

SCOMM

#6:34

Keep together  
as one packet

AFN-  
material

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PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED  
AS A UNIT IN THE ORIGINAL DOCUMENT.

AFN - (Ting)

## GOALS

1. Individuals who understand the effects of alcohol on their bodies and their lives, and who can maintain good control of themselves.

## PURPOSES

1. Bring about improvement in individuals, their families, and society as a whole.
2. The enchancement of the ██████████ community in particular.

## POLICY

1. Follow the lead of the most successful program on alcoholism.
2. Align all existing resources to the advancement of that program.
3. Develop a program which will bring an alcoholic person off his dependence and up to the point of being a valuable and productive member of society!
4. Have the ideal scene<sup>1</sup> (purpose) attainable and clearly defined. Keep it in view at all times while working on the program.
5. Use the Administrative Scale<sup>2</sup> technology to bring about the ideal scene.
6. Use the full alcoholism gradient scale<sup>3</sup> in order to attain the ideal scene.

- (1) People who are not dependent upon alcohol and are self-determined.
- (2) The Administrative Scale was developed by L. Ron Hubbard as a management tool.
- (3) Alcoholism Gradient Scale:
  - (a) Education and prevention
  - (b) Crises intervention and counseling
  - (c) Rehabilitation
  - (d) Job training
  - (e) Job placement
  - (f) Follow-up to correct any of the earlier steps not done properly.

## P L A N S

1. Understand as much about the Narconon<sup>4</sup> Program as possible.
2. Explore the practical application of this program to the situation of alcoholism in general in Alaska and the Native alcoholic situation specifically.
3. If needed, for a task force of interested public people in order to enact the Narconon Program.
4. Approach the subject on a gradient, the Alcoholism Gradient Scale.
5. Review the Narconon and other existing programs in light of this gradient scale<sup>2</sup>. Any program agreed upon should be capable of bringing about the ideal scene.

## P R O G R A M S

1. Find out what groups and individuals are responsible for the planning and implementing of existing programs.
2. Create and exchange of information between the groups and individuals identified in number 1 above, with Narconon in order to coordinate the Alcoholism Gradient Scale.
3. Develop and implement the solutions thus far agreed upon.
4. Review, plan, and implement any areas of the Alcohol Gradient Scale not covered.
5. Conduct a follow-up review and evaluation.
6. Correct any points found to be ineffective.

## P R O J E C T S

### Program Information Gathering

1. Get a list of groups and individuals who are responsible for planning and
- (4) Narconon-comes from the words non-narcosis meaning the absence of stupor or insensibility.

implementing existing alcohol and drug abuse programs.

2. Do a survey of these people to find out the difficulties and possible solutions to alcoholism as they see it.
3. Tabulate and distribute the survey results.

#### Planning Meeting

1. Bring program directors and Board directors together with Narconon people.
2. Come up with a coordinated plan to handle Alcoholism in Alaska.
3. Designate one office as the Central Communication Center for overall coordination of the effort.

#### Implementation

1. Acquire additional funding if needed.
2. Provide organizational assistance so that an effective delivery system can be placed in effect.
3. Deliver training to existing personnel and new personnel as hired.
4. A full Admin Scale will be used to assist in implementation of the Alcoholism Gradient Scale.

#### Follow Up

1. By using the Admin Scale for each program it will be possible to monitor its own effectiveness by its statistics.
2. If the program needs assistance in any area it can notify the Communication Center.
3. The need for assistance will be relayed to the proper person.
4. That person will deliver the needed assistance.

## ORDERS

1. There will be good communication between all people involved.
2. Time targets will be set and agreed to by all concerned.
3. We must have full agreement on this Admin Scale.
4. We must keep the purpose of our work in mind at all times.

## I D E A L S C E N E

People who do not depend on alcohol and are able to exercise control over their lives.

## S T A T I S T I C S

1. The number of programs working together.
2. The full implementation of this Admin Scale.

## V A L U A B L E F I N A L P R O D U C T

Alcoholism programs working together implementing all parts of the Alcoholism Gradient Scale with the resultant drop in the amount of Alcoholism.

NARCONON®

# NEWSLETTER

MARCH 1977

THIS ISSUE: GOOD NEWS FROM NARCONON MINNESOTA &  
NARCONON NEW ORLEANS  
ARTICLE: "THE ROAD OUT" BY L. RON HUBBARD

THE MCKNIGHT FOUNDATION

2600 1/2  
Dixie Street  
Minneapolis, Minnesota 55426  
612/545-3414

December 8, 1976

Lotte Seidler  
Vice President  
Narconon Minnesota  
1816 Grand Avenue South  
Minneapolis, Minnesota 55409

Dear Ms. Seidler:

The Directors of the McKnight Foundation met on Tuesday, November 27th, and approved a grant of \$3,000 to Narconon Minnesota to be used to assist in the establishment of a Drug and Alcohol Rehabilitation Program at St. Cloud Reformatory.

Our grant will be paid in full in early January of 1977.

We are pleased to be of assistance to you.

Sincerely,

Russell V. Ewald  
Executive Vice President

RVE:mp

UNITED STATES AIRMAIL

United States Airmail

POSTAGE WILL BE PAID BY ADDRESSEE

December 3, 1976

Ms. Lotte Seidler  
Narconon of Minnesota  
1816 Grand Avenue South  
Minneapolis, Minnesota 55409

Dear Ms. Seidler:

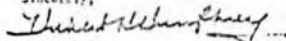
I have just recently been informed that the McKnight Foundation has given a grant to your organization to assist in your continuing work.

I just want to congratulate you on the reception of that grant and tell you how pleased I am that you have received it. I surely know of the good work that the McKnight Foundation does for our area and state, but I also know of the excellent work which your organization does.

The work which you and your staff provide to our community is most helpful in making this a better community in bringing human concern to our society.

My continued best wishes to you and your staff.

Sincerely,

  
Hubert N. Humphrey

## Narconon Gets Results in Orleans Parish Prison

Narconon Minnesota is not the only Narconon to receive community support. The Narconon in New Orleans, Louisiana is also getting excellent backing based on results gotten at the Orleans Parish Prison.

A letter to Narconon New Orleans from John Vodicka, Director of the Louisiana Coalition on Jails & Prisons written on November 18, 1976 states:

"I want to let you know that the Louisiana Coalition on Jails and Prisons supports wholeheartedly the efforts of NARCONON in the New Orleans area.

"Many solutions to our city's crime and drug abuse 'epidemics' have been suggested and implemented in the last few years. None are as socially, economically, and psychologically sound as the approach used by NARCONON.

"NARCONON enables individuals who are dependent on drugs to learn how to achieve the conditions they desire much better *without* drugs than with them. I am confident that with organizations like NARCONON, the crime and drug abuse problems we experience here can be significantly reduced.

"NARCONON has proven its effectiveness in other parts of the country. I am pleased to learn of your efforts in New Orleans. If I can be of any further assistance, please don't hesitate to contact me."

A letter from Frank Minyard, Coroner, Parish of Orleans, written on 12 November 1976 to an Orleans Parish Prison inmate participating in the Narconon program said this:

"Thank you for your letter of November 7, 1976. I am happy to know that you believe the NARCONON Program in Parish Prison is working for you. I can assure you of my support for the program."

Another letter was received from Phyllis Nabonne, Director of the Parish Prison Drug Unit, who had this to say:

"This letter is to state the feedback I have received concerning the operation of the Narconon Program in Orleans Parish Prison.

"I have spoken with three participants of the program, namely E.H., C.H., and K.P. [names deleted—ed.]. Each has stated how helpful and important these classes have been to them. They expressed the changes that have been occurring in their ways of thinking and how the techniques of Narconon have assisted them in handling problem situations.

"I am happy to submit a positive evaluation of your program as shared with me by three of your participants."

The staff at Narconon New Orleans are commended for their dedication and for their honesty and openness in working with the inmates at the parish prison.

## THE ROAD OUT

There are two ways to escape the raw deal that this universe sometimes hands out.

One is to go to sleep or wholly unreal and forget it.

The other is to attain a calm serene beingness that is proof against the knocks and arrows of misfortune.

The first method has distinct liabilities. However it is the most usual route taken by human beings who find the going too rough.

Alcohol, drugs, self-hypnotism, are all men have proven to use. The only real trouble with them is that one wakes up into the same world but a bit weaker, a bit redder of eye, feeling a bit worse.

The drug or other knocks on the head didn't change the universe any and one is still in it, still catching it, probably with even an even lower resistance to it. So the first method is not a very good one.

The second method, the ability to rise above it all had long been preached. But unfortunately there wasn't any readily available technology to accomplish it.

It's one thing to hear that we should rise above it all and quite another to do it.

The road out is the road of increased awareness. It is not a wholly painless road.

Those who had already taken the road down had a rough time going up again. If they increased their awareness enough they would arrive at a high level where they were at cause and in which they could not only cope with their environment but could prosper in it, well above the reach of suffering.

But how to get them up from the point to which they had already gone down? I was finally able to map an easy road which could be travelled despite drugs, despite the starting point, and of course that made it easier for everybody. That road begins with the Narconon Course.

I would feel pretty bad if a lot of good guys had to live with the road blocked.

Like anybody else I have had my own share of Slings and Arrows over the years and I know what it is like.

It isn't all that easy to help one's fellows and to be helped in return. But the end product is itself worth a lot of slings and arrows.

The road out is the way up.

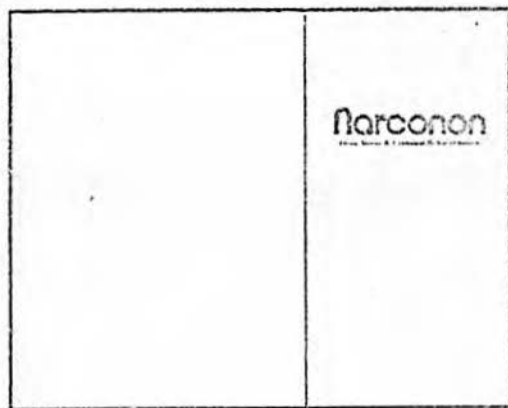
I hope you make it.

Best of luck

RON

*(Reference:—Article written on 22 Sep 1969 by L. Ron Hubbard for Narconon, Arizona State Prison)*

Narconon is handling drug  
abuse and drug addiction and  
restoring self worth and self respect to individuals.



You can find out more about how NARCONON is doing this by means of our new publication, "Narconon—Drug Abuse and Criminal Rehabilitation." This booklet includes all the information on Narconon's approach and results that anyone interested in the handling of drug abuse should know. It includes actual case histories, evaluations and studies, endorsements, procedures, and results.

Order your copy from the Publications Dept. of Narconon U.S.

I enclose \$\_\_\_\_\_ for \_\_\_\_\_ copies of the Narconon Book.

Price: \$2 per single copy. 50% discount for orders of 25 or more.

California residents add 6% sales tax.

Narconon U.S.

6425 Hollywood Bl., Suite 206

Hollywood, CA 90028

(213) 469-8347

NARCONON U.S.  
6425 Hollywood Blvd.  
Suite 206  
Hollywood, California 90028

## WHAT IS NARCONON:

Narconon (meaning non-narcosis or the absence of stupor or insensibility) is an effective drug and criminal rehabilitation program that works to reduce drug abuse and drug-related crime. Narconon utilizes the very workable technology of American writer and humanitarian L. Ron Hubbard.

## WHAT TYPES OF SERVICE DOES NARCONON OFFER:

- A special "Study Course" to help your client get a better education.
- Rehabilitation from drugs and crime.
- Individual, one-on-one counseling.
- Specialized youth counseling.
- Employment assistance.
- Education about drugs and their use.
- Helps your client get back into the community.
- Assist the person in getting the type of vocational training he desires.
- Comfortable living space and recreational activities both on the premises and at the public park less than 2 blocks away.
- 3 hot, well-balanced meals a day with special attention given to supplemental vitamins.
- A drug free, painless withdrawal done with 24 hour supervision, medical liaison and supplemental vitamins.

## SUPERVISION:

While Narconon is not a "lock-down" program, there is a limited restriction period, and close supervision thereafter. Close liaison is maintained with you while your client is at Narconon and after he leaves.

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ALL RIGHTS RESERVED.  
NARCONON® IS A REGISTERED NAME.

## NARCONON CAN HELP YOU:

Narconon can take your client under our arrangements with the California Youth Authority, California Department of Corrections (Civil Addict Program) and Ventura County Alcohol and Drug Abuse Placement Service. If your client does not qualify under one of these categories, we will gladly make special arrangements to assist you in any way possible. Narconon cares about your client making it in society.

## WITHDRAWAL:

Narconon offers a drug-free, painless withdrawal for those clients who are still on drugs when they are referred to us.

## FAMILY:

Whenever possible, Narconon maintains close contact with the client's family in helping them to fully understand his problem and to let them know what progress is being made by the individual. Narconon has good communication with all family members.

## WHO DOES NARCONON ACCEPT:

Narconon accepts your client whether he is a long-time heroin user or a young glue-sniffer. Narconon also accepts those persons with an alcohol problem. Narconon has good staff that care for your client regardless of which of the above problems he has.

## FOLLOW-UP AND REPORTS:

Narconon has a graduate follow-up program whereby close contact and liaison is maintained with each graduate. Special assistance is given to all Narconon graduates in helping them return to society.



NARCONON LOS ANGELES DIRECTOR JEANNIE JURICH

## SUCCESS:

A 1976 survey of all clients handled from 1972-1976 at Narconon Los Angeles showed over 60% to be leading drug free lives. Narconon is an effective program that works.

### SUCCESS STORY:

"After more than half my life — 12 years — on different drugs, heroin, barbiturates, morphine, alcohol intensively, I decided to come to NN. I'm very glad I did. I was extremely shy, I had no motivation to understand myself or face my problems. Through just 3 days of the program I have found truth, honesty and friendship within myself and others here at NN. I never realized I could feel happy and positive about just 'being' without the drug-induced state. It's been half my life in the shadows of misfortune, and finally the light is shining through. My mind and body have never been more positive and happy with myself and reality. I urge all of those who are in trouble, and I mean big trouble—'drug dependency'—to help themselves now by at least trying NN. If it can help me, you are a sure winner here at NN.

"Thank you all."

—S.L.

REFER YOUR CLIENT  
TO NARCONON L.A.  
TODAY—  
213 / 487-1088

Client photos and statements used by permission.

NARCONON LOS ANGELES  
519 SOUTH WESTMORELAND AVE.  
LOS ANGELES, CALIFORNIA  
90020

ARE YOU LOOKING FOR A RESIDENTIAL PROGRAM OR A HALF-WAY HOUSE THAT:

- REDUCES CRIME AND LOWERS RECIDIVISM,
- REHABILITATES YOUR CLIENTS SO THAT THEY CAN BECOME PRODUCTIVE INDIVIDUALS AGAIN,
- GETS DRUG ABUSERS OFF DRUGS AND KEEPS THEM OFF?



NARCONON COUNSELOR WORKING WITH A STUDENT

FIND OUT ABOUT

# NARCONON

STAMP

# Narconon

Dear Sir:

My name is Rick Henley. I'm a "Course Supervisor" for the Narconon Drug and Crime Rehabilitation Program in L.A. We use the study and rehabilitation technology developed by L. Ron Hubbard with great success.

Participants learn "never to go past an undefined or mis-defined word" as it leads to confusion. The result is a superior ability to apply the "tools" we make available to handle the environment (communication, study, objectivity and others). As a result we have almost triple the success rate of other methods of treatment.

The Narconon success rate ranges from 61% in understaffed programs to 99% in our Delaware program. These percentages reflect not only drug usage but related crimes as well. And we're training more staff now than ever before.

We now have access to nine prison programs, with the Ventura Youth School as the most active. Miss Joyce, Chief Counsellor for V.Y.S., strongly approves of the Narconon approach. Rather than paroled criminals, most of whom are embittered and some of whom are retaliative, society receives a new source for stable yet creative producers.

Our public lectures include students(Jr. High through College). Narconon L. A. has a "street facility" to handle relatively painless drug withdrawal and concurrent rehab training. No doubt you agree this is a worthwhile alternative to the downward spiral of criminality and insanity so prevalent today.

Our specific appeal to you would be a contribution of

Please know that our combined efforts are creating a safer and saner space to be in.

Sincerely,

Narconon, L.A.

*A non-profit corporation founded in 1966 for the reduction of crime and drug abuse*

519 SOUTH WESTMORELAND / LOS ANGELES, CALIFORNIA 90020 / TELEPHONE (213) 487-1933

# ALASKA FEDERATION OF NATIVES, INC.

*Integrity, Pride in Heritage, Progress*

## PATTERNS OF MENTAL ILLNESS, ALCOHOL ABUSE, & DRUG ABUSE AMONG ALASKA NATIVES\*

Robert Kraus\*\*

- \* Report prepared under the auspices of the Alaska Federation of Natives, Inc.
- \*\* Professor, Medical Science, the Washington/Alaska/Montana/Idaho (WAMI) Program, University of Alaska, and Clinical Professor, Psychiatry, University of Washington.

Research upon which portions of this report are based was supported in part by National Institutes of Mental Health Research grants MH 18749 and MH 23233 and by an agreement for Financial Assistance dated June 25, 1974 between the University of Alaska and the Center for Disease Control, Dept. HEW.

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The Alaska Native community is struggling with mental health problems of great complexity and severity. The Aleut, Athabascan, Yupik, Inupiat, Tlinget, Haida, and Tsimpsian peoples of the American North, reacting to generations of neglect of their needs in this area, are united in their determination to reverse the steadily increasing tide of mental illness, behavioral disturbance, and social disorder under which they have labored in recent decades. This report, prepared under the auspices of the Alaska Federation of Natives, Inc. (AFN), outlines the scope and severity of the Alaska Native mental health problem. Utilizing a variety of indices it shows that the Alaska Native population suffers under a burden far exceeding that of Alaska non-Native, American Natives, and various other American minority groups. In recent years Native leadership, working closely with State and Federal agencies and with the technical assistance of the Alaska Area Native Health Service (AANHS), has made an outstanding beginning in meeting these problems. It is, however, a beginning. Continuing and increased support is urgently needed. The data in this report do more than outline an urgent health problem. They suggest that a fundamental reordering and rethinking of mental health and public health priorities and models for Alaska are indicated.

### ALASKA: THE SETTING AND THE PEOPLE

The Arctic and Subarctic regions make up some 20% of the earth's land mass. They constitute the last great frontier and reservoir of untapped resources and are everywhere undergoing intense exploitation and development. Alaska, the American North, is participating in this worldwide process of socio-cultural and economic change. This fact plus other characteristics of life in Alaska make for unique problems and make models for the delivery of mental health services developed in other States of questionable value. This is especially true of rural Alaska.

Sheer geographical size and distance are a problem. Alaska's 586,000 square miles would enclose three (3) states of Texas. The distance from Spenya in the Aleutians to Ketchikan in the Southeastern panhandle is equivalent to the distance from Los Angeles to Charleston, South Carolina. The distance from Barrow, the northern-most town in the United States, to Kodiak in the Gulf of Alaska is roughly equal to the distance from the Northern Minnesota border to the Arkansas/Louisiana line. Alaska covers four (4) different time zones; when it is 3 p.m. in Anchorage, the State offices in Juneau are closed for the day.

This vast area manifests great ecological diversity. The rain forest of the Southeastern area with its relatively mild climate and abundant natural reservoir constitutes one of the richest and most diverse natural environments in the world. The Alaska Interior, bounded on the North by the Brooks Range and on the South by the Alaska Range is felt by some to constitute one of the harshest environments in the world with winter temperatures ranging to  $-70^{\circ}$  and summer temperatures in the 90's. In contrast, the Aleutian Islands constitute a typical maritime environment which, in turn, is quite distinct from the flat, treeless windswept tundra and frozen coasts of North and West Alaska.

Within this diverse range of ecosystems over thousands of years the Native people of Alaska have developed their distinctive cultural adaptations. "Alaska Native" is fundamentally an administrative term. The Aleuts of the Aleutian Chain, the Athabascans of the Interior, the Tlinget, Haida, and Tsimpsian of the Southeast, the Yupik of West Alaska, and the Inupiat of North Alaska are historically, linguistically, socially and culturally quite distinct. Figure 1 illustrates the traditional geographic distribution of the Native people, a distribution which holds true to a great extent today.

The dotted line across the center of the State demarcates Native from non-Native Alaska. North of the line the population is predominantly rural and Native. South of the line, it is predominantly urban and non-Native with heavy concentrations in Anchorage and Fairbanks.

Alaska Natives are, therefore, widely scattered and live in a wide range of physical environments. Table 1 shows a recent compilation of population figures (Buller and Kraus, 1977) for the year 1974. The 1977 total figure would probably be in the neighborhood of 64,000. The majority (60%) of Natives live in rural villages. These are remote locations, usually accessible only by airplane, boat, or snowmachine, in which the Native language tends to be spoken and traditional subsistence techniques figure prominently in the way of life. Villages tend to have populations under 500. A smaller number of Natives (approximately 20%) reside in rural predominantly Native towns. These towns tend to have populations of 2,000 or more. English tends to be spoken and there is greater emphasis on a wage and cash economy. Other Natives (approximately 20%) live in the western urban environments of cities such as Anchorage, Fairbanks, and Juneau.

It is clear, therefore, that the patterning of mental illness and the delivery of mental health services in rural Alaska is complicated by a variety of factors that render the application of concepts and models developed elsewhere difficult. Distance which adds enormously to expenses of travel, isolation due to geographical inaccessibility and the vagaries of the weather, problems of communication via radio, wide regional differences in perceived needs, and cultural diversity are only some of the factors which must be taken into account in planning. (Kraus, 1971).

#### MENTAL HEALTH: THE HISTORICAL DIMENSION

Mental illness has always been a part of Native life just as in all other cultures of the world. The earliest explorers in the Arctic noted the presence of people who appeared to be mentally ill and remarked upon the kindness and compassion with which they were treated in comparison with the abysmal standards of care then prevalent in the Western world. Certainly in precontact and contact times each Native culture had its own concepts of mental illness, its cause, and its effective treatment. Much of this knowledge has been lost in the process of acculturation; however, much persists (Vallee, 1967). The systematic elucidation of Native traditional concepts of mental illness and its treatment should have a high research priority. Such a body of knowledge would be invaluable to both Native and non-Native practitioners.

Until statehood, the only provision for mental health services in Alaska consisted of a contract between the Department of the Interior and Morningside Hospital in Oregon under the terms of which mentally ill Alaskans could be hospitalized. Between January 1, 1904 when the contract was initiated and its termination around the time of Statehood several thousand Alaskans including hundreds of Natives were hospitalized at Morningside (Albrecht, 1948). Statehood with the subsequent construction of the Alaska Psychiatric Institute and the opening of State clinics in Anchorage, Fairbanks, and Juneau raised the standard of care for non-Natives somewhat but had little impact on Native needs other than providing hospitalization in Anchorage at the Alaska Psychiatric Institute as an alternative to Morningside. In the 1950's and 1960's, mental health services in rural Alaska were provided by an informal network of Indian Health Service personnel, Public Health Nurses, Social Workers, and Clergymen none of whom were trained and all of whom were overburdened with other pressing responsibilities. As recently as 1971, it was possible to state that in all of the Native communities of rural Alaska there was no person, Native or white, professional or non-professional, who was working full-time in the provision of mental health services (Kraus, 1971).

The 1970's have seen two (2) important developments. The first was the Alaska Native Land Claims Settlement which resulted in the formation of 15 Native regional corporations, 12 located in Alaska. Through the Regional Health Corporations of their non-profit components, the Native Regional Corporations began to address themselves to their own health affairs. Mental health and alcohol and drug abuse were early assigned a high priority. For years Native leaders had pointed out the urgency of mental health and alcohol problems to no avail; the Native Health Corporations now provided a structure through which they could take affective action. The second development was the reorganization of the State Department of Mental Health. Under new and continuing leadership work was completed which led to the passage of community mental health center legislation for Alaska, years after the implementation of such legislation in other States. The monies thus made available have ushered in an era of cooperation between the Federal government, the State Department of Mental Health, and the Native Health Corporations of benefit to all concerned. Fifteen mental health centers have been set up in Alaska. Five of these have strong Native sponsorship and affiliation.

#### AN OVERVIEW OF NATIVE MENTAL HEALTH & ALCOHOL PROBLEMS

The encouraging first steps of the Native people and their leaders outlined above offer a note of encouragement in a picture which is otherwise quite serious and alarming. The Alaska Native people suffer under a crushing burden of problems related to mental illness and drug and alcohol abuse. A small number suffer from illnesses of a traditional nature, fully understandable only in terms of their culture. In addition they are subject to all of the standard mental illnesses found worldwide and it would appear that as a population, they are experiencing an increased incidence of these. Also, they are experiencing a variety of behavioral and social disruptions in reaction to the stress an acculturative process which is excruciating in its speed and intensity. Alcohol abuse relates to and exacerbates all of the above and is in all regions of Alaska a major and serious problem. Starting from a baseline which goes back to 1950, the standard indicators of mental disorder and social stress in populations all indicate that Alaska Natives represent cultures that are being heavily stressed. The number of Natives treated on an inpatient and outpatient basis for mental illness and alcohol and drug abuse in Indian Health Service facilities has been rising steadily. Institutionalization of Natives at the Alaska Psychiatric Institute (API) is at a rate 2.6 times that of Caucasians. The first full year of reporting for the Community Mental Health System reveals a Native utilization rate  $\frac{1}{2}$  times that of Caucasians. Suicide attempts in the Native population occur at a high frequency as do non-fatal accidents. Native death rates due to suicide, homicide, accidents and alcohol are high and rising. A variety of indicators show that alcohol abuse problems in both the Native and non-Native populations in Alaska are among the most severe in the nation. The available information suggests that the magnitude of problems experienced by Alaska Natives is far greater than that of Alaska non-Natives or the United States population generally and significantly greater than that of American Natives outside of Alaska.

#### A DETAILED SURVEY OF NATIVE MENTAL HEALTH & ALCOHOL PROBLEMS

In the next two (2) sections, certain data relevant to mental illness and drug and alcohol abuse in Alaska Natives mentioned briefly above will be reviewed in greater detail. The first section, "Patterns of Utilization" will deal primarily with various mental health service facilities and the rates of utilization of these services by Alaska Natives as compared to other groups.

It should be pointed out that true figures for the incidence and prevalence of mental illnesses and alcohol abuse have not been established with certainty for Alaska Natives or any other major United States population. Judgments concerning Alaskan problems are particularly difficult to make because of the lack of any uniform State health and mental health information system. The development of such a system for the Native population should have a high research priority and would provide information of considerable utility. Establishing the number of people who utilize a service or calculating utilization of service rates for a population is not a direct measure of the frequency of a disorder in that population rather, they are statistics from which it is possible to make inferences about the frequency of the disorder and whether it is increasing or decreasing.

The next section, "Patterns of Mortality", will present certain informative as to mortality patterns in Alaska Natives and other populations with particular references to violent death and discuss these patterns in terms of their mental health and alcohol abuse significance.

### PATTERNS OF UTILIZATION

Background and baseline data as has been noted, epidemiological information concerning the incidence and prevalence of mental illness and alcohol and drug abuse in Alaska Natives has been sadly lacking; therefore, adequate baseline data do not exist. Foulks and Katz (1973) made a limited attempt to survey the problem by analyzing all discharges from the seven Alaska Area Native Health Service General Medical and Surgical (GM & S) hospitals during 1968. The Native Health Service is part of the Indian Health Service (IHS) and is the principal provider of health services to Native Alaskans. Foulks and Katz found alcoholism to be the most prevalent mental disorder in all the Native ethnic groups; however, it appeared most common in Athabascan Indians and Aleuts. Aleuts appeared to have a low incidence of schizophrenia. Paranoid disorders were most common among the Southeastern Indians who generally lived in larger communities and who had a larger history of contact into white society. Overt depression was most common among Eskimos and was particularly frequent in the larger villages. In fact, all types of mental disorder seemed several times more prevalent in the larger rural Native towns than in the more traditional Native villages. Anxiety neurosis and alcoholism were felt to be most common in the urban environment.

Kontsky (1971) surveyed all admissions to API during the interval 1965-1971. A total of 464 cases were involved. Kontsky commented at length on the difficulties encountered in applying Western psychiatric concepts and techniques across cultural lines, extreme problems of maintaining communication with the distant Native communities from which many of his patients came, and the virtual absence of a follow-up and aftercare system for rural Native patients which resulted in relapse and re-admission for many. He noted that 54% of Native hospital admissions had a history of difficulty with alcohol and 26% of Native patients had a positive history for suicidal behavior. He also noted that both of these percentages were higher than corresponding percentages for the non-Native population.

### III: GENERAL PATTERNS OF SERVICE

Using this incomplete and superficial information as a baseline an attempt will be made to delineate current trends.

Alaska's seven (7) IHS hospitals and their related outpatient facilities continue to be the principal providers of mental health and alcohol services to Alaska Natives. Tables 2, 3, and 4 show the overall pattern of IHS services during the

interval 1971-1976. Table 2 shows admissions to IHS GM & S hospitals and admission rates for the interval. Tables 3 and 4 show outpatient first visits and total visits and respective workload rates. The figures in Tables 2, 3 and 4 illustrate the steadily increasing rates of Native utilization of outpatient services and a corresponding gradual decrease in use of inpatient services, a statistic which reflects the increased amount and quality of outpatient care.

#### IHS: INPATIENT & OUTPATIENT SERVICES FOR DRUG & ALCOHOL ABUSE

Table 5 shows admissions to IHS hospitals for an admitting diagnosis related to alcohol and drug abuse during the interval 1971-1976. Since 1971, the number of admission diagnoses of drug and alcohol abuse has increased from 334 to 453. The percentage of total admission diagnoses of this type has increased from 3.1% to 4.5% while the admission rate/ 100,000 individuals has increased from 659.4/100,000 to 791.3/100,000.

Table 6 relates also to hospital admissions and shows all diagnoses of drug and alcohol abuse made in IHS hospitals during the interval 1971-1976 regardless of reason for admission.

During the interval, the number of such diagnoses increased from 602 to 818. The percentage of total diagnoses increased from 3.7% to 5.2% and the morbidity rate went from 1188.5/100,000 to 1494.9/100,000.

Table 7 and 8 deal with outpatient or ambulatory care for diagnoses of drug and alcohol abuse in the IHS hospitals. Table 7 shows that first visits for drug and alcohol abuse increased from 1012 to 3712. The percent of total visits increased from 1.8% to 2.5% and the incidence of such first visits increased from 3972/100,000 to 6783/100,000. Table 8 shows total visits for drug and alcohol diagnoses and total workload rates for the interval in question. It can be seen that the total visits increased from 2985 to 5487. The percent of total visits went from 1.5% to 2.0% while the total workload rate increased from 5892/100,000 to 10,027/100,000.

#### IHS: INPATIENT & OUTPATIENT SERVICES FOR MENTAL ILLNESS

Table 9 shows the IHS figure for admissions to hospitals with an admitting or first diagnosis of mental illness. The number of such admissions during the interval 1971-1976 has increased from 625 to 773 while the percent of total admission has climbed from 5.7% to 8.1%. The admission rate for persons diagnosed as mentally ill went from 1233/100,000 to 1412/100,000.

Table 10 also deals with hospital care and shows all diagnoses of mental disorder made in IHS hospitals between 1971 and 1976 regardless of reason for admission. The number of such diagnoses has risen from 4171 to 1365 during the interval. The percent of total diagnoses that they comprise has risen from 7.1% to 8.7%. The rate has gone from 2311.8/100,000 to 2494/100,000.

Tables 11 and 12 deal with outpatient care for mental illness in the IHS and show a pattern consistent with the one already described. Table 11 shows that first visits for mental illness have increased from 2180 to 3111 in the interval 1971-1976. The percent of total first visits rose from 2.0 to 2.4 while the rate increased from 4303/100,000 to 5695/100,000. Total outpatient visits for mental illness, as illustrated in Table 12 increased from 5496 to 7886. The percent of total visits has varied between 2.8% and 3.4% being 2.9% in 1976. The total workload rate for mental

illness has risen from 10,850/100,000 to 14,411/100,000.

The IHS statistics are worth considering in detail because of the relatively consistant picture they portray. Alaska Natives have been utilizing both outpatient and inpatient services for mental illness and drug and alcohol abuse in steadily increasing numbers since 1971. Treatment of the alcoholic and the mentally ill now comprises a significant percentage of the total workload in these general medical and surgical hospitals. On close examination of the tables decreases will be noted in some areas in the year 1976. Two possible explanations exist which might account for these decreases. The first is the availability of Community Mental Health Services to the Natives for the first time in 1976. An analysis of Native utilization of these services is presented below. Second, the decrease may simply represent a random variation by year since incomplete data for 1977 suggest that utilization is once again rising.

#### IHS: ACCIDENTS AND ALCOHOL

The incidence of accidents and injuries is commonly held to be an indicator of mental health and degree of stress in a population. Alaska Natives have an extraordinarily high rate of fatal and non-fatal accidents. As will be discussed later, accidents are the leading cause of death for Alaska Natives. Non-fatal accidents and injuries contribute a significant portion of the workload in the IHS system. Table 13 illustrates this phenomenon during the interval 1971-1976. It can be seen that the number of accidents seen went from 10,043 to 12,584 in the interval with 13,543 accidents and injuries seen in 1975. A significant percentage of these ranging from 11.5% to 17.8% were alcohol related.

#### IHS: SUICIDAL BEHAVIOR

As with accidents, suicide attempts and gestures are considered an index of mental difficulty and stress in a population. Tables 14, 15 and 16 outline this problem with respect to Alaska Natives. Table 14 shows the number of suicide attemptors treated on an outpatient basis each year during the interval 1971-1976. It can be seen that the number of attemptors has varied from 104 to 161 per year with rates ranging from 205/100,000 one year to 198/100,000 per year. A significant percentage of these suicide attempts ranging from 43.3% to 59.7% in various years were alcohol related. Table 15 outlines another dimension of the problem. It shows the number of Natives hospitalized for suicide attempts during the same interval. The number ranges from 90 to 129 with rates ranging from a low of 164.5/100,000 per year to 250.9/100,000 per year. It is worth noting that if one combines the outpatient and inpatient rates for the year 1973, a year in which suicidal attempts seemed quite frequent, a combined rate of 518/100,000 per year is obtained. This is a questionable procedure since there is probably some overlap between the two populations with a small number of hospitalized attemptors not being admitted directly as emergencies but being recorded as outpatients first. The combined rate is pointed out only to suggest the magnitude of the problem. Tables 14 and 15 deal only with attempts severe enough to receive medical attention at a hospital. The true incidence of suicidal attempts involves a more comprehensive survey and is more difficult to establish. Such surveys have been attempted of various populations and are summarized in table. Table 16 shows suicide attemptor rates calculated by various investigators for different populations. The city of Los Angeles rate was reported by Mintz (1970) to be 150/100,000 per year. Shore (1972) reported a rate of 450/100,000 per year for a combined Northwest American Indian Reservation population. Miller and Schaenfeld (1971) calculated a rate for Navajo of 89.6/100,000 per year. Kraus (1974) calculated a rate for a rural Alaskan Native town of 1450/100,000 per year and a rate for the Native population of Anchorage of 1000/100,000 per

year. Thus, it seems clear that suicidal behavior, much of it alcohol related, is a major and ongoing problem for Alaska Natives and that it is a problem of greater magnitude than is seen in other American Native and non-Native populations. (Kraus, 1972<sub>a</sub>, 1972<sub>b</sub>)(Kraus & Buffler, 1976).

#### COMMUNITY MENTAL HEALTH CENTERS

The developing Community Mental Health Center system in Alaska has been mentioned above. 1976 was the first full reporting year for the 15 centers. Table 17 summarizes Native and Caucasian utilization of the services of the various centers statewide. 617 Natives were seen in Community Mental Health Centers in 1976 for a rate of 1011/100,000 per year. 1993 Caucasians were seen in Community Mental Health Centers for a rate of 664/100,000 per year. These low and preliminary figures show that Alaska Natives are being treated in Centers at a rate  $1\frac{1}{2}$  times that of Caucasians.

#### ALASKA PSYCHIATRIC INSTITUTE

The Alaska Psychiatric Institute (API), the States only psychiatric hospital, plays a significant role in offering mental health services to Natives. Rates of admission to psychiatric hospitals have long been one of the classical indices of the mental health of a population as well as a measure of the quality of alternative modes of treatment available. Table 18 shows Alaska Native and Caucasian admissions to the API by number of patients, admission rates, and fiscal year 1973-1976. It can be seen that Native admissions have ranged from 184 to 227 with admission rates falling between 325/100,000 per year and 381/100,000 per year. Caucasian admissions have numbered between 309 and 481 with rates between 115/100,000 per year and 160/100,000 per year. State and County hospital admission rates have been calculated for various other United States populations and are available for comparison. Table 19 illustrates such a comparison. The combined from year admission rate (1973-1976) for Alaska Natives to the State hospital is 353/100,000 per year. The corresponding rate for Alaska Caucasians is 156/100,000 per year. In 1972, the U.S. total white rate for admission to State and County hospitals was 181.7/100,000 per year. The corresponding rates for U.S. Hispanic/American and U.S. non-white populations are 133.7/100,000 per year and 306.3/100,000 per year respectively. The total U.S. population rate in 1972 was 197.2/100,000 per year. The high admission rate for the non-white population, which is overwhelmingly composed of Black Americans, is a well known statistic and is commonly cited as evidence of the stress experienced by Blacks in our society and of the unavailability to them of treatment alternatives short of hospitalization. The Alaska Native admission rate is higher than that for American Blacks and 2.6 times the rate for Alaska Caucasians.

#### PATTERNS OF MORTALITY IN ALASKA

People in different populations tend to die at different rates from a variety of causes. The comparison of patterns of mortality of populations gives insight into their health status and the differential stresses which infringe upon them. Violent death, that is, deaths due to accident, homicide, suicide, and alcohol is seen by many as an indicator of the mental health of a population. The stresses which are endured by its members, and its degree of social disorganization. In this section, overall patterns of mortality and patterns of mortality due to violence in Alaska Natives will be presented and compared with other U.S. populations. (Kraus & Buffler, 1977)

### OVERALL PATTERNS (1950-1974)

The flow of events in Alaska in recent decades has been accompanied by rather distinctive changes in the patterning of mortality among the various populations in the State. The data presented here represent a synthesis and analysis of a sample of all deaths due to violence in Alaska during the period 1950-1974 as well as relevant data from a variety of sources. (Frederick, 1975) (Iskraat & Johet, 1968) Erhardt & Berlin, 1974).

Figure 2 shows mortality, expressed as percent of total mortality, for the total Alaskan population for selected causes for five year intervals during the period 1950-1974. The general categories for cause of death are: infectious disease; chronic disease, which comprises heart disease, cancer, stroke, and a variety of other chronic diseases usually classified separately; violent, or preventable deaths, which comprise deaths due to accident, suicide, homicide, and alcohol; and deaths due to other causes. It can be seen that deaths due to infectious disease are decreasing and deaths due to chronic disease are increasing although the percentage of deaths due to chronic illness is significantly lower than that of the total U.S. pattern. Violent death is undergoing a steady increase until in the most recent interval it comprises in excess of 30% of the total picture. It should be noted that the total Alaskan population is heavily weighted towards non-Natives. Only 20% of the population is Native.

Figure 3 presents comparable data for the non-Native population of Alaska. This pattern is characterized by an increasing percentage of deaths due to chronic illness although the percentage remains significantly below the United States, all races, percentage. Apparent again is a high percentage of mortality attributable to violent deaths.

Figure 4 illustrates the mortality pattern for the Native population of Alaska. Striking changes over the last 25 years are evident. Deaths due to infectious disease have declined precipitously while deaths due to chronic disease have increased, a phenomenon due at least in part to greatly improved medical care. Of particular note is the stepwise increase in the percentage of violent deaths. During the interval 1950-1954, the percentage of deaths among Natives due to violence was slightly more than half the percentage for non-Natives even though the Natives, by and large, lived in a more dangerous environment. In the more recent intervals the percentage of violent deaths grew more rapidly for Natives than non-Natives until, in the most recent interval it constitutes slightly in excess of 40% of the total Native mortality.

### VIOLENT DEATHS (1950-1974)

Further definition of this emerging problem of death due to violence can be obtained by examining the death rates for each type of violent death-accident, suicide, homicide, and alcohol-for both Natives and non-Natives for the same time period and comparing the rates to those of other United States populations.

Figure 5 shows annual accident death rates for Alaskan non-Natives, Alaskan Natives, total American Indians (including Alaskan Natives), and the U.S., all races. The Alaskan rate seems to be a manifestation of a phenomenon effecting American Indians generally. The Alaskan non-Native rate fell during the interval 1950-1964 and has remained stable although significantly higher than the U.S., all races, rate.

Comparable figures for homicide are summarized in Figure 6. Current Alaskan Native and American Indian homicide rates are high, roughly comparable, and reflect an increasing problem of homicide in the U.S. generally. It is of interest to note

that the Alaskan non-Native rate has decreased in each time interval and currently is lower than the United States, all races, rate.

Examination of Figure 7 reveals that the Alaskan Native suicide rate diverged sharply from the American Indian and United States, all races, rates after 1965. As with homicide, the suicide rate for Alaskan non-Natives has decreased steadily since 1950 and is now below the United States, all races, rate.

Deaths due to alcohol present problems of recognition and definition. The alcohol death rates for Alaskan Natives and non-Natives summarized in Figure 8 are based on review and analysis of all alcohol related deaths recorded by the Bureau of Vital Statistics, Alaska, during 1950-1974. Only those cases coded according to the International Statistical Classification of Diseases, Injuring, and Causes of Death as due to alcoholic psychosis, acute alcoholism, chronic alcoholism, alcoholic cirrhosis, or alcohol poisoning as the primary cause of death were utilized. Comparable figures are difficult to obtain because of wide variation in way alcohol mortality statistics are recorded in different areas and health care systems. Deaths due to these causes are increasing in both Natives and non-Natives with the Native increase being more noticeable.

The data presented above concerning overall patterns of mortality and mortality related to violence are summarized in Table 20 which presents figures for the year 1970. The familiar U.S. pattern, mentioned previously, with its large preponderance of deaths due to heart disease, cancer, and stroke is at sharp variance with the Alaskan pattern. Violence, defined as accidents, homicides, suicides, and deaths due to alcohol, is the leading cause of death in Alaska. This is true of both Native and non-Native populations. Among the non-Natives over the last ten years, the pattern has been maintained by a consistently high rate of death by accident and an increasing rate of deaths due to alcohol. Suicide and homicide are decreasing. Among Natives, the pattern of violent death is related to increases in all four categories.

#### SUMMARY

Although the information incorporated in this report is uneven in quality, incomplete, and drawn only from those health care systems available to Natives which are Statewide in scope, the picture which emerges is clear, ominous, and urgent. Within the various facilities of the Indian Health Service the number of individuals treated both as inpatients and outpatients for mental illness and drug and alcohol abuse rises year by year. Currently over 1/5 of the Native population is treated in a hospital facility for non-fatal accidents and injuries each year and many of these accidents are alcohol related. Suicide and suicide attempts are common; the rates for each of these behaviors far exceed recorded rates for other American Native and non-Native groups. Within the newly developmental health centers, the Native populations are utilizing services at a rate significantly exceeding that of Caucasians despite the fact that all of the best established and larger centers are in predominantly non-Native environments. The institutionalization rate for Natives at the State hospital far exceeds that for Caucasians and is greater than rates recorded for other American minority groups, most notably Blacks, which have long been considered evidence of higher incidence of mental illness and unavailability of an adequate range of services short of hospitalization. These figures are all the more noteworthy since they are very conservative. It should be remembered that they are derived from a population which has for the most part little or no access to mental health and alcohol services available to them. Also they are derived from a health information system which is at best rudimentary. Review of the documents submitted in conjunction with this report will identify various small, local Native mental health and alcohol programs to be in

operation. By and large, the individuals served by these programs are not included in the data surveyed here. Alaska Native rates of violent death are cause for profound concern. For each category of violent death, suicide, homicide, accidents, and alcohol, Alaska Native rates are higher than non-Native, Native, and all races rates and are rising.

Descriptive statistics upon which a report at this level of inclusiveness must rely give the illusion that the problems dealt with are discrete, separable, and specific. They obscure the inter-relatedness and inseparability of the issues. Alcohol abuse, for example, cuts across all the categories covered above. It complicates and exacerbates most mental illnesses in Natives. A majority of the morbidity and mortality due to violence is alcohol related. In addition, however, alcohol abuse produces a host of problems related to family description, child abuse, spouse abuse, physical illness, and behavioral and social deviance which defy precise enumeration. Most clinicians whose practice includes Native patients feel that a significant but unknown increment of physical illnesses among Natives, such as diabetes mellitus, heart disease, certain neoplasms, cirrhosis of the liver, influenza and pneumonia, gonorrhea and other venereal diseases, nutritional disturbances, and complications of pregnancy are caused and/or aggravated by alcohol abuse. A family unit disrupted by alcohol is a fertile breeding ground for a variety of physical, psychological and social disorders.

A single clinical example might serve to develop this point further. In recent years, a Native family received intensive and ongoing psychiatric evaluation. The family consisted of an aged father and nine living adult sons and daughters. The mother and 3 children had died some years prior to the evaluation. At the time of evaluation, the family members were found to have the following history: 20 episodes of hospitalization involving all 10 of the living members, 12 suicide attempts involving five members, 2 homicides, 1 negligent homicide, 11 hospital admissions involving 6 members, 7 divorces involving seven members, 3 cases of severe drug abuse involving 3 members and, 1 accidental death of a member. One member was married to a mentally ill person who required hospitalization. Another member was married to a person who made a living selling drugs. (Richards, Kraus, & Shields, 1977)

This family, of course, is not presented as being representative of Native family life. Rather, it is presented to demonstrate the inter-relationship and concurrence of the problems reviewed in this report. This extreme case highlights the plight of many large, multiproblem, Native families and illustrates the demoralizing impact that mental illness and alcohol abuse has upon them.

The documents submitted by Native organization and various components of the Indian Health Service fill in the local and regional detail which does not emerge in this general summary. Thus, we hear the people of Barrow state that "alcohol stands alone" as the major cause of death and crime on the Slope. The Pacific Rim Corporation states "accidents, acute alcohol intoxication, chronic alcoholism, cirrhosis of the liver, and depressive neurosis occur consistently." Mameluk states "40% of the 4,995 people in the service area are in need of some mental health services."

The Native people of Alaska and their leaders have mobilized themselves and are determined to meet the crisis in mental health drug and alcohol abuse which confronts them. They are struggling to organize programs which are family oriented, community based, culturally appropriate and which utilize the indigenous resources of the area. Continued and increased cooperation and support on the State and Federal level are essential. It is a time for fundamental rethinking of mental health priorities in Alaska so as to assign the areas outlined in this report and the accompanying reports the emphasis they deserve. Moreover, it would appear that the overall model for public health priorities and services in Alaska, oriented as it is towards such traditional themes as chronic illness and infectious disease, needs revision in that it seems not

to address itself to the primary Public Health problems in the State-Behavioral disturbances and violent death.

TABLES & FIGURES  
IN ORDER CITED  
IN TEXT

Figure 1

TRADITIONAL GEOGRAPHIC DISTRIBUTION  
OF ALASKA NATIVE PEOPLE

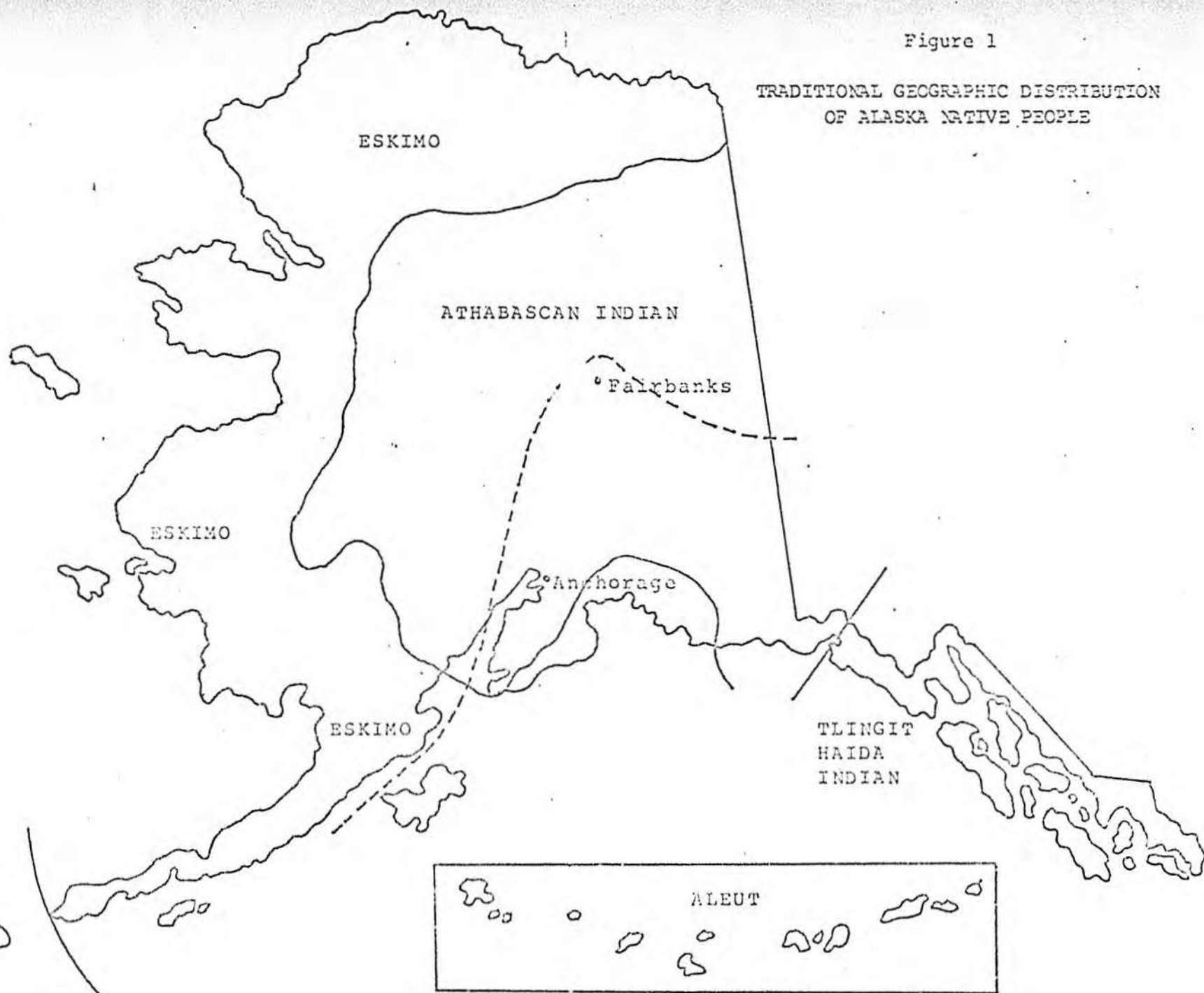


Table 1  
THE POPULATION OF ALASKA, 1974

Natives (N=56,861)	
Northern Eskimo	11,842
Western Eskimo	24,255
Athabascan	7,291
Aleut	2,869
Tlingit, Haida, Tsimpshian Indian	10,604
Non-Native (N=294,214)	
Caucasian	280,215
Black	10,547
Asian American	3,452
Total	351,075

TABLE 2

Alaska Area Native Health Service, Admissions to IHS GM & S  
Hospitals and Admission Rates by Fiscal Year, 1971-1976

<u>FISCAL YEAR</u>	<u>TOTAL ADMISSIONS</u>	<u>ADMISSION RATE/100,000</u>
1971	10,904	21,526.4
1972	11,396	22,166.5
1973	10,664	20,441.7
1974	10,524	19,821.8
1975	9,677	17,951.6
1976	9,575	17,498.5

Office of Systems Development

TABLE 3

Alaska Area Native Health Service, First Visits and Incidence rates for Ambulatory Patient Care Given in IHS Facilities For All Diagnoses by Fiscal Year, 1971-1976

<u>FISCAL YEAR</u>	<u>FIRST VISITS</u>	<u>RATE/100,000</u>
1971	110,877	218,890
1972	121,187	235,721
1973	141,425	271,095
1974	122,452	230,636
1975	143,645	266,473
1976	149,665	273,515

Office of Systems Development

TABLE 4

Alaska Area Native Health Service, Total Visits and Total Workload Rates for Ambulatory Patient Care Given In IHS Facilities For All Diagnoses, by Fiscal Year, 1971-1976

<u>FISCAL YEAR</u>	<u>TOTAL VISITS</u>	<u>TOTAL WORKLOAD RATE/100,000</u>
1971	199,519	393,886
1972	202,038	392,985
1973	223,954	429,293
1974	246,896	465,025
1975	264,402	490,487
1976	268,409	490,522

Office of Systems Development

TABLE 5

Alaska Area Native Health Service Admissions to IHS - GM & S Hospitals and Admission Rates for Patients Receiving Care For Admission Diagnoses (First Diagnoses) Relating to Alcohol and Drug Abuse by Fiscal Year, 1971-1976

<u>FISCAL YEAR</u>	<u>ADMISSIONS</u>	<u>% OF TOTAL ADMISSIONS</u>	<u>ADMISSION RATE/100,000</u>
1971	334	3.1	659.4
1972	384	3.4	746.9
1973	377	3.5	722.7
1974	476	4.5	896.5
1975	428	4.4	794.0
1976	433	4.5	791.3

Office of Systems Development

TABLE 6

Alaska Area Native Health Service All Diagnoses Related to Drug and Alcohol Abuse of Patients Receiving Care In IHS - GM & S Hospitals Regardless of Reason for Admission by Fiscal Year 1971-1976

<u>FISCAL YEAR</u>	<u>NO. OF DIAGNOSES OF DRUG AND/OR ALCOHOL ABUSE</u>	<u>% OF TOTAL DIAGNOSIS</u>	<u>MORBIDITY RATE/100,000</u>
1971	602	3.7	1188.5
1972	658	3.7	1279.9
1973	711	4.6	1362.9
1974	871	5.6	1640.5
1975	796	5.5	1476.6
1976	818	5.2	1494.9

Office of Systems Development

TABLE 7

Alaska Area Native Health Service First Visits and Incidence Rates for Ambulatory Patient Care Given in IHS Facilities For Diagnoses Relating to Alcohol and Drug Abuse by Fiscal Year, 1971-1976.

<u>FISCAL YEAR</u>	<u>FIRST VISITS</u>	<u>% OF TOTAL VISITS</u>	<u>INCIDENCE RATE/100,000</u>
1971	2,012	1.8	3,972
1972	2,401	2.0	4,670
1973	3,592	2.5	6,885
1974	3,501	2.9	6,594
1975	4,129	2.9	7,659
1976	3,712	2.5	6,783

Office of Systems Development

TABLE 8

Alaska Area Native Health Service Total Visits and Total Workload Rates for Ambulatory Patient Care Given in IHS Facilities For Diagnoses Relating to Alcohol and Drug Abuse by Fiscal Year, 1971-1976

<u>FISCAL YEAR</u>	<u>TOTAL VISITS</u>	<u>% OF TOTAL</u>	<u>WORKLOAD RATE/100,000</u>
1971	2,985	1.5	5,892
1972	3,457	1.7	6,724
1973	4,880	2.2	9,354
1974	5,297	2.1	9,976
1975	5,747	2.2	10,661
1976	5,487	2.0	10,027

Office of Systems Development

TABLE 9

Alaska Area Native Health Service Admissions to IHS - GM & S  
Hospitals and Admission Rates for Patients Receiving Care For  
Admission Diagnoses (First Diagnosis) of Mental Illness By  
Fiscal Year 1971-1976

<u>FISCAL YEAR</u>	<u>ADMISSIONS</u>	<u>% OF TOTAL ADMISSIONS</u>	<u>ADMISSION RATE/100,000</u>
1971	625	5.7	1,233
1972	663	5.8	1,289
1973	659	6.2	1,263
1974	773	7.3	1,455
1975	722	7.5	1,339
1976	773	8.1	1,412

Office of Systems Development

TABLE 10

Alaska Area Native Health Service All Diagnoses of Patients Receiving care in IHS and GM & S Hospitals for Mental Disorders by Fiscal Year 1971-1976

<u>FISCAL YEAR</u>	<u>ALL DIAGNOSES</u>	<u>% of TOTAL DIAGNOSES</u>	<u>MORBIDITY RATE/100,000</u>
1971	1,171	7.1	2,311.8
1972	1,254	7.0	2,439.2
1973	1,177	7.6	2,256
1974	1,365	8.8	2,571
1975	1,324	9.2	2,456
1976	1,365	8.7	2,494

Office of Systems Development

TABLE 11

Alaska Area Native Health Service First Visits and Incidence Rates for Ambulatory Care Given in IHS Facilities for Diagnoses of Mental Disorders by Fiscal Year 1971-1976

<u>FISCAL YEAR</u>	<u>FIRST VISITS</u>	<u>% OF TOTAL FIRST VISITS</u>	<u>INCIDENCE RATE/100,000</u>
1971	2,180	2.0	4,303
1972	2,664	2.2	5,181
1973	3,837	2.7	7,355
1974	2,858	2.3	5,383
1975	3,252	2.3	6,032
1976	3,111	2.1	5,695

Office of Systems Development

TABLE 12

Alaska Area Native Health Service Total Visits and Total Workload Rates for Ambulatory Patient Care Given in IHS Facilities For Diagnoses of Mental Disorders by Fiscal Year 1971-1976

FISCAL YEAR	TOTAL VISITS	% OF TOTAL TOTAL VISITS	TOTAL WORKLOAD RATE/100,000
1971	5,496	2.8	10,850
1972	5,984	3.0	11,639
1973	7,694	3.4	14,748
1974	7,881	3.2	14,843
1975	8,123	3.1	15,068
1976	7,886	2.9	14,411

Office of Systems Development

TABLE 13

Alaska Area Native Health Service Accidents and Injuries  
 Comparison of Total Accidents and Alcohol Related Accidents  
 as Defined by Volume of New Cases by Fiscal Year 1971-1976

FISCAL YEAR	TOTAL ACCIDENTS	RATE/ 100,000	ALCOHOL RELATED ACCIDENTS	RATE/ 100,000	% OF TOTAL
1971	10,043	19,826	1,151	2,272	11.5
1972	10,233	19,904	1,358	2,641	13.3
1973	11,388	21,829	1,811	3,471	15.9
1974	11,913	22,438	2,067	3,893	17.4
1975	13,543	25,123	2,415	4,480	17.8
1976	12,584	22,997	2,122	3,878	16.9

Office of Systems Development

TABLE 14

Alaska Area Native Health Service Suicide Attempts Comparison of Total Suicide Attempts and Alcohol Related Suicide Attempts Treated on an Ambulatory Basis as Defined by Volume of New Cases by Fiscal Year 1971-1976

FISCAL YEAR	TOTAL SUICIDE ATTEMPTS	RATE/ 100,000	ALCOHOL RELATED SUICIDE ATTEMPTS	RATE/ 100,000	% OF TOTAL
1971	104	205	45	88	43.3
1972	106	206	39	75	36.8
1973	158	302	63	120	39.9
1974	146	275	83	156	56.8
1975	161	298	86	159	53.4
1976	139	254	83	151	59.7

Office of Systems Development

TABLE 15

Alaska Area Native Health Service Suicide and Self-Injury  
Total Suicide attempts with Discharge Rates of Person Treated  
in IHS - GM & S Hospitals by Fiscal Year 1971-1976

<u>FISCAL YEAR</u>	<u>NUMBER OF SUICIDE ATTEMPTS</u>	<u>RATE/ 100,000</u>
1971	98	193.5
1972	129	250.9
1973	113	216.6
1974	107	201.5
1975	108	100.3
1976	90	164.5

Office of Systems Development

TABLE 16

Incidence of Suicide Attempts Among Various Alaska Native,  
American Native, and United States, All Races, Populations

POPULATION	SUICIDE ATTEMPT RATES/100,000
City of Los Angeles (Mintz, 1970)	150
Combined Northwest American Indian Reservation Populations (Shore, 1972)	450
Navajo (Miller & Schoenfeld, 1971)	89.6
Rural Alaska Native Town (Kraus, 1974)	1,450
Native Population of Anchorage, AK (Kraus, 1974)	1,000

TABLE 17

Comparison of Alaska Native and Alaska Caucasian Utilization of Outpatient Community Mental Health Services, Fiscal Year 1976 (Mental Health Information System, 1977)

<u>POPULATION</u>	<u>TOTAL NO. PATIENTS</u>	<u>RATE/100,000</u>
Alaska Native	617	1,011
Alaska Caucasian	1,993	664

TABLE 18

Alaska Native and Caucasian Admissions to the Alaska Psychiatric Institute by Number of Patients, Admission Rates and Fiscal Year 1973-1976

FISCAL YEAR	TOTAL NO. NATIVE ADMISSIONS	RATE/ 100,000	TOTAL NO. CAUCASIAN ADMISSIONS	RATE/ 100,000
1973	184	325	309	115
1974	203	349	372	133
1975	227	381	405	139
1976	218	357	481	160

Analysis of State of Alaska Data (Smith, 1977)

TABLE 19

Comparison of Admission Rates to Alaska Psychiatric Institute for Alaska Native and Caucasians to Admission Rates to State and County Mental Hospitals for Various United States Population.

POPULATION	ADMISSION RATE/100,000
Alaska Natives, API*	353
Alaska Caucasians, API*	136
U.S. Total White Population, 1972 (Meyer, 1974)	181.7
U.S. Spanish American Population, 1972	133.7
U.S. Non-white Population, 1972 (Meyer, 1974)	306.3
Total U.S. Population, 1972 (Meyer, 1974)	197.2

Figure 2

PERCENT OF ALL MORTALITY AMONG TOTAL ALASKAN POPULATION  
FROM SELECTED CAUSES FOR FIVE YEAR INTERVALS  
1950 - 1974

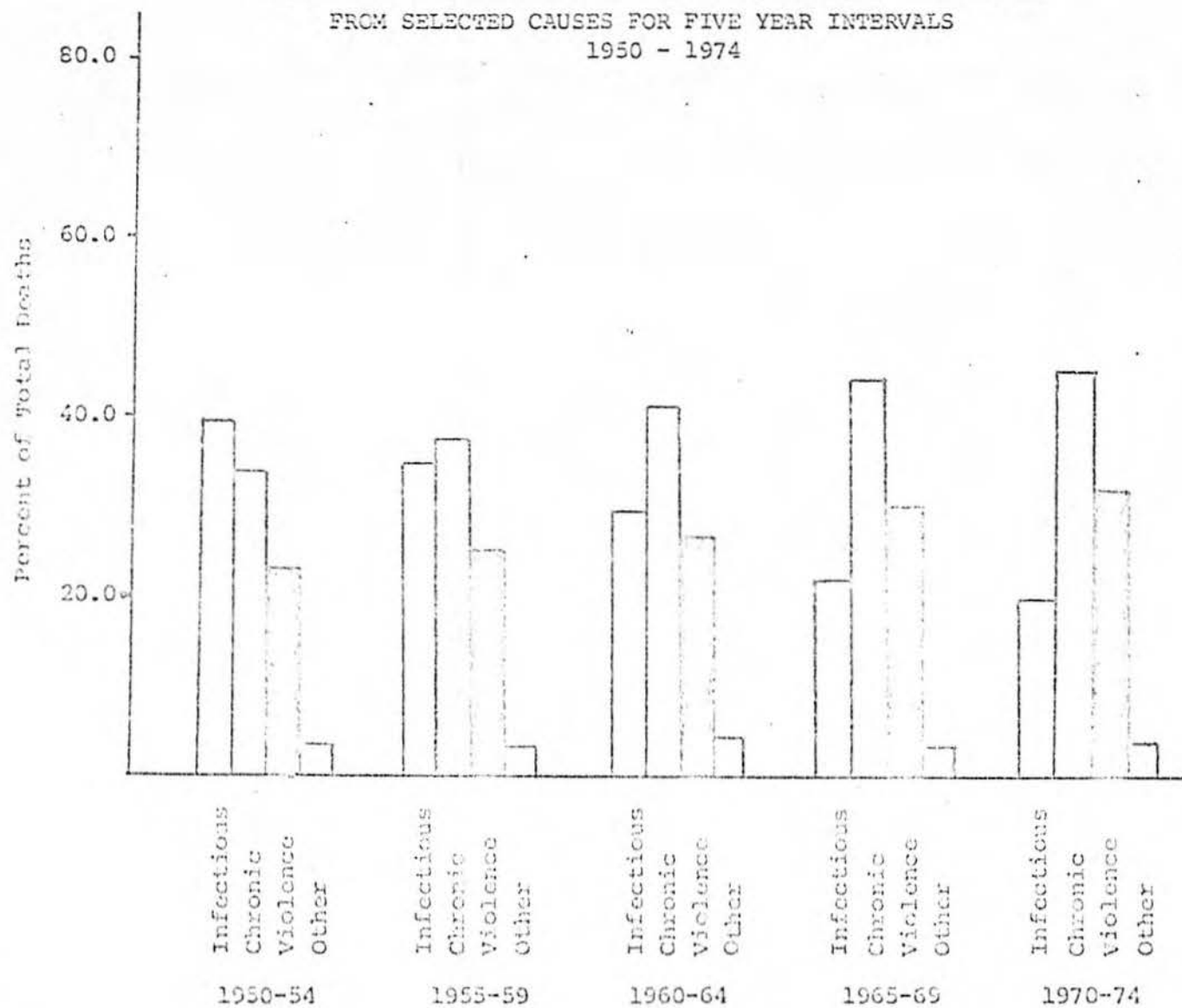


Figure 3

PERCENT OF ALL MORTALITY AMONG NON-NATIVE POPULATION OF  
ALASKA FROM SELECTED CAUSES BY FIVE-YEAR INTERVALS  
1950 - 1974

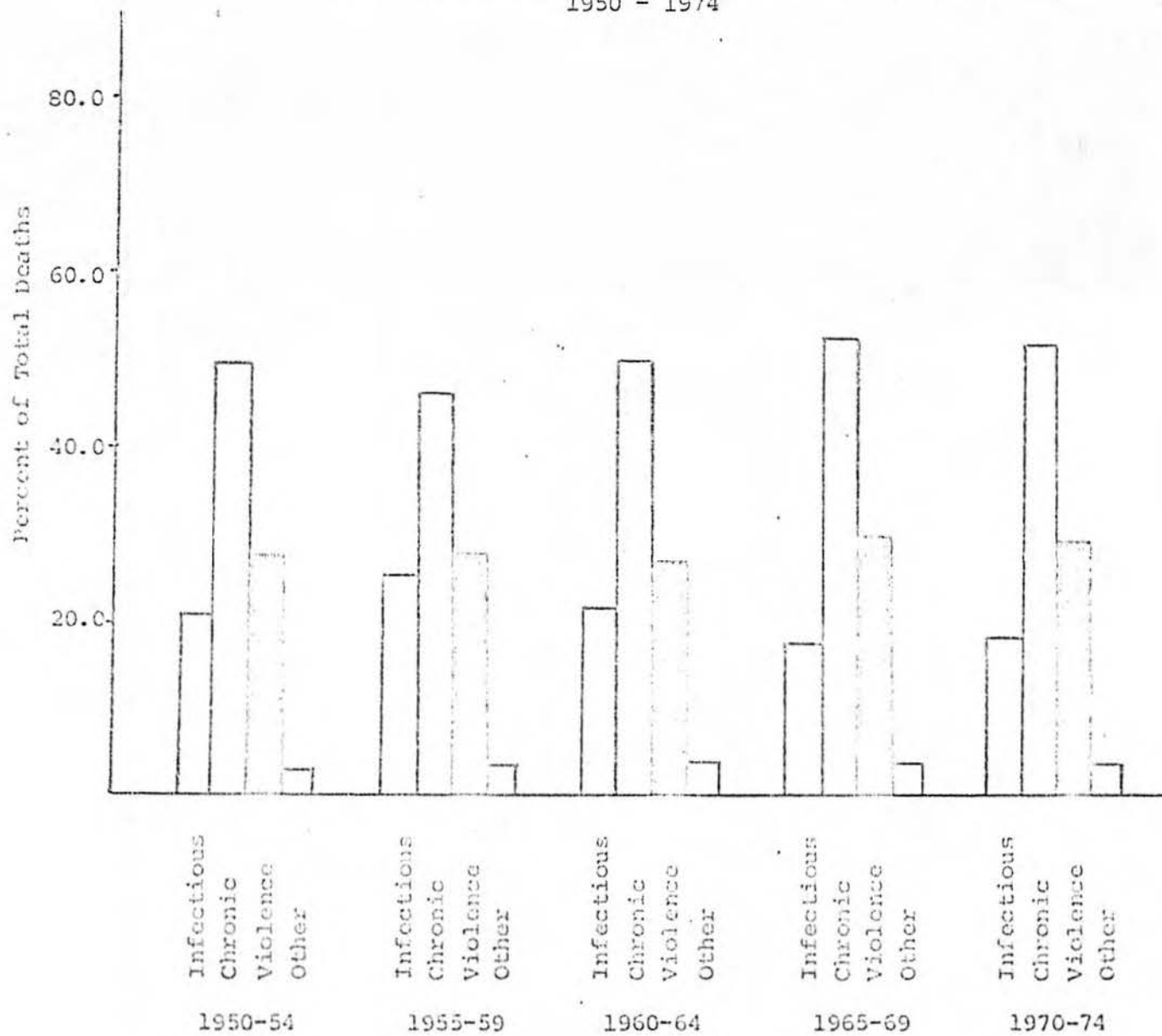


Figure 4

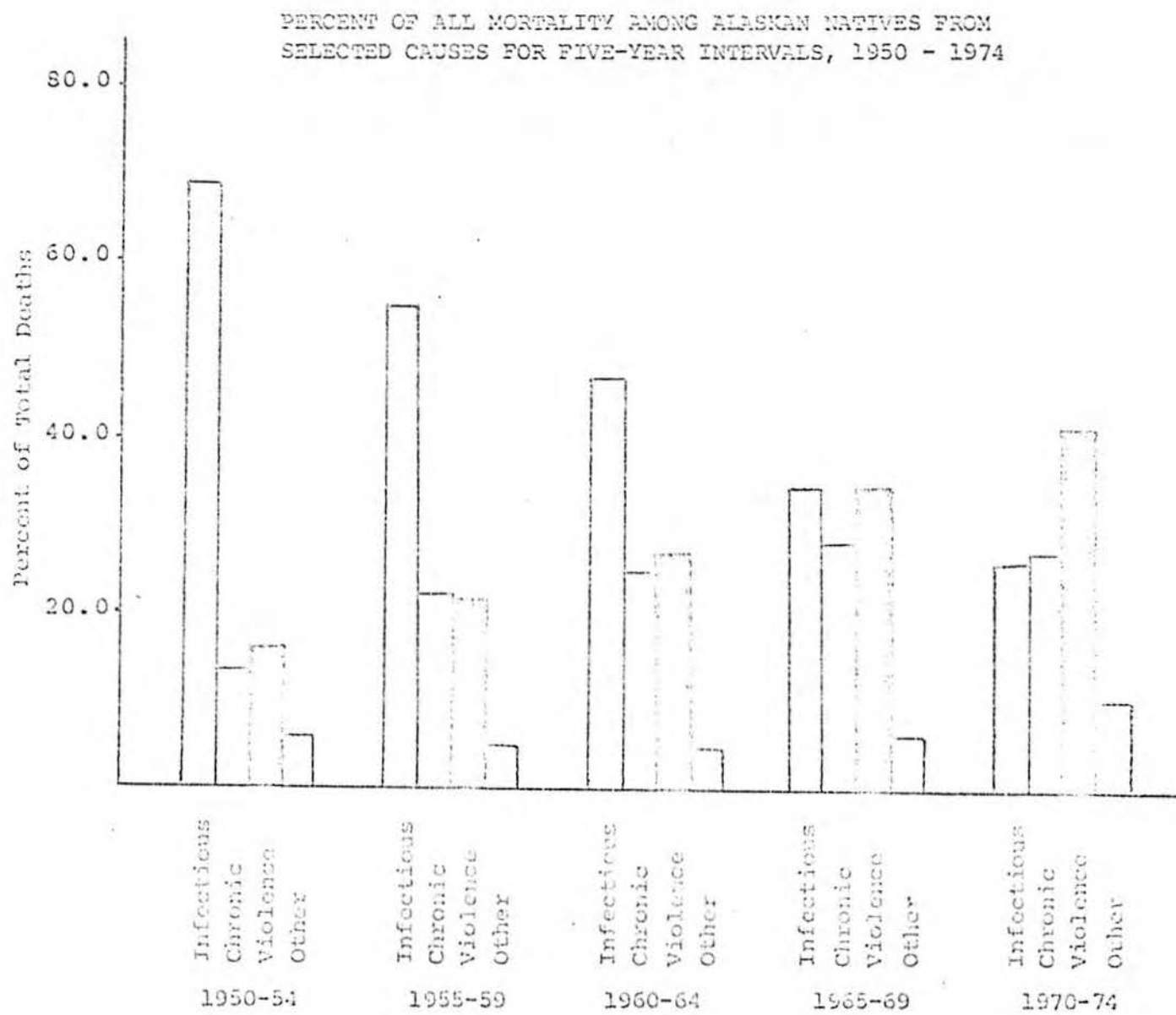


Figure 5

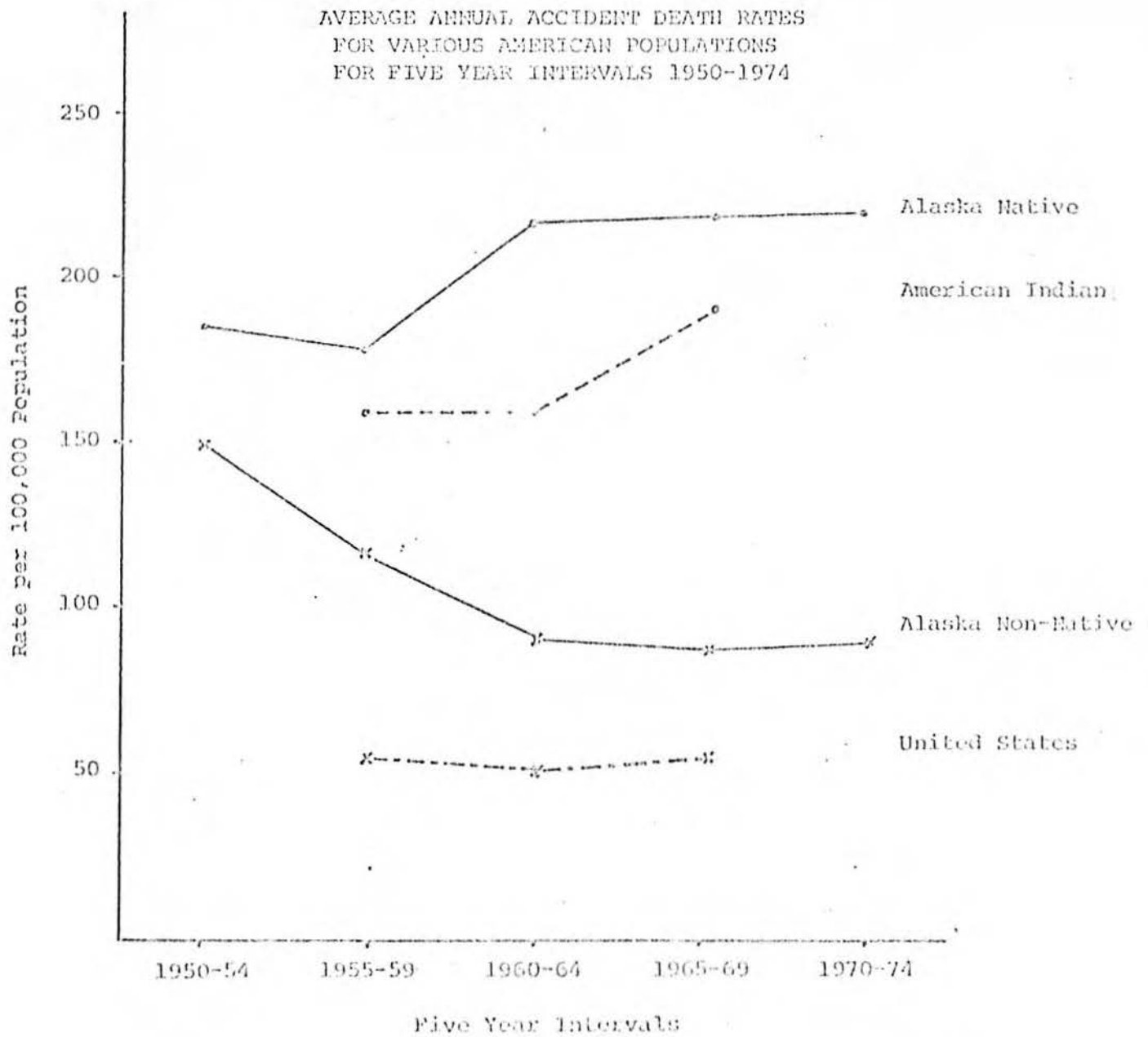


Figure 6

AVERAGE ANNUAL HOMICIDE DEATH RATES  
FOR VARIOUS AMERICAN POPULATIONS  
FOR FIVE YEAR INTERVALS 1950-1974

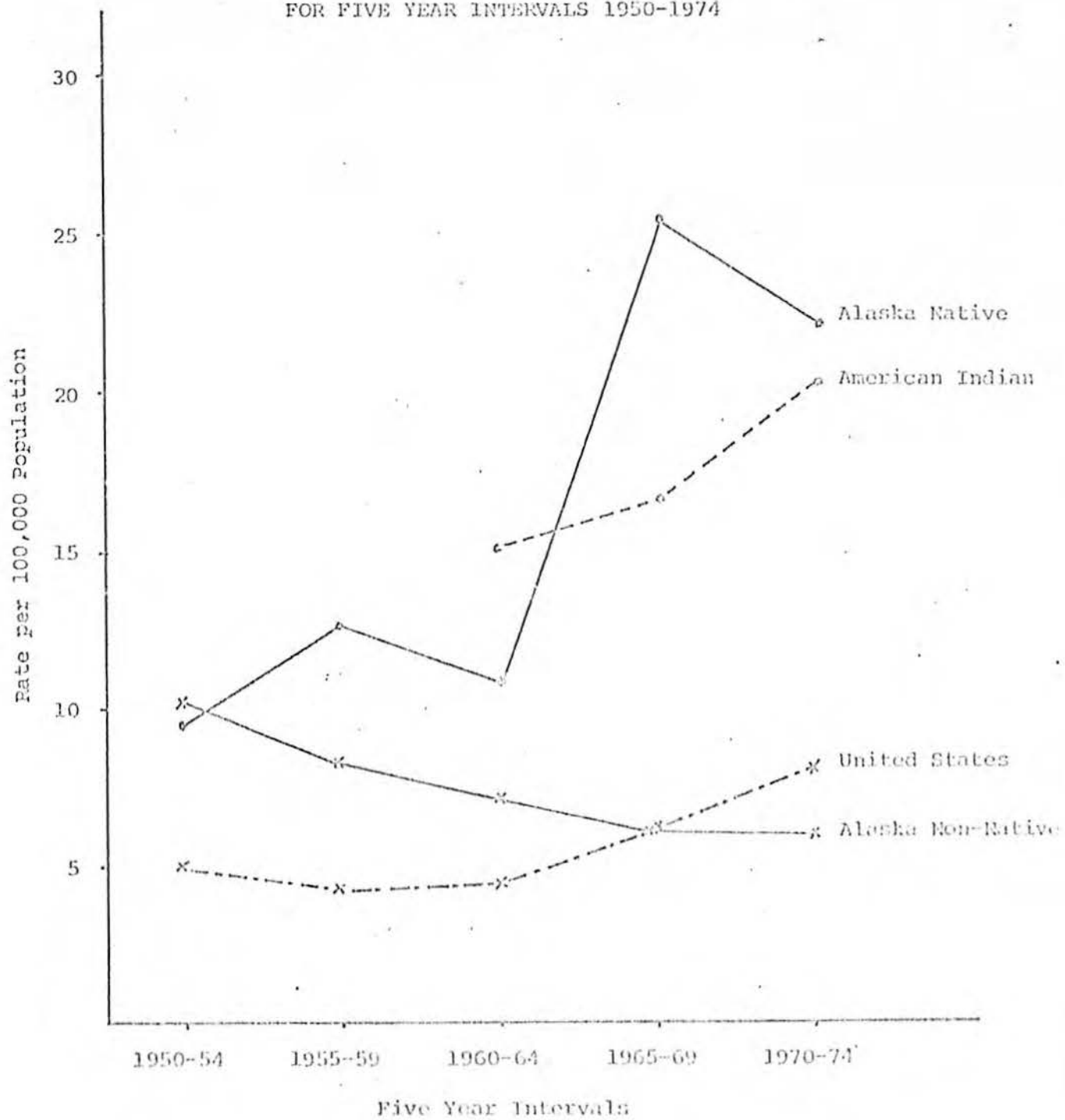


Figure 7

AVERAGE ANNUAL SUICIDE DEATH RATES  
FOR VARIOUS AMERICAN POPULATIONS  
FOR FIVE YEAR INTERVALS 1950-1974

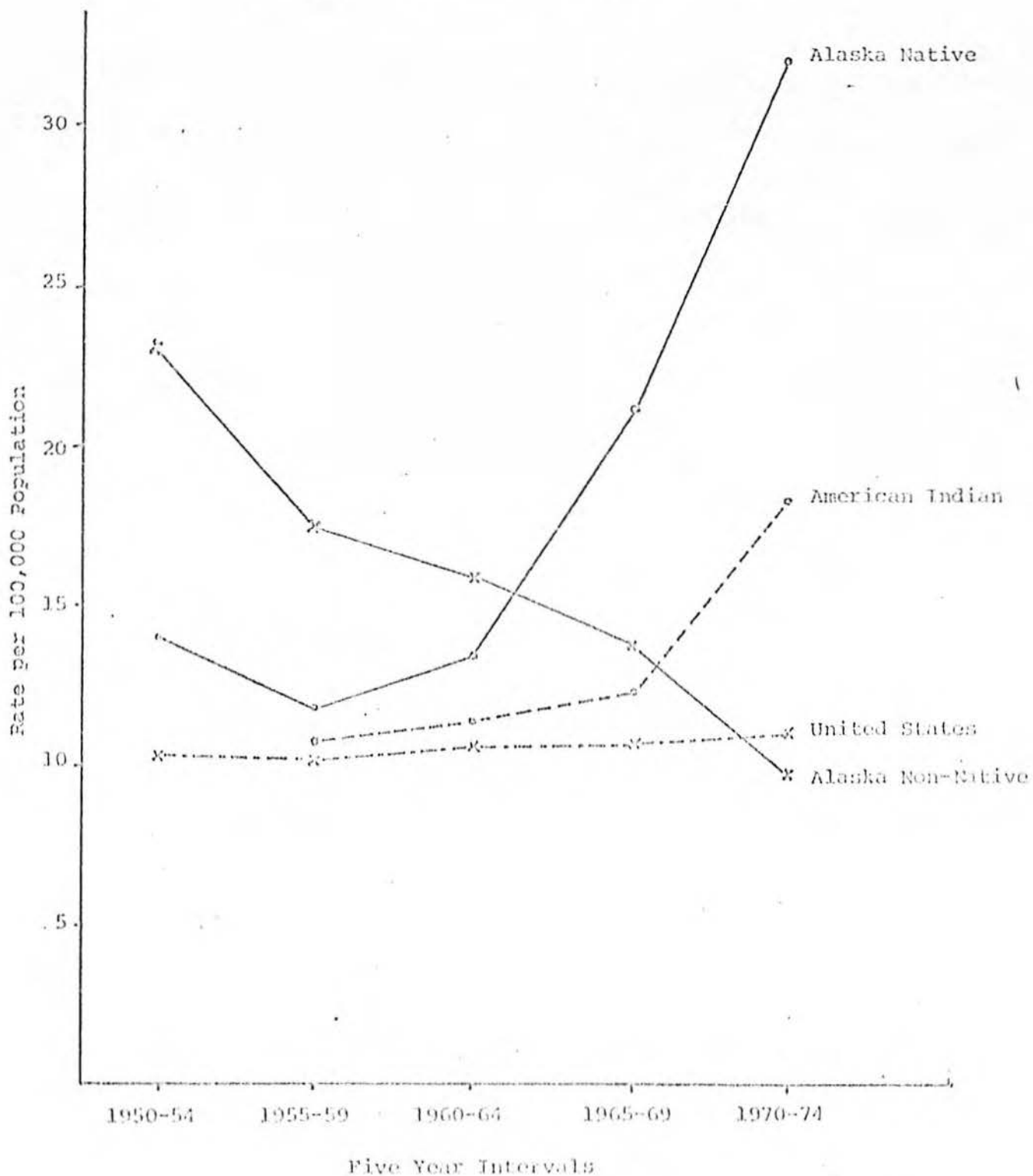


Figure 8

AVERAGE ANNUAL ALCOHOL DEATH RATES  
FOR ALASKA NATIVES AND NON-NATIVES  
FOR FIVE YEAR INTERVALS 1950-1974

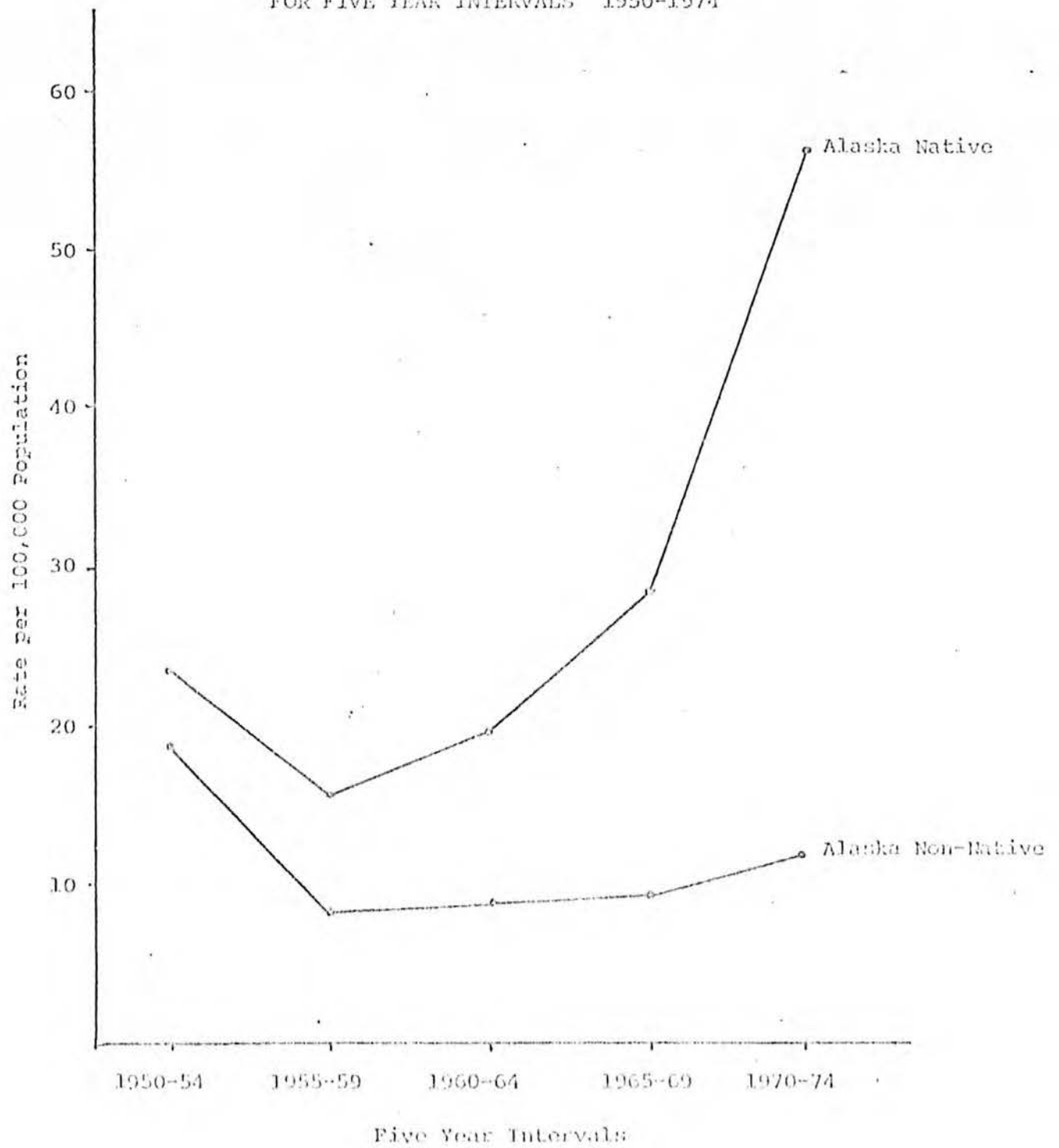


Table 20

LEADING CAUSES OF DEATH AMONG ALASKAN NATIVES,  
ALL ALASKAN RESIDENTS AND UNITED STATES, 1970

Rank(1)	Cause	Rate per 100,000 Population		
		Alaskan Natives	Alaska Total	United States
1.	<u>Accidents</u>	199.4	116.9	56.4
2.	Dis. of the Heart	73.0	87.4	362.0
3.	Malignant neoplasms	67.1	61.6	162.8
4.	Influenza & Pneumonia	49.3	17.9	30.9
5.	<u>Alcoholism</u>	41.4	10.9	-
6.	Vas. lesions of CNS	35.5	26.2	101.9
7.	Dis. of early infancy	29.6	25.5	21.3
8.	<u>Suicide</u>	29.6	13.2	11.6
9.	<u>Homicide</u>	27.6	10.6	8.3

(1) Ranked by order of importance as a cause of death in Alaska Natives.

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