or failure of an individual little or no credit can be tabulated for the marginal success or progress achieved in behavioral change.

For example,in this study multidisciplinary teams involving professional and non-professional staffs were coordinated to provide individual planning, and recommended courses of action in the total rehabilitation of the problem drinker. The many hours by these planning staffs at inpatient treatment units and evaluation centers include members from: the Iowa Division of Vocational Rehabilitation, Education and Services, nurses, psychiatrists, doctors, employment representatives, alcoholism specialists, social workers, and other sub-professionals.

After all this planning and coordination of agencies very little success is achieved in training or upgrading skills. In addition most of these clients are unable to meet the criteria for a closure "26" (Rehabilitated status) as compiled by the Iowa Division of Vocational Rehabilitation, Education and Services. However, the follow-up information compiled by the project staff indicates some employment history in 143 out of 195 individuals for 73 percent. Again most of this work is limited to day labor, spot jobs of an unskilled type.

Thus, the Indian problem drinker's inability to adapt to a machine-time clock culture exemplifies the problems of tabulating progress or success, behavioral change and some assimilation.

HYPOTHESIS 2

LESS ABSENTEEISM FROM WORK

Discussion:

In virtually all community treatment units providing service for the study group much importance is attached to reducing absenteeism from work and training. Various services and different approaches by the workers are used to reduce the client's many predicaments.

For example, these workers are involved in many activities such as: requesting the court to release a client so he could return to work if he had a regular place of employment. A telephone call is made to the employer telling him that the client would be late or he would be in the next day. Transportation is furnished to take the individual to his place of employment. The payment of a fine is arranged to be delayed or paid later as an alternate to incarceration.

Generally this process of helping the client stay on the job was so frequent and continuous that it was almost a foregone conclusion in working with the majority of them. Thus, no numerical tabulation is tallied to illustrate results or numerous times the rescue service was put into action. In addition it is extremely difficult to tabulate absenteeism of a worker employed in day labor.

HYPOTHESIS 3

RELATIVE DECREASE IN ARRESTS FOR DRUNKENNESS.

Discussion:

It is estimated that the individual arrest rate was reduced in 34 out of 60 clients for 56 percent at the Tama location and 43 out of 135 clients for 32 percent at the Sioux City location. These figures are based on the evaluation by the project staff along with a review of the base line material and follow-up information tabulated in the descriptive narratives.

At the Sioux City Center statistically the total number of Indians arrested for problem drinking remained almost unchanged during this period. One reason is due to the increased growth of the Indian population. At one point the police-court system agreed to allow the Indian community to take the inebriate home rather than incarcerate them for intoxication. However the Indian community refused to accept this challenge and responsibility which may not have influenced the behavior of the individual drinker to any great extent, but would have reduced the arrest rate for the Sioux City area.

Limitations

There are some limitations in tabulating and recording the arrest rate of a highly mobile, transient clientele. The loss of contact as the client moves from city to city over several states makes it extremely difficult to accurately state the exact number of arrests for each individual. Also the various judicial systems incarcerate clients to different blocks of time. For example, in the Tama area individuals may be sentenced to 15 or 30 days on a drinking charge while in the Sioux City area the intoxication charge maybe 3 days. So the individual in the Sioux City area maybe arrested, released and arrested 3 or 4 more times during that 15 day period than an individual from the Tama area.

Frequently the problem drinker is arrested on various charges not directly stating the use of intoxicating beverages. For example, individuals followed by the project staff were charged with various offenses in connection with problem drinking. As tabulated these violations are listed under several headings such as:

Suspicion, Disorderly Conduct, Hit and Run, Drinking Beer on the Highway, Striking an Unattended Vehicle, Illegal Parking, Intoxicated on the Highway, Driving with License Suspended, Failing to Yield, Injury to a Building, Operating a Motor Vehicle While Intoxicated, Uttering a Forged Check, Petty Larceny, Assault, Contributing to a Minor, Disturbing the Peace, Reckless Driving, Simple Assault, Distruction of Public Property, Illegal Possession, Intoxication, Violation of Liquor Laws, Other Assaults, Driving Under the Influence, Offenses Against Family and Children.

HYPOTHESIS 4

A MORE STABLE FAMILY RELATIONSHIP

Discussion:

A major concern of the study was to examine the structural aspects of the family and to help provide for a more stable family relationship.

The records show that at the time of referral and intake a high structural collapse was due to divorce, death or separation. In the Sioux City area, seventy eight people or 58 percent fell in this catagory. A much lower figure for the Tama area totaled eight people, 13 percent of the Indian group and eleven people or 31 percent of the non-Indian group. Table 6 illustrates the family structure at the two centers for the three groups.

Table 6 - Marital Status at Intake

Sioux City Center

TRIBE	Married	Single	Divorced	Widowed	Separated	N
Omaha	6	2	3	2	6	19
Ponca		3				3
Winnebago	8	9	5	4	14	40
Sioux	6	10	9	2	13	40
Sioux Winnebago		1	2		2	5
Winnebago Kickapoo	1		1	1		3
Navajo			1			1
Omaha Winnebago					2	2
Winnebago Sac Fox		1		1		2
Chippewa Sioux		1				1
Chippewa			1		1	2
Sac Fox		1				1
Other		8		2	6	16
TOTAL	21	36	22	12	44	135

Tama Center

TRIBE	Married	Single	Divorced	Widowed	Separated	N
Sac Fox	15	30	6	0	2	53
Sac Fox-Winnebago	2	1				3
Sac Fox-Kickapoo	1					1
Sac Fox-Potawatomi	2					2
Sac Fox-Other		1				1
TOTAL	20	32	6	0	2	60

Tama Center

	Married	Single	Divorced	Widowed	Separated	N
Non-Indian	23	2	6	0	5	36

FAMILY COUNSELING

One of the specific hypothesis in the project is to provide counseling services to the total family thus creating a more stable relationship. The marital status upon first contact and completion of intake reveals that only 41 out of 195 individuals or 21 percent are married. This marital status is an extremely important index of social integration.

Mr. Richard D. Elefson, assistant director of the Alcoholic Service Unit from the State Mental Health Institute was employed to provide family counseling for the group at the Tama location. His extensive experience and successful family counseling background with other groups is ideal for this situation.

Based on this background, previous experience and effectiveness, Mr. Elefson made the following general observations and comments concerning these sessions. Some of these questions are difficult to appraise due to the limited number of meetings, a different group attending each time, and the lack of sincerity in relation to stopping drinking.

Question: 1. Are these counseling sessions for the number of Indian families that attended effective in stabilizing the family relationship and changing behavior?

Answer: I do not believe that these sessions have any positive effect in terms of establishing some stability in family relationships or change in behavior with the exception perhaps of one family. This was the only couple to attend all sessions held at the rehabilitation center in Tama.

Question: 2. Did it make any difference to have both Indian and non-Indian people participate in the counseling sessions?

Answer: It would appear that the sessions were more effective when non-Indians were excluded from participating in the counseling sessions. At two of the sessions there were non-Indians present and the interaction of the members was much more limited than during those sessions when only Indians were present. I very frankly discussed this with several of the families the afternoon I spent on the reservation and without exception they expressed a desire to have the sessions limited to members from the reservation.

Question: 3. Were these sessions as effective as those conducted by you and your staff at the treatment unit and nearby communities. Again I'm sure you will want to make a comment on motivation and the realization that there must be a need or a desire by the individuals concerned that participate in the sessions.

Answer: These sessions at Tama were not nearly as effective as those conducted here at the hospital or in many of the nearby cities primarily due to the lack of motivation. I believe one of the key factors lies in the fact that I was unable to see these couples individually prior to entering into the group. I have felt that it is important that a certain amount of individual counseling take place before they are placed in a group and when such counseling has taken place they are more effective and verbal within the group situation. In accepting couples for group counseling here at the hospital or in other communities, I have only done so when both husband and wife realize the need for counseling and had in fact asked for the opportunity of entering the group.

Question: 4. What can be done in the future to make these more effective sessions in terms of changing behavior, stabilizing the family, and higher self-esteem?

Answer: Regarding future plans in working with the family I believe it would be beneficial to have the subprofessional counselor explain in more detail the nature of family counseling and to point out some of the changes that might possibly occur if they have a desire to improve their living situations. I believe one to one counseling would be quite beneficial and I understand that beginning next week you will be adding a staff member who might contribute greatly to this phase of the program. It might be helpful to point out to the families that in a marriage they are beginning a new institution and that while certain tribal customs are brought into the marriage, it must be realized that if a husband and wife are going to have a successful marriage that both must recognize that it has to be an entirely new family situation. It would appear to me that one of the big difficulties lies in the fact that many of the women feel that they should be a dominating force in the family. There were several in the group who had lived away from the reservation for sometime and having returned are now experiencing considerable conflict over accepting some of the mores of the non-Indian and attempting to integrate these into the Indian culture. This is presenting a considerable problem for both the husband and wife. The inability of the marriage partners to discuss such cultural differences has increased conflict between several of the families that I have endeavored to work with.

Question: 5. Is there basically any difference in conducting the family sessions at the Tama location compared to the ones at the treatment unit?

Answer: No, however it would seem to me that you would have a better chance of maintaining more attendance if it would be possible to work at a location on the reservation rather than in the community of Tama. I certainly would investigate the possiblity of using one of the classrooms at the Indian school for this purpose.

Question: 6. Do you recommend long term counseling sessions in a group type setting or individual counseling? Depending on the need should we utilize both types of counseling?

Answer: Certainly with most of these couples long term counseling is indicated. I would begin with individual counseling and then when the therapist feels the couple is ready, I would endeavor to move them into a group situation. As near as practical, I would endeavor to make the group hetrogenous for the best anticipated response.

Question: 7. Part of the answer to the success in the family counseling program would be our ability in the project to motivate the Indian families to see a need in this type of therapy. Other than motivation in a concerted effort to get the families to attend these sessions are there any other suggestions that should be implemented or utilized?

Answer: In response to this question, I think it would be quite helpful if the sub-professional that spoke the native tongue would communicate to them the need and purpose for marriage counseling. I think in this way it might instill some motivation and perhaps the recently assigned worker will be able to function in this capacity.

Question: 8. Are there any general comments concerning the use of these family counseling sessions either of a positive or negative nature, which might be used in evaluating this program?

Answer: In discussing the overall results of these sessions with the sub-professional counselors, I believe the inability to communicate with understanding, due to the language barrier, was perhaps the most negative draw back. Also should you decide to continue this program I certainly would suggest working with those couples who indicate some motivation and desire to particiapte in counseling. Further than this I think that much can be done in terms of education regarding the dynamics of counseling and why it might be indicated for some of these families.

Results of Family Stability

In addition to the special family counseling program from the State inpatient treatment unit other services are provided by the local mental health unit, social services, clergy, and subprofessional counselors from the project. Many times use was made of various combinations of two or more agencies in helping the family adjust to a crisis.

A review of the base line material and follow-up information from the descriptive narrative indicates a positive change or a more stable family relationship in 32 of the 41 married individuals provided services and counseling.

HYPOTHESIS 5

HIGHER SELF ESTEEM

Discussion:

Formulating a criteria to measure exactly how a person feels about himself, his surroundings and general attitude can often be subjective and vague. These judgments or estimates measuring the individual's behavioral change and esteem suggests several questions. For example, Is he happier now than when we started treatment? Did we motivate him to feel better about what's important to him or to the project staff? Is the therapy and treatment by the inpatient staff sufficient criteria to state that a person has developed a higher esteem? Is drinking with his friends more important to him than moderation or sobriety? Is the occupation that is considered of lower esteem for others really higher esteem at this point for the problem drinker?

In some individuals it is relatively easy to determine the change and progress for higher self-worth. The successful individual processed through the inpatient treatment unit and later promoted to a staff position working with other patients usually indicates this in their conversation and actions. Another individual moderated his drinking over a period of 2 years, his family stabilized through marriage counseling, and he attends AA regularly. In these two people the background, progress and stability is very evident that they have progressed in self importances or higher esteem.

In other cases we made the judgment that little or no progress has been made in a change of behavior and esteem. One individual continuously reverted back to living at the city jail for periods of several months. Numerous attempts were made to counsel him into leaving the jail, live at the halfway house and be employed in some type of occupation with a higher remuneration. However, he rebuffed all these attempts of motivation and change as he continued his self imposed jail sentence.

Considering the limitations in this area we did make some judgments on the individuals that had a higher self-esteem as a result of our working with them. This estimate is based on a review of the base line material prior to providing services and the overall evaluation by the project staff at each location.

It was estimated that we improved higher self-esteem in 66 percent of the individuals from Tama and 51 percent of the individuals from Sioux City. In addition evidence of motivation to moderate their drinking behavior was estimated in 33 percent at Tama and 26 percent at Sioux City. These estimates are based on the individuals AA attendances, request for inpatient treatment, and the positive relationship they established with the workers.

Inpatient treatment services were provided for 58 out of 195 individuals or 29 percent of the cases. Generally these treatment units stressed AA attendances while in treatment and upon discharge with a group in their community. This AA indoctrination and understanding helped build a nucleus for the Indian AA clubs at both centers.

Continuation of hypothesis 5

Esteem of the Group

The program of treatment should take into account the need for human approval and self-respect. In most communities the problem drinker is at the bottom of the economic and social pole. As a result of his behavior he is the least respected in the community and his treatment up to this time has been mostly negative or limited to a punitive action. He is a prisoner in a loss of self esteem producing behavior which causes him to be further disesteemed. Unless this situation is reversed it is doubtful any positive results can be achieved.

The negative public sanctioning of the total group for individual misconduct has little or no effect on the behavior of the offender but usually disesteems the group. These newspaper bylines illustrate the futility of applying middle class values in changing an individual act by criticizing the group.

"TWO FINED AFTER BEER BUST IN INDIAN HOME"
published in the Toledo Chronicle, February, 1968.

"MESQUAKIE BOY, 16, ADMITS BREAKING TWO LARGE STORE WINDOWS DOWNTOWN"
published in the Tama News, September, 1970.

"INDIAN GIRL JUMPED OFF BRIDGE, SWAM DOWN RIVER TO ESCAPE LAW OFFICERS"
published in Tama News, September, 1968.

"INDIAN GIRL PROVES HER DEXTERITY BEHIND STEERING WHEEL; LAW OFFICERS PURSUE HER AT 95 MPH FOR 30 MILES"
published in the Toledo Chronicle, September, 1968.

A more realistic and positive approach must be taken toward Indian problem drinking. Something along the thoughts expressed by Dailey in his paper is a recommended starting point. He writes, "I do not think we can anticipate any appreciable moderation in the Indians use of alcohol until one of two things happen; either they rapidly acculturate thereby losing their separate identity in the parent society or they overcome their apathy, define their drinking problem themselves and take steps, probably with our help, to do something about it."[30]

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[30]Dailey, op. cit. p. 27.

SUMMARY

This report has presented the results of a two and one-half year demonstration-research project that was conducted by the State of Iowa. The general objectives of the project are to determine if Indian problem drinkers who accept treatment will indicate a higher percentage of increased employment, less absenteeism from work, relative decrease in arrests for drunkenness, and higher self-esteem.

The sample included all Indian problem drinkers provided a service, treatment, and counseling during a period from October, 1968 to June, 1971. During this time treatment was provided for 36 non-Indians and 195 Indian problem drinkers representing more than 17 tribes. (Generally no reference is made to the non-Indian problem drinker in the study).

Higher Percentage of Increased Employment

In coordinating all the community resources employment was documented during follow-up on 90 percent of the cases at Tama and 66 percent of the cases at Sioux City. Almost all of this employment is limited to unskilled or day labor that provides the least remuneration.

The training programs designed to help the problem drinker up-grade his skills includes: evaluation, MDTA training, and formal schooling. Of the 51 individuals that applied or started these programs, 13 completed, 8 were still enrolled, and 30 dropped, a 59 percent failure rate.

Less Absenteeism From Work

As the project became operational it was increasingly difficult to tabulate the frequency and many types of service furnished each client by the subprofessional workers. Thus, no statistical data is estimated on the reduction of absenteeism except for the majority it was almost continuous. These varied activities covered a wide range of tasks: financial help, release from incarceration, transportation to a place of employment, guidance in a legal entanglement, and many other health or personal related problems.

Relative Decrease in Arrests for Drunkenness

The arrest rates tabulated on each problem drinker were reduced significantly in those individuals receiving services. It is estimated a reduction was evident in 56 percent of the cases at Tama and 32 percent of the cases at Sioux City. The cooperation by the police-court system gave the worker an alternate to punitive action for those individuals indicating sincerity or motivation in moderation of their destructive drinking pattern.

More Stable Family Relationship

At the time the intake form was completed only 41 individuals or 21 percent were married. Individual and family counseling for those married individuals indicated a positive change in 32 families. The network of resources providing these service includes: mental health, social services, inpatient treatment unit, clergy, and subprofessional counselors.

Summary continued

Frequently, the communication barrier, lack of motivation and understanding reduces progress and change in those participating in the marriage counseling. Also many of these agencies efforts are geared to the middle class level of functioning. This can be overcome by phasing in or utilizing the subprofessional counselor as needed in understanding and motivating the individual or group.

Higher Self-Esteem

The estimates made from the base line material, follow-up information and the project staff evaluation indicates higher self-esteem in 66 percent of the cases at Tama and 51 percent of the cases at Sioux City. Some evidence of motivation to moderate their drinking behavior is revealed in 33 percent of the cases at Tama and 26 percent of the cases at Sioux City. Inpatient treatment by the State Alcoholism Units were provided in 29 percent of the individuals.

Recommendations

Applications of the findings

1. It is recommended that the Indian problem drinking rehabilitation services continue as a coordinated treatment effort. The process of referral to the caregiving agencies should be strengthened, expanded and utilized to an even greater extent. This would include a continued referral of patients from the local service center, and an increased emphasis on treatment of problem drinking, both at the inpatient level and during follow-up in the community.

2. A long range training program should be implemented to qualify more subprofessional Indian Counselors to work in the alcoholism field. Often in the past, the professional leadership, medical care facilities and social agencies have been reluctant to provide care and treatment for these problem drinkers. The subprofesssonal counselor can bridge some of the cultural gaps and help overcome the narrow or segmented treatment of these clients.

3. A cooperative effort should be continued with the penal-court system to explore alternate techniques and methods for handling public intoxication. In most instances, use was made of incarceration to motivate the client in a "crisis creating situation." Generally this punitive approach tends to solidify the drinking group rather than creating a confrontation of their destructive drinking.

4. It is suggested that an increase in Alcoholics Anonymous emphasis be strengthened and made more meaningful to the Indian problem drinker. For example, the AA program should be translated into a tribal language, and educational efforts or printed material be based on situations that are familiar to the Indian.

5. It is recommended that increased emphasis be made at the reservation level on all alcoholism related problems. Based on the results of the Iowa study more progress was made at the rural reservation level than at the urban center. In-group loyalty, lack of identification and tribal rivalries in the urban area often "nullify or paralyze" the program's planning and progress.

6. Problem drinking among Indians should be approached from the standpoint of a health problem with priority given to assimilation rather than first stressing employment or occupational training. After some management of this problem drinking, vocational planning should be phased in according to the needs and abilities of each client.

7. It is recommended that more use be made of the Disulfiram (antabuse) program as it becomes accepted by the problem drinker and the caregiving agencies. For certain chronic drinkers this is the only alternate in controlling the pressure exerted on them by the bottle gang desiring to continue a destructive drinking.

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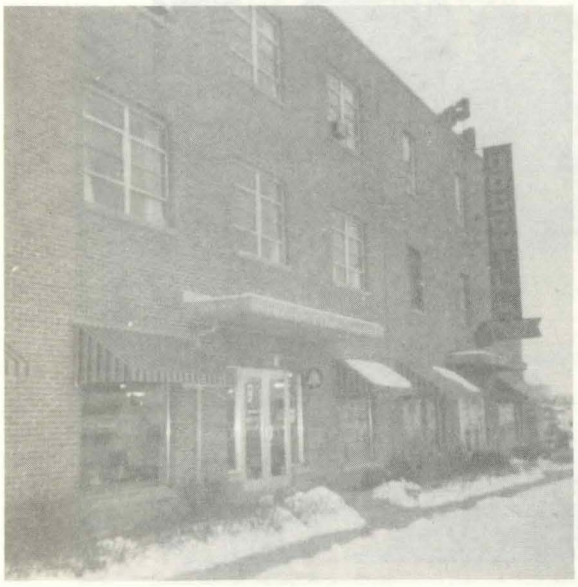
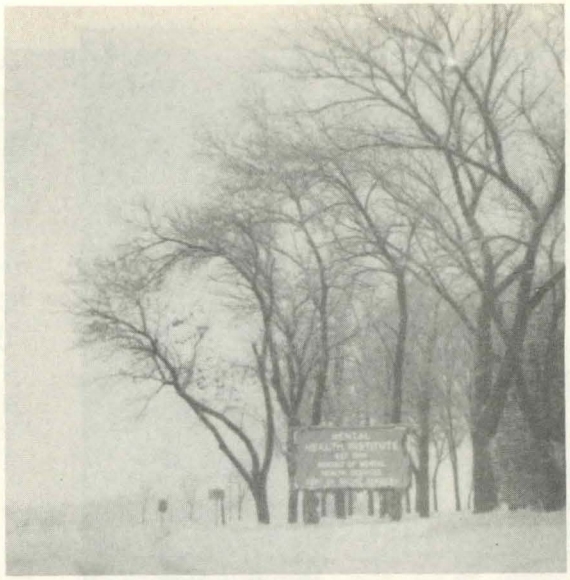
APPENDIX A

PERRY MANYWOUNDS
Sioux City Office



INDIAN PROJECT OFFICE
Located at:
Goodwill Industries
Sioux City, Iowa



TREATMENT UNIT
Mental Health Institute
Cherokee, Iowa

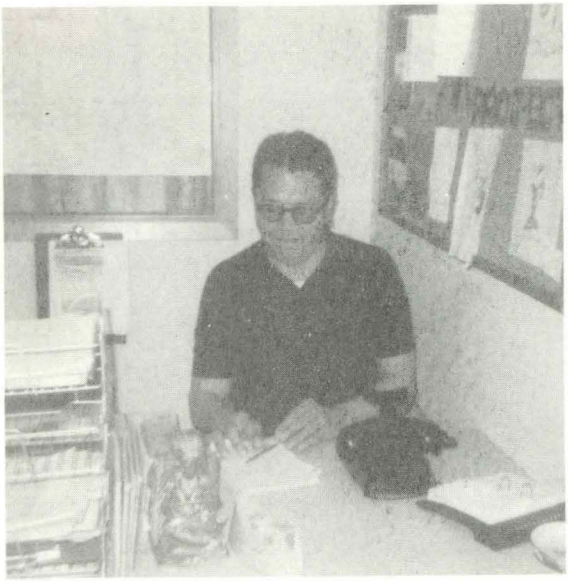
NELSON CLAY, DIRECTOR
Alcoholism Treatment
Unit
Cherokee, Iowa

JOHN E. MACKEY
Consultant
Sioux City Center

AL JUNG

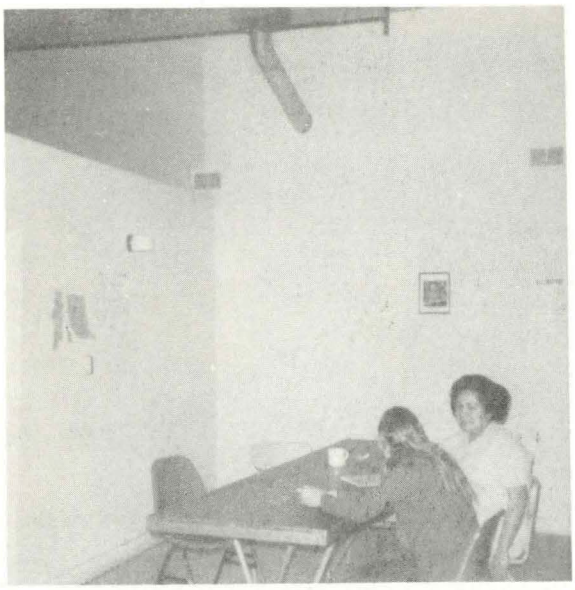
REHABILITATION COUNSELOR
Iowa Division Vocational
Rehabilitation Education
and Services

Sioux City Center



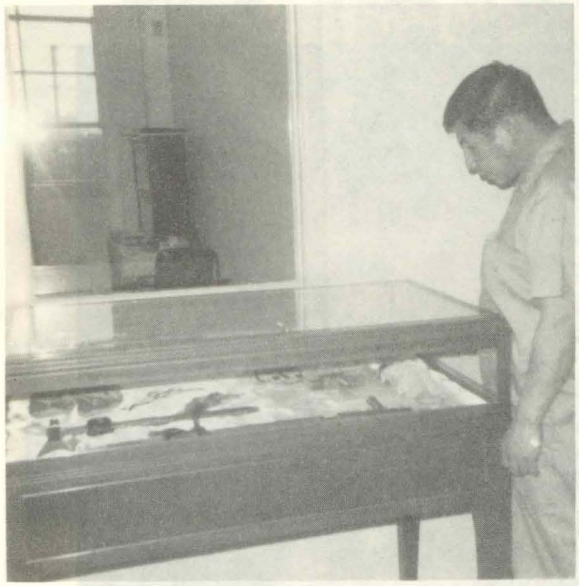
LEONARD MACKEY

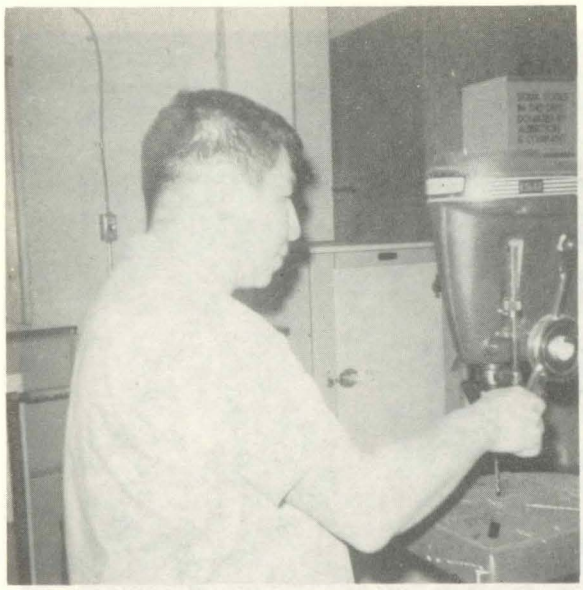
Subprofessional Counselor
Sioux City Center



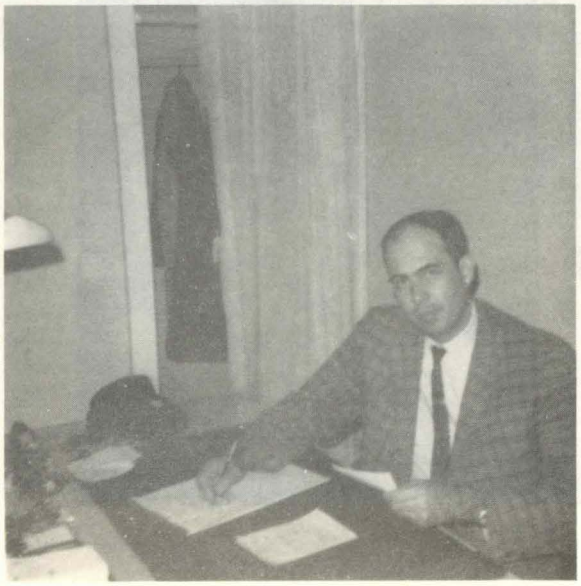
One-and-one counseling
at the Tama Center.

EVALUATION CENTER LOCATED AT GOODWILL INDUSTRIES IN SIOUX CITY

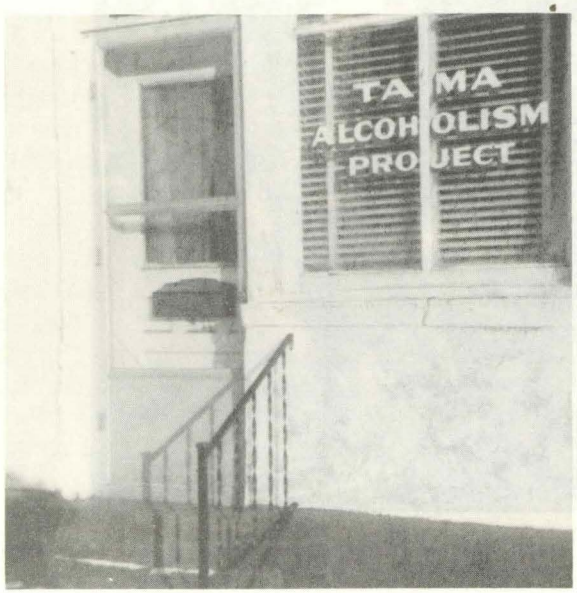




RICHARD L. RATTRAY,
Project Director



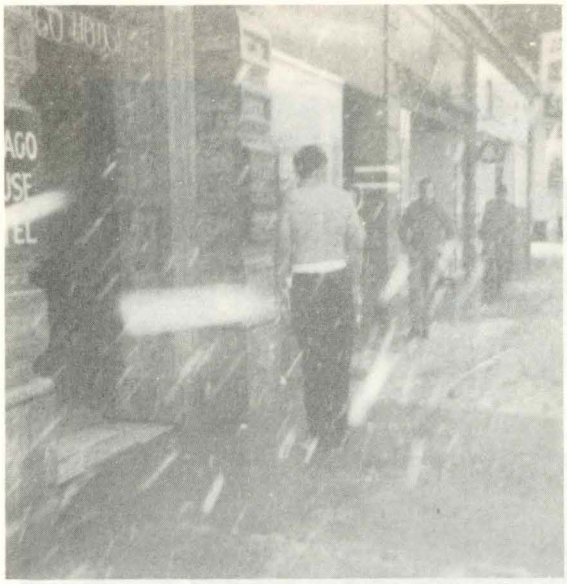
RICHARD McLAUGHLIN,
Community Coordinator,
Tama Center



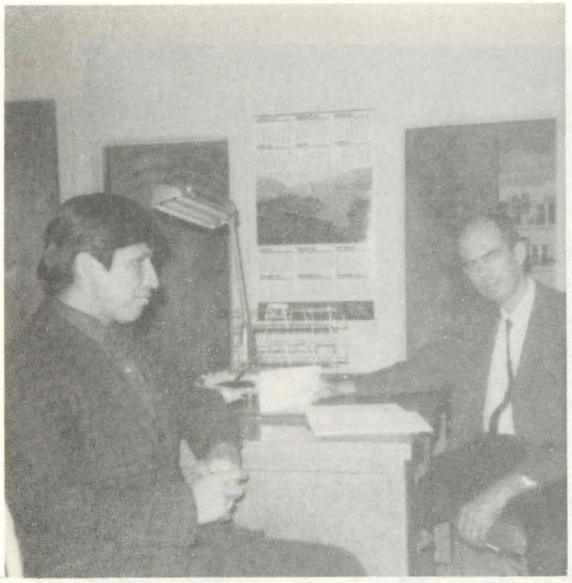
PROJECT OFFICE

Tama Center

FRANCES BLACKCLOUD,
Secretary-Counselor
Tama Center



This client is walking in snow and subfreezing weather without any shoes or shirt.



RICHARD MCLAUGHLIN
Tama Office

Case conference with subprofessional, Harold Mitchell.

A P P E N D I X B

Disulfiram (Antabuse) Program

ANTABUSE PROGRAM FOR HARD CORE ALCOHOLICS

The antabuse program is designed for the resistant alcoholic - the person who has tried almost every treatment and failed, the person who doesn't want to be helped, has had several admissions to jail or hospitals for inebriety. They must curb their drinking as they have become community problems.

The program involves cooperation of the Court, police, doctor, mental health and project personnel. This proposal follows the patient from the time he is apprehended through detoxification and close follow up.

The actual implementation of the program varies from patient to patient and in each community, but typically the individual is in jail after being picked up by the police for his latest offense committed while under the influence of alcohol.

The patient is transferred to an in-patient treatment unit for detoxification. It usually takes from three to five days to recover from an acute alcoholic experience to the point that the patient no longer is shaking, has delusions, or incoherent speech.

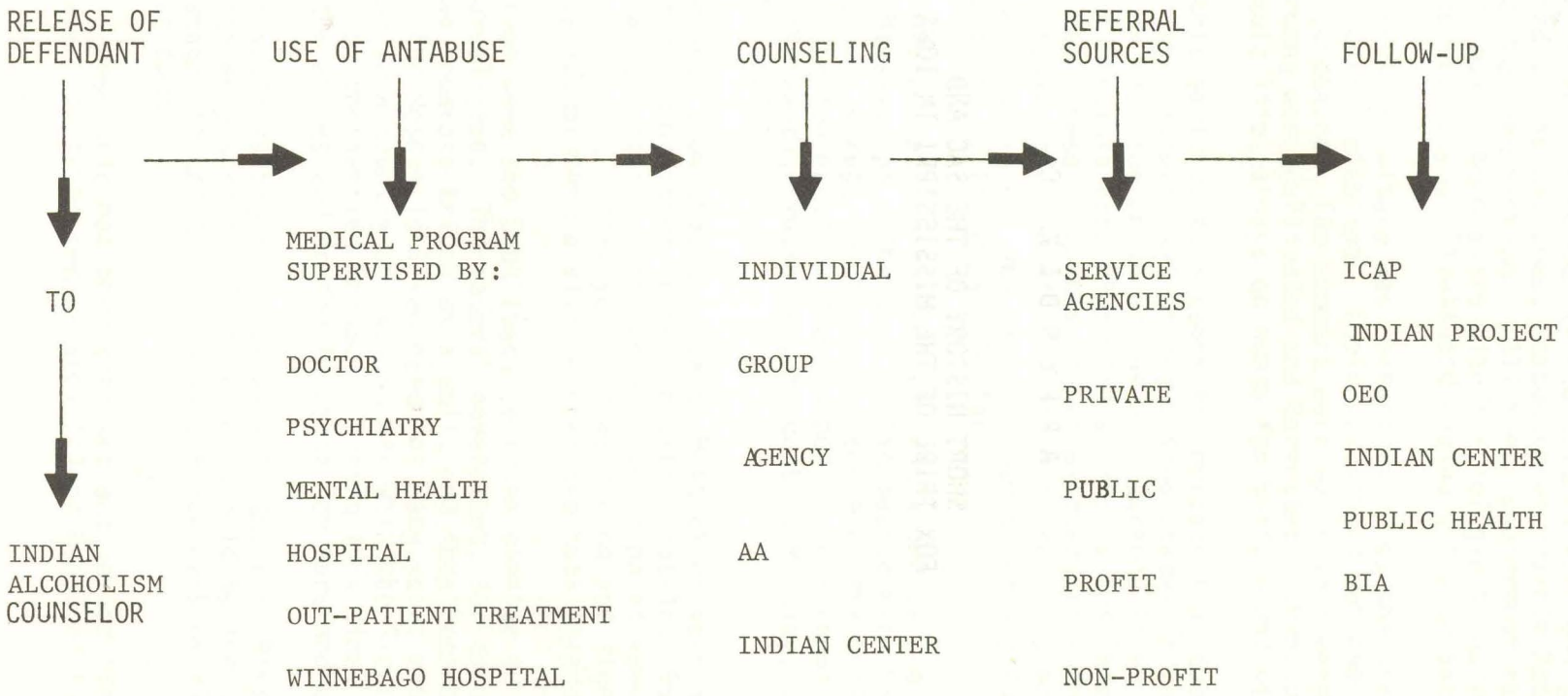
After the patient is completely dried out, the Antabuse (Disulfiram) is started. The antabuse alone usually produces no symptoms in a person, but even a small amount of alcohol in an individual who is taking the drug produces vomiting, dizziness, trouble breathing and collapse. Each patient is told to avoid all wine, alcohol and medicines containing alcohol.

Prior to the patient leaving the in-patient treatment unit, he is given the "Alcohol Challenge" in which he consumes one ounce of alcohol. This is to prevent the patient from experimenting or imbibing at a later date. Also it is to show those who are administering the program what his personal reaction is so that they will be aware of it immediately, should the patient start drinking. In the treatment unit emergency drugs and oxygen are available in the room in which the test is given as are experienced personnel to administer them, whereas, in a bar the experience could be fatal. (However the alcohol challenge may be optional depending on the philosophy and discretion of the physican and treatment unit.)

After the Alcohol Challenge test the patient is conditionally released from the treatment unit on antabuse. Twice a week for one full year or as required the patient must take liquid antabuse under the supervision of a nurse at a specified location.

If the patient fails to come for his antabuse it is promptly investigated. This close follow-up is one of the most important factors in the whole program. If the patient has simply forgotten or has a good reason for failing to come, arrangements are made to get it the next day. However, if he refuses to come or cannot be located, the patient is in violation of his parole and will be returned to jail unless some amicable agreement can be reached.

JAIL RELEASE PROPOSAL



A P P E N D I X C

SHORT HISTORY OF THE SAC AND FOX TRIBE OF THE MISSISSIPPI IN IOWA

The Sac and Fox Tribe of the Mississippi in Iowa

The Mesquakie Tribe is a member of the Eastern Woodland group of Indians closely related to the Chippewa, Mascoutin or Prairie Potawatomie, the Menominee, Ottawa, and Kickapoo. All these members of the Woodland group speak languages much alike with the religious customs, arts, crafts, and general way of livelihood having a common pattern.

This early Mesquakie culture was characterized by the use of round bark or mat houses called wickiups. Their livelihood was one of hunting, fishing, and gardening. The summers were spent in a permanent village where the gardens were cultivated and harvested. Then, during the winter, it was a nomadic life, always on hunts for buffalo and other animals.

Evidence of this early culture seems to indicate that the Mesquakie once lived on the eastern part of the United States in the State of Rhode Island or near the mouth of the St. Lawrence River in Canada. As a result of pressure from other Indian groups and later the arrival of the white man, these Mesquakies moved westward into the Wisconsin area. Later, toward the end of the 18th century, they moved farther west beyond the Mississippi and divided into several groups settling in various sections of the United States.

One of these groups settled in Iowa and was known as the Sac and Fox Tribe of the Mississippi. The Sauk or Sac people were known by the Indian name of Osa kiwug, which means "people of the outlet," or "people of the yellow earth." The Fox people were known as the Muskawakiwuk (Muskwaki, Muskutawa, Musquakie, Musquky, and Mesquakie), or "red earth people."

Historical records show that the Fox or Mesquakies were a very war-like people, often engaging other tribes in bitter battle. During these battles they were credited with the extermination of several tribes that have disappeared. After years of wandering and fighting, these people finally established a village near the Rock Island, Illinois area.

Across the river were the Sauk (Sac), a tribe similar to the Mesquakie in custom and religion. The federal government, for convenience, dealt with these two separate tribes as a unit, and they became known as the Sac and Fox. The Mesquakie lived here for many years making winter hunts into the Iowa country and waging war with the Sioux, Omaha, and other tribes for the hunting grounds. During this time, they were not bothered by the whites and traded in peace for furs and other items.

Soon, several settlers began to stream into the rich Mississippi Valley and looked with envy upon the fertile acres held by the Indians. How the whites managed to get this land is a black mark or blemish in the history of our country.

Around 1802, a Mesquakie had been arrested and jailed for murder in St. Louis. When his tribesmen at Rock Island heard of his imprisonment,

a party was sent to St. Louis for the purpose of trying to get him out of jail. At that time, the government agent at St. Louis had been instructed to secure a treaty with the Fox, whereby, they would cede their lands in Illinois to the United States and move west to the Mississippi. Prior to this, all efforts to secure signatures for such a treaty had failed. Unscrupulous agents managed to get the Indians, that had been sent to St. Louis to free their tribesman, drunk and then to sign the treaty for the land claims. Upon returning to Rock Island, the Indians had no remembrance of signing anything; however, the treaty was acted upon and the Fox were driven from their homes.

The so-called Black Hawk War followed this treaty. Black Hawk was a leader among the Sauk, who fought with some of the Fox to preserve their homes and way of life against the government. The Indians were hopelessly out-numbered and suffered many casualties; thus, Black Hawk was defeated in 1812, so his people fled from Illinois into Wisconsin and across the Mississippi into Iowa.

During the next few years, the Mesquakie, or Fox, lived on the Des Moines side of the Iowa River, hunting, fishing, and gardening as usual. They avoided the white man as much as possible, as they were no equal in arms or combat with him.

In 1842, Iowa was taken from them, and they were granted a reserve in Kansas. Great difficulty was experienced by government agents charged with making this removal to Kansas. The bands of Mesquakies scattered along the rivers of Iowa, hid from the soldiers and policemen who came to transport them away. Some never went to Kansas, others escaped from the reservation and drifted back to the old hunting grounds in Iowa.

About the time the government was preparing to move the Mesquakies out of Kansas into Indian territory, which was later called Oklahoma, a band of Mesquakies bought 80 acres of land near Tama, Iowa. They purchased this land with money paid to them as annuities and other money obtained from the sale of some ponies. This 80 acres was bought with individual Indian money and not from tribal funds. The title of the land was vested in the Governor of Iowa because the Mesquakies distrusted the guardianship of the federal government, who had moved them so often. More land has been added from time to time, purchased with tribal funds, until they now have 3200 acres.

The tribal lands at Tama are held in common and are not owned by individuals. A tribal farm of 500 acres is leased and the rent from this land pays limited state and county taxes for the entire Sac and Fox settlement.

At the present time, the Mesquakies are one of the smaller tribes, having about 790 members. The population of the Mesquakie settlement is approximately 430 people. No Indian in the United States is restricted to a reservation, as is commonly believed. The Indians are free to come and go as any other citizen of the United States. They may remain on the reservation as an individual preference and not a restriction of the federal government.

The Indians receive technical assistance from the government in fulfillment of treaty obligations. They furnish health and educational services to these people. They have established day schools on the settlement and also send interested children to boarding schools in South Dakota, Minnesota, and Kansas. In 1937, a school was built to accommodate grades one through four. Kindergarten and grades five through twelve attend the community schools in the nearby town of Tama. Also, the Bureau of Indian Affairs maintains a staff at the settlement.

APPENDIX D

SOCIAL HISTORY FORM

SOCIAL HISTORY

Service Center_____ Interviewer_____

Date_____

NAME:_____ SOCIAL SECURITY NUMBER:_____
First Middle Surname

ADDRESS:_____
Street City County State

HOW LONG AT THIS ADDRESS:_____ PHONE NO._____

SEX:_____ RACE:_____ NATIONALITY:_____

PREVIOUS ADDRESSES:

_____ DATE:_____ PHONE:_____

_____ DATE:_____ PHONE:_____

LEGAL:_____ DATE:_____ PHONE:_____

DATE OF BIRTH:_____ AGE:_____ PLACE OF BIRTH:_____

MARITAL HISTORY: Living With Family? _____ Yes _____ No

MARRIED (1)_____ Date (2)_____ Date (3)_____ Date (4)_____ Date

DIVORCED (1)_____ Date (2)_____ Date (3)_____ Date (4)_____ Date

WIDOWED (1)_____ Date (2)_____ Date (3)_____ Date (4)_____ Date

SEPARATED (1)_____ Date (2)_____ Date (3)_____ Date (4)_____ Date

NUMBER OF CHILDREN:_____ NUMBER OF CHILDREN SUPPORTED BY CLIENT_____

MILITARY SERVICE:

BRANCH:_____ DATE OF ENTRY:_____ DATE OF DISCHARGE:_____

TYPE OF DISCHARGE:_____ VA CLAIM NO:_____ SERIAL NO._____

OCCUPATIONAL HISTORY:

Employer	Job Performed	Started	Ended	Income
1. Present				
2.				
3.				
4.				

USUAL OCCUPATION?_____ OCCUPATIONAL SKILLS?_____

HOW MANY DAYS WORK WERE LOST DUE TO DRINKING?_____

INSURANCE:_____ COMPANY:_____

EDUCATION:_____ VOCATIONAL TRAINING:_____

HEALTH CONDITION: _____ _____ _____
Poor Good Excellent

DO YOU HAVE ANY PHYSICAL HANDICAPS, LIMITATIONS OR INABILITIES? _____

PHYSICIAN:

NAME:_____ADDRESS:_____DATE OF LAST CONTACT:_____

RELIGION:

CATHOLIC: _____PROTESTANT:_____OTHER:_____

NAME OF MINISTER:_____ADDRESS:_____

ECONOMIC:

INCOME LAST 12 MONTHS? _____
HIGHEST ANNUAL INCOME? _____
PRESENT INCOME? _____
PROPERTY OWNED? _____ (Home, car, etc.)
SPOUSE EMPLOYMENT? _____

FINANCIAL AID RECEIVED: _____ _____
Yes No

Agencies	Type	Location	Date	Amount
(a)				
(b)				
(c)				
(d)				
(e)				

OTHER FAMILY MEMBERS INCOME:_____

INDEBTEDNESS:

AMOUNT:_____WHOM:_____URGENCY:_____
AMOUNT:_____WHOM:_____URGENCY:_____
AMOUNT:_____WHOM:_____URGENCY:_____

PREVIOUS TREATMENT FOR ALCOHOLISM OR MENTAL ILLNESS:

INSTITUTION:_____DATE:_____
INSTITUTION:_____DATE:_____
INSTITUTION:_____DATE:_____

ARREST RECORD: _____INTOXICATION OR OMVI_____

OTHER ARRESTS:_____

_____

WAS DRINKING INVOLVED: _____ _____
Yes No

WHO REFERRED:_____

DRINKING DATA:

NUMBER OF YEARS DRINKING? ______________________________

DO YOU FEEL YOU ARE A HEAVY DRINKER? ______________________________

DOES YOUR DRINKING CREATE PROBLEMS FOR YOU? ______________________________

WHEN DID YOUR DRINKING BEGIN TO CREATE PROBLEMS? ______________________________

REHABILITATION PLAN: (including referrals you make)

(DATE)

CASE CLOSED ______________________________ Reason ______________________________

CASE REOPENED ______________________________ Reason ______________________________

CASE CLOSED ______________________________ Reason ______________________________

CASE REOPENED ______________________________ Reason ______________________________

- -

COMMENTS ON THIS CLIENT'S PROGRESS:

PROGRESS REPORT:

	REPORT DATE	INITIALS
ADM.		
30 day		
60 day		
90 day		
180 day		
1 year		
Final		

APPENDIX E

DESCRIPTIVE NARRATIVES AND FOLLOW-UP HISTORY

Client Number: A-30
Intake Date: 8-14-68

Description:

This twenty-six-year-old single male client is a self-referral with a long history of problem drinking. Client has over twenty-five arrests for intoxication, bad checks, and other drinking related convictions. From the initial intake up to the present time, the client has made remarkable progress in the areas being researched. His arrest rate has dropped to a total of three in 1968, one in 1969, and no arrests the first six months of 1970. In the area of employment, he did job hop or move from job to job frequently, however, he worked longer at these positions than during any previous employment history. No family relationships have been documented as the client is single and was living with his grandfather until the latter's death.

Social History:

Military Service:

None, he passed his physical but was disqualified for Army duty as a result of low GCT test scores.

Occupational History:

Client's work history is entirely unskilled manual type employment: automatic car wash worker, janitor, construction, foundry, brick tender, and kitchen helper.

Education:

Sixth grade

Referral Agencies Utilized:

Alcoholism Education Classes
Iowa Division of Rehabilitation, Education, and Services
In-patient Treatment Units
Detoxification (out-patient treatment)
Iowa State Employment Services
MDTA counseling
Alcoholics Anonymous (AA)
Office of Economic Opportunity
Halfway house
Cedar Rapids Citizens Committee
Social Welfare Services

Follow-up History:

9-14-68	Referral and intake information
9-14-68	In-patient treatment
11-15-68	Discharge from treatment
	Living at Gateway Halfway House
	Employed at automatic car wash
	Attends regular AA meetings
	Employed at college as a dorm janitor

Client Number A-30
Intake date: 8-14-68

Follow-up History: (continued)

5-69	Unemployed - sober
6-69	Unemployed - sober
7-69	Unemployed - sober
8-69	Social Welfare Aid
	Gethman Construction Employment - $2.25 per hour
9-19-69	Accepted for MDTA Vocational Evaluation Assessment
9-25-69	Failed to attend MDTA training at Comprehensive Vocational Facility
	Started drinking after missing training program
10- 8-69	Re-employed at Gethman Construction at $2.65 per hour
10-14-69	Sober attending AA meetings at Tama Rehabilitation Office
10-30-69	Started drinking
	Jailed for intoxication
	Physical from doctor and started on disulfiram (antabuse)
	Loss of employment
11-21-69	Employment at Gra-Iron Foundry - $2.47 per hour
	Applied for drivers examination and passed test after third time
	Employment terminated due to absenteeism and unable to meet production schedule
	Sober and attending AA group meetings
12-15-69	Employed at Masonry Contracting - $2.50 per hour as brick tender
	Sober attend AA
	Employment terminated after a short time
1- 5-70	Started drinking
	Re-admission to Gateway Halfway House for Alcoholics
	Re-employed at Auto Car Wash at $1.75 per hour
4- 1-70	Three months training under Iowa Division of Rehabilitation, Education and Services program to qualify for an Out Reach Alcoholism Aide.
6-30-70	Client has completed training as an alcoholism aide. Project Staff contacted the Anamosa State Penitentiary for the client's employment as an alcoholism aide. Client is sober and well-motivated.
7-27-70	Client has completed three workshops on Alcoholism, is motivated, and sober. Rehabilitation plan now includes employment with Hawkeye Community Action Program at Cedar Rapids as an out-reach worker. Still living at the Halfway House under supportive environment.
9- 3-70	Client sober, employed at the Hawkeye Community Action Program for $325 per month. At times he becomes dissatisfied with his job, however project staff has provided close follow-up counseling and client is stabilized at this time. He has been very successful during a long period of sobriety.
9-11-70	Project staff provided supportive environment for client during a period of personal turmoil.

Summary:

Client is successfully rehabilitated as he is sober, trained and employed. Close follow up and supportive counseling is needed.

Client Number: A-8
Intake Date: 3-15-68

Description:

This thirty year old male client was referred to the project by the BIA Representative for help with his drinking problem. He states he has a drinking history of 14 years and now considers himself a heavy drinker. He just can't stop after two beers. It seems the client has some insight and realization into his troubles and drinking. Rehabilitation planning covers treatment at the in-patient treatment units and training under MDTA from the Iowa Employment Service. Help will be solicited from the minister and local AA members also family and marriage counseling is recommended to help the family overcome some problems.

Social History:

Military Service:
U.S. Marines, entered 10-21-54 to 4-4-56. Received Bad Conduct Discharge.

Occupational History:

Gilbert Builders, Inc. at $2.50 per hour
Gra-Iron Foundry, Inc. at $2.43 per hour
Brick Tender at $2.00 per hour
Mueller Construction Company at $2.50 per hour
Midwest Springs Mfg. Company
Handy Manufacturing at $1.70 per hour
Gethman Construction Company at $2.75 per hour

Education:

9th Grade - Local high school
Completed 12th grade at Reformatory

Referral Agencies Utilized:

Sac & Fox Area Field Office (Bureau of Indian Affairs)
In-patient Treatment Unit
Social Welfare Services
Physician
Alcoholics Anonymous
Mental Health Clinic (out-patient)
Iowa State Employment Service
Manpower Training
Office of Economic Opportunity
Counseling
Ministerial Counseling

Client Number: A-8

Follow-up History:

3-25-68	In-patient treatment
4-15-68	Referral and intake information
4-30-68	Released from in-patient treatment
	Unemployed
	Sober
5-9-68	Employed Mueller Construction at $2.50 per hour
5-22-68	Invited to AA
6-5-68	Sober
	Attended AA
7-31-68	Sober
8-31-68	Intoxication on highway - fined $55.00
9-2-68	Drinking and in jail - first time drinking since treatment
9-28-68	Intoxication - fined $15.00
9-28-68	Simple assault - 8 days
11-1-68	Invited to AA
11-26-68	Drinking and in jail - fined $15.00
12-2-68	Started MDTA training in combination welding at Sioux City (12 wks)
12-19-68	Intoxicated
	In jail and fined
	Stabbed with a knife
3-24-69	Invited to AA - refused
3-27-69	Drinking - AA and family counseling recommended
6-9-69	Drinking and in a fight
7-8-69	Invited to AA - refused
	Counseling
	Discussed training with BIA Program
	Employed at manufacturing concern at $1.75 per hour
	Client is purchasing a home
7-11-69	Invited to AA - refused
7-24-69	Intoxicated, in jail for refusing to pay cab fare
8-24-69	Changed jobs from Handy Manufacturing to construction at $2.75 per hour
9-5-69	Invited to AA - refused
9-12-69	Invited to AA - refused
9-30-69	Attended AA meeting
10-17-69	Attended AA meeting
10-28-69	Left construction to be employed by another construction company at $2.50 per hour
11-6-69	Drinking
11-18-69	Attended AA meeting
4-14-70	Attended AA meeting
5-2-70	Started drinking
5-3-70	Intoxication - jailed
	Feels marital problems caused him to drink
5-8-70	Client hurt his back on the job, is receiving two weeks workman's compensation from Gra-Iron Foundry
6-6-70	Client in jail for intoxication, needed $25.00 cash bond to get out. Client's employer posted $25.00 bond and client was released from jail.

Client Number: A-8
Intake Date: 3-15-68

Follow-up History:

6-7-70	Client requests in-patient treatment at Independence
6-8-70	Obtained a volunteer admissions for in-patient treatment at Independence. MHI briefed in-patient treatment staff on the client's status
6-17-70	Client started on antabuse the second day at Independence He seems well motivated and has a good outlook on his rehabilitation
6-19-70	Client requested and received a weekend pass to visit his family
7-7-70	Client requested project staff to help him locate an AA sponsor. He was going to be discharged from in-patient treatment in about a week. Real estate agent in home town was assigned as sponsor for client.
7-14-70	Client discharged from in-patient treatment unit, employed by Gra-Iron Foundry at Marshalltown. Sober, attending AA.
9-3-70	Client is sober, employed at Gra-Iron Foundry in Marshalltown and is doing extremely well and has progressed, in the opinion of the project staff, better since at any other time. His family relationship has stabilized and has experienced no problems since in-patient treatment.

Client Number: B-22
Intake Date: 4-2-69

Description:

This thirty-nine-year-old veteran referred himself to the project for help as a problem drinker. Client states he has been a problem drinker for several years. He has some insight into his drinking, however, he is not motivated and does not have the willpower to arrest his drinking for a long period of time. He feels that his drinking does cause him problems. He has attended AA meetings, was exposed to numerous in-patient treatment units and various other rehabilitation programs. At the time of intake he has not responded to any positive long-term program. His rehabilitation plan involves AA counseling, use of antabuse, in-patient treatment, and the possibility of training and employment in controlling or arresting his problem drinking.

Education:

High School graduate
Two years of college

Referral Agencies Utilized:

Veterans Administration
Goodwill Industries
AA
Counseling
Court
Cherokee M.H.I.
Siouxland Opportunity Center
Jewish Federation
Winnebago Public Assistance
D.R.E.S.
Social Services
Ministerial Counseling

Occupational History:

Hide Puller
Goodwill Industries
Spot jobs

Follow-up History:

4-29-69	Intake and referral date
5-2-69	Client was in need of living quarters
8-25-69	In jail for intoxication
10-17-69	Client attending AA meetings, positive attitude
	Client is sober
10-28-69	Client is drinking
	In jail for intoxication
11-4-69	Client in jail for intoxication
11-12-69	Client jailed for intoxication

Client Number: B-22

Follow-up History: (continued)

12-15-69	Client sober
12-24-69	In Jail for intoxication
2-5-70	Client asked to be taken to Cherokee MHI for treatment
2-10-70	Client still at Cherokee MHI; doing art work at Cherokee
2-17-70	Client enjoys active group therapy at Treatment Unit Client has been asked to do some drawings and painting for an engineering company
2-25-70	Client leaving Cherokee before his full treatment program was completed
3-24-70	Client is on antabuse - sober Client is back working at Goodwill
4-28-70	Client received $85.00 for painting Staff counseling provided - sober
5-3-70	Client making arrangements to enter college in the fall Still employed and sober
5-8-70	Client was injured in a freak accident. Suffered serious injury to his right arm, which is also his painting arm. Client receiving Public Assistance until he can paint again. Attending AA and is sober Client has been corresponding with college he will be attending in the fall, under BIA, DRES and Veterans' benefits
5-21-70	Sober for three months; employed part-time as an artist Taking antabuse; still planning on training to finish college
5-27-70	Drinking, in jail for intoxication, disorderly conduct, for a total of 8 days. Judge refused to release him from jail.
6-1-70	Released from jail Has been accepted for physical education course in college training program
6-3-70	Drinking - uncooperative
6-8-70	In jail for intoxication
6-9-70	Transported to reservation by project staff. Counseling provided to stop drinking. Client requests use of antabuse and in-patient treatment by the Public Health Service. It is the opinion of the staff at this time that the client does desire to quit drinking and has shown some motivation to return to the antabuse program and arrest drinking. Close follow-up will be provided to give supportive therapy and counseling to the client.
6-15-70	In jail for intoxication
6-22-70	In jail for intoxication
6-29-70	In jail for intoxication
7-1-70	In jail for intoxication
7-6-70	In jail for intoxication
7-9-70	Counseled at jail by project staff
7-10-70	Released from jail. Returned to reservation to see his mother. Seems motivated to some extent after this last intoxication-jail series

Client Number: B-22

Follow-up History: (continued)

7-16-70 Still drinking
Refuses antabuse program upon doctor's request to take the tablet

8-5-70 Client sober, rehabilitation plan still developed to attend college in South Dakota. He is taking antabuse. Self-employed, painting and doing artistical work for personal expenses. The Veterans administration and DRES are being utilized to develop the tuition and maintenance charges to attend college.

8-11-70 Client is sober, self-employed and still on antabuse
Completed a physical for DRES

8-27-70 Counseling provided by project staff
Enrollment fee has been mailed to the admissions office for college training
At this time, client seems well motivated to enroll in training

Summary:

9-10-70 The rehabilitation plan for this client is to re-enroll him in college in the physical education program he originally dropped. The Iowa Division of Rehabilitation, G.I. Bill under the Veterans Administration, Tribal Council at Winnebago, and Sioux City Goodwill Industries are providing funds for the education program. Close follow-up will be maintained by a counselor and AA sponsor while attending college.

Client Number: A-31
Intake Date: 9-9-68

Description:

This twenty-nine-year-old Army veteran with a drinking history of at least 14 years, referred himself to the project for services. He has a minimum of 12 intoxications and 2 OMVI convictions. It is felt at this time he is making satisfactory progress and showing some stability in training and rehabilitation, however, he still has to understand his drinking problem. During the time from intake until now, he has been moving from job to job and location to location with very little ties to any particular employment or area. No family relationship has been described as he is separated from his wife and three children.

Military Service:

Six-year veteran with an honorable discharge

Education:

High School (GED)

Referral Agencies Utilized:

In-patient treatment - MHI
Alcoholics Anonymous (AA)
Counseling
Halfway House
Division of Rehabilitation Education and Services
Iowa State Employment Service
Social Welfare
BIA Area Field Office
Out-patient Treatment Center - Des Moines and hospital

Follow-up History:

1-4-68 Simple assault - $15.00 fine
3-3-68 Intoxication arrest - $15.00 fine
6-16-68 Intoxication on highway - $105.00 fine
9-3-68 Self-referral to project for services
In-patient treatment at Mental Health Institute
In-patient treatment report from MHI:
Client has been drinking since early teens. He has had numerous auto accidents while under the influence. Motivation for sobriety - fair; employment - fair; AA - poor; halfway house residence - poor; follow-up counseling - poor.
This was the client's first hospitalization at the in-patient treatment unit. The client is bright and learns quickly. He is impulsive and easily angered which affects

Client Number: A-31
Intake Date: 9-9-68

Follow-up History: (continued)

his judgment. Employment history indicates his inability to hold steady, gainful employment, although he appears to be quite capable and a good worker when sober. He can handle responsibility if closely supervised, however, he resents supervision which has been a factor in job changes.

10-22-68	Discharged from in-patient treatment
12-4-68	Employed at ACME Brass and Aluminum Foundry Sober
3-24-69	Released from employment due to excessive absenteeism which amounted to 32% of his work time. Employer stated that client's work was satisfactory.
4-14-69	Employed as a sheet metal worker at $2.00 per hour. Missed first days work, however, close follow-up by project staff,client was retained. Purchased car to have transportation to work Sober and attending AA
6-8-69	Left sheet metal work Received Land Claim money to purchase another car
7-1-69	Traveled to Oklahoma City to find a job. Stranded, so requested $40.00 from grandparents
7-16-69	Client returned to project area. Vocational rehabilitation counselor provided counseling, long-range planning on current debts, and possible training after some stability and sobriety Employed at Mid-West Springs Machines at $2.10 per hour
8-6-69	Apprehended for driving with suspended drivers license Started drinking
8-20-69	Laid-off at Mid-West Springs due to absenteeism Unemployed, drinking
8-28-69	Employed at Sheet Metal Manufacturing Client faces prison term on third charge filed for driving with suspended drivers license Sober
9-12-69	Client is drinking, car accident and finedin mayor's court, $25.00
10-14-69	Attending AA Left job with sheet metal for higher paying job at Air Conditioners Mfg. Co.
11-1-69	Started drinking
11-20-69	Unemployed, decided to leave his job due to transportation problems and low wages
12-69	Iowa State Employment Service arranged for MDTA training starting 12-15-69, as a welder
1-7-69	Client attending MDTA training Client was attacked, robbed, and cut up Staff counseling

Client Number: A-31
Intake Date: 9-9-68

Follow-up History: (continued)

3-23-70	Client reported someone had stolen his billfold and $15. He needed money to live on. Staff counseling
2-3-70	Client missed MDTA training and started drinking
2-8-70	Client drinking, picked up for intoxication and fined $50 for leaving the scene and not reporting an accident Staff counseling
3-13-70	Fighting and jailed for intoxication, fined $15. Client was stabbed twice and required six stiches and new glasses. Public Health Service authorized purchase of medication and a pair of glasses.
4-21-70	Client was requested to answer lawyers complaint on neglect to pay child support. It is hoped to delay legal action until client graduates from welding school on 5-29-70.
5-18-70	Client came into the State Office for counseling, however, he was under the influence of "acid" or LSD. After a short time, the client left.
5-20-70	Client graduated from welding school
5-27-70	Client contacted Project Staff and stated that the police had picked him up as he was high on LSD Staff counseling
5-30-70	Client unemployed Returned to the Tama Settlement
6-24-70	Client traveled to Des Moines to start employment as a welder
6-27-70	Client still drinking
6-30-70	Client working at Capitol City Mills at $2.25 per hour, working as a fabric worker operating a machine
7-13-70	Client requests $15.00 from his grandmother
7-21-70	Client still employed at Capitol City Mills. Client states he had a fight with three people and was shot at. Requests money from home. Counseling provided the client. Client's grandmother sent him $10.00 for expenses. Staff counseling.
9-3-70	Client did contact project staff when intoxicated. Missed one day's work at Capital Mills, however, they retained him as an employee and he returned to work the next day after some absenteeism. Client still requests money from his grandmother. Client, during intoxicated condition, had another fantastic story about the CIA checking around Des Moines about his personal life. There was no such truth to this story.
9-11-70	Employed Drinking occasionally

Client Number: A-24
Intake Date: 5-20-68

Description:

This twenty-three-year-old divorced male client was referred to the project by the County Sheriff's Department. On first interview client relates he has a drinking history of about 7 to 8 years. In his opinion he does not feel he is a heavy drinker. He does feel he has some problems when he drinks. He has had 50 arrests since 1964 on intoxication, disturbing the peace, and simple assault. He states he has no OMVI's. At first interview and referral contact, client was in jail charged with intoxication. At this time he was enrolled in training at the Des Moines Comprehensive Vocational Facility as a machinist. He started the training 5-15-68 and hopes to finish 11-22-68. The training was discontinued due to excessive absenteeism.

Military Service:

None

Education:

12th Grade - graduated

Referral Agencies Utilized:

Sheriff's Department
Iowa State Employment Service
Counseling AA
In-patient treatment unit
Project Staff

Occuaptional History:

Chicago & Northwestern Railroad at $2.62 per hour
National Quaker Oats at $2.62 per hour

Follow-up History:

Date	
6- 9-68	Simple Assault; fined 30 days
6-20-68	Referral intake. Client held in County Jail for intoxication and simple assault - 30 days. Contacted Training Unit and requested to return to training after release from jail.
8- 4-68	Intoxication; fined $30.00
8-10-68	Intoxication; fined $15.00
9-22-68	Failed to display registration; jailed
9-22-68	Reckless driving; jailed
10-22-68	Failing to yield; fined $25.00

Date	
11-16-68	Intoxication; 8 days in jail
11-24-68	Injury to building; fined $15.00
12- 2-68	Intoxication; jailed
12- 9-68	In jail for intoxication - 15 days
12-12-68	Client did not complete training period. Dropped from MDTA
12-20-68	Intoxication; 15 days in jail
3-26-69	Contributing to minor; fined $109.00
4-11-69	Intoxication; jailed
6-14-69	Simple Assault; fined $30.00
6-16-69	Intoxication; jailed
7- 1-69	Several arrests for intoxication
8- 9-69	Intoxication; 15 days jailed
9- 4-69	Counseling
9-22-69	License under suspension; fined 8 days Client refused to cooperate and appears unmotivated
10-26-69	Simple Assault; fined $30.00 In-patient treatment
10-27-69	In-patient treatment unit. Client has been drinking heavily. Unemployed due to poor work record. In jail for simple assault
11-10-69	Discharged from in-patient treatment without staff approval. Temporarily lost contact and moved from area.
4-23-70	Client in jail for intoxication. Unmotivated and not very cooperative.
9- 3-70	Client has been in trouble and in jail for intoxication at least once. Client is employed at the Quaker Oats Company. At the present time he is living with his father, still drinking. Not rehabilitated.