UNIVERSITY OF MINNESOTA
TWIN CITIES

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April 12, 1974

Senator James Abourezk
Dirksen Senate Office Building
Washington, D.C.

APR 1974

Dear Senator:

Unfortunately I was unable to prepare a statement for you in the short time between being notified of your hearings and attending them in Washington. However, two of the appended papers (numbered 1 and 2) document some aspects of the child welfare problem. The other three papers (numbered 3 to 5) are in regard to alcohol problems among Indian people in Minnesota, and these may be of interest to your staff.

Those of us involved with working among Indian people appreciate your efforts in trying to ameliorate the heavy burdens placed by history and the majority society on these people. Such efforts will in the long run benefit us all, Indian and non-Indian.

Sincerely yours,

Joseph Westermeyer, M.D.
Department of Psychiatry

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This paper discusses problems encountered by health workers and ghetto-minority patients in their relations with each other and how they may be handled. The problems are seen in a practical way.

Absentee Health Workers and Community Participation

Joseph Westermeyer, M.D., M.P.H., Ph.D.

The Problem

As social awareness becomes the order of the day, health professionals are launching forth to meet ghetto and minority health needs. Much of the motivation appears as altruistic as motives can humanly be. Some incentive is provided for others by the gold in "them thar health programs." Political realities require certain health workers to become involved regardless of their own preferences.

How is this recent reformation in health services proceeding? Recent events in some areas suggest the changes outlined above have resulted in a paper-reformation only. Despite the promises and polemics, many American citizens remain outside the health care system. Provision of care often stays as demeaning as it ever was. Many neighborhood health clinics have not provided the anticipated solution. Frustrations engendered in these new health centers are manifest in the political storms waging about and within them, and in the turn-over of their directors, personnel, advisory boards, and patients.

The professional personnel involved in these efforts have been among the best their various disciplines could provide in terms of intelligence, flexibility, and training. Huge sums of money have been made available for the task. Why then have so many intensive efforts been met with dismal failure or only the most mediocre success?

Method

This analysis rests primarily on experience as a physician in the Twin City area over the last decade. During the last four years especially, work in local teaching hospitals and community clinics has brought these problems to attention. At the same time, community concerns have become known while serving as a volunteer consultant to three self-help groups: a health committee formed by Indian citizens, a halfway house for minority alcoholics, and a group comprised of minority alcoholics and drug abusers.

Two years spent with a village health program in Asia (1965-67) served as an initiation into community medicine. It provided the opportunity to be personally involved in (and sometimes responsible for) the difficulties encountered in cross-cultural provision of health services. Formal training in anthropology and public health, together with a residency in psychiatry, have contributed a conceptual frame of reference. While retaining responsibility for my conclusions, I also recognize the considerable impact which a few friends and colleagues have had in the genesis of this paper (see acknowledgments).

Misunderstanding

Health workers frequently misinterpret the behavior which they observe among ghetto-minority patients. Should the health worker choose to act on the misperceived behavior, the target patient group in turn usually misinterprets the health worker's activity. An inter-group *folie à deux* results, accompanied by hostile polarization of patient population from health worker. A recent crisis, during which I had channels of communication open to both sides, will serve to illustrate this phenomenon.

> Sharon M., a fourteen year old Indian girl who has recurrent asthma attacks, lives with her grandmother and attends a nearby high school. Recently the neighborhood health clinic had been responsible for her medical care. As clinic doctors and nurses became increasingly more concerned about the recurrent nature of the attacks, Sharon's grandmother became perceived as the noxious agent. She was indicted by the clinic for failing to provide an acceptable environment for Sharon and for failing to assume responsibility for Sharon's condition. As a result, the clinic urged the child protection agency to make Sharon a ward of the state.
>
> An officer of the child protection agency and a policeman appeared at school one day to take Sharon to a custodial foster home. Sharon had no intention of leaving her own home and proceeded to lead the officer, school nurse, and policeman on a chase around the school. During the lengthy disruptive pursuit, an Indian activist movement was contacted. They promptly arrived on the scene, dozens strong, to protest such outrageous official conduct. A hasty parley led to the agreement that the court be allowed to decide the girl's destiny. The next day the court assigned the leader of the activist group to be the girl's foster parent.

Who was to blame for this Keystone Cops-type farce? The grandmother was merely behaving as a normal Indian grandmother. She loved the girl and was concerned for her welfare; but at fourteen years of age her granddaughter was considered to be a free agent, responsible for herself and her behavior. And within the limits of her own environment, grandmother was providing as good a home as she could.

On the other hand, the clinic workers were following the Hippocratic oath as they understood it. Despite the best medical attention that they were capable of providing, the girl continued to have asthma attacks. Searching about for an answer, they saw that the home was not well kept by their standards, and grandmother did not seem responsible by their standards. To them, the solution was obvious: put Sharon in a clean home under the direction of responsible adults. Their motivations were (from their own ethnic context) beyond reproach; they only wished the best for their patient. However, they ignored the most important ethnic context: that of the patient.

Of course Sharon wished none of the clinic's interference in her life; she was prepared to defend her autonomy to the death. Neither did her family on her community want any outside meddlings. They interpreted the entire sequence as another example of the tyranny of the dominant society.

Each side failed to understand the other. Why? Partly because neither understands the normal spectrum of behavior among the other. And partly because of a failure to communicate.

Communication Problems

Communication breakdown can, in a generic way, account for virtually any and all inter-personal problems. More specifically, however, some failures in health care result in the patient's problem not ever being transmitted to the care giver. Thus, a pseudo-relationship develops without any goal orientation. Frustration results for everybody concerned, as in this example.

> Percy S., a twenty-four-year-old black man born and raised in the Minneapolis black ghetto, presented himself to the University Hospitals requesting help. For two weeks he was evaluated on the Psychiatry Service. No problem was evident, and he had no mental or emotional sequelae from his chronic use of marijuana. He refused to attend group sessions and was quite guarded during dyadic interviews. Staff frustration led to a decision for discharge.
>
> On the day of the proposed discharge, Percy prophesied the slaughter of all whites, the destruction of the hospital, and rise of a black elitist people. Confronted in the heat of the discussion about his reasons for seeking hospitalization, he related his problems.
>
> From age eleven he had worked as a procurer. Proud of his ability to "pimp any woman in town," he had always made good money. On the side he sold marijuana and amphetamines to teenagers. He loved his common-law wife and two children, and—prior to the year before—had been quite happy with his life.
>
> The year before admission, black nationalism came to have a strong influence on his neighborhood. They preached that one should not sell his black sister or push junk to his younger black brothers. They got him a job with a federally funded program.
>
> Caught up in the black movement, Percy felt his life was better. Then, with a change in administration, the federal program came to a halt. Unable to read or write beyond a first grade level, he took an unskilled job. The work was all right, but he could not tolerate his white boss. He decided to quit and return to his old way of life.
>
> Then his problems began. Neighbors who had formerly admired his "con" abilities now censured his pandering and pushing. The family went on relief. His wife grew cold toward him and implied that he ought to leave.
>
> At this point Percy was both enraged and depressed. He thought of killing himself. However, he was unsure what to do with his wife. He wanted to kill her too, but did not want to leave his children parent-less. After two weeks on the horns of this dilemma he decided to go to the hospital for help.

Following his admission for "taking drugs," Percy decided the hospital staff could not be trusted. He assessed the staff as belonging to "the white establishment." If he told them about his suicidal impulses, he might be put away as crazy. If he mentioned his dilemma about killing his wife, he could go to jail. And if black nationalists were discussed, he had visions of the F.B.I. or assassination entering the picture. It was better to be quiet, he decided.

By the same token, the staff had no way of understanding what Percy's social context might be. None of them had ever known a pimp, nor did they know of the social changes in his neighborhood. Few non-psychotic blacks ever appeared on the psychiatric service (except as housekeepers), so the staff had no fund of experience from which to draw.

Without some mutual appreciation of motivation, normal spectrum of behavior, and social dynamics, communication becomes eminently difficult. We search for bridges, mutual interests or experiences, over which we might convey our thoughts or feelings. The same bridges bring thoughts and feelings of others to us. Where such bridges are remarkably sparse, and when racial conflict and distrust are rife, the provision of any health care requiring human discourse becomes virtually impossible.

Middle Class Standards

Often the frustration boils down to the fact that health professionals simply do not like behavior or values which are unlike their own. Given the opportunity to exert control over the "undesirable" behavior, even though there be no direct health implications, they can and do sometimes wield such control unreasonably.

> The T. family is a large white family who live in a lower class neighborhood. Finances are always a problem, for Mr. T. works a semi-skilled job and Mrs. T.'s cancer treatment has exhausted family resources. At the end of a long down-hill course, it appears that Mrs. T. will die shortly.
>
> At a clinic conference held to discuss the T. family, school authorities express concern about recent attention-seeking behavior of the young T. children at school. Clinic workers are worried that the eldest T. daughter will drop out of high school after the mother's death to assume the maternal role. A child protection worker has been invited to the meeting.
>
> From the opening of the meeting, the hidden agenda unfolds. "Expert medical opinion" (by the beginning pediatric resident and newly graduated nurse) is given to show that the only solution is for the state to assume guardianship of all the children. The children's "incipient psychiatric problems" and Mr. T.'s "incompetence" are given as reasons for guardianship. Mr. T. is said to work overly late hours instead of being at home, and allusions are made to the undocumented possibility that "he may have been a pervert" several years ago. Further investigation elicits that Mr. T. has always been a regular worker, does not drink or gamble to excess, is loved and respected by his wife and children, and has no police record. The children have had no behavioral difficulties prior to their mother's recently becoming bed-ridden in the terminal stages of cancer.

Faced with disturbed behavior in a lower socioeconomic family, the health workers in this case chose to denounce the family as "pathological." Even more frightening is the support given them by the school (who did not like the children's recent behavior) and the protection agency (only too willing to "do their thing" in the name of social welfare). No attempts were made to understand the family or the stress it was going through. No thought was given to how the clinic, school, and welfare agency might support the grieving family through the death of the mother.

Instead attention was focused on "disturbed childhood behavior" and "drop-out teenager" and "perverted father." Specters of childhood schizophrenia and unwed adolescent mother were raised, with the implication that clinic members would feel personally responsible if either event ensued. While the naïveté of the fledgling pediatrician and nurse can be understood, the responsibility of their supervisors in such matters cannot be so easily dismissed.

Stereotypes

Just as any other human being, the health professional conjures up stereotypes regarding people from unfamiliar groups. This maneuver allows a small sample of experience with a certain group to be generalized to the entire group. It avoids the more time-consuming exercise of accumulating a wider breadth of personal experiences with the group in question. And after a day spent on the ward or in the clinics with social foreigners, the middle-class health workers is only too happy to leave the core city and return to his middle-class neighborhood. Like the absentee landlord and the absentee bar owner, the absentee welfare worker and absentee teacher, he becomes the absentee health worker. The result: stereotyping.

The painful results of this mechanism afflict both patient, in terms of poor medical care, and care giver, in terms of frustration from his work. An infinite variety of problems result, as in the following case report.

> Eugene F., a 57-year-old single Indian born and raised in northern Minnesota, has worked for several years as a maintenance man for a large apartment complex. He has an excellent work record and is highly regarded by the Indian community in Minneapolis.
>
> One Friday evening a police ambulance brought Eugene from a bar to the receiving room of the hospital. No history was available. Eugene appeared confused and was gibbering in an unintelligible manner. Without further ado, he was transferred to a psychiatric ward some miles away to sober up.
>
> On admission to the psychiatric ward, routine pulse and blood pressure suggested increased pressure on the brain. A Chippewa translator was obtained, and the patient was found to be complaining of a severe headache. Further studies revealed a spontaneous hemorrhage from an arterial aneurysm in the head.

To the initial physician the combination of "Indian," "bar," and "confused" lead to one conclusion: another drunken Indian. No further examination was carried out. While most Indian people in Minneapolis do not fit the stereotype, those Indian patients seen by this physician do fit it. In the case above, he generalized from his own limited experience and purveyed a substandard level of medical care.

First Class Medical Care

The ghetto health worker frequently draws around himself the protective cloak called "first class medical care." Professionals assert that they can only practice their art on this level. It is repeatedly affirmed that minority patients have a right to this kind of care. Yet let us look at a few examples of it.

> A series of forty Indian patients with alcohol problems were admitted to a university psychiatry service over several months. So long as only one or two such patients were in hospital for less than a week, ward routine ran smoothly. As soon as three or more Indian patients were in the hospital for longer than a week, the Indian patients automatically became an in-group on the ward.
>
> Some ward staff became vexed with the later state of affairs. They felt unable to move into the Indian group and function therapeutically. To quote one staff member, the patients "might as well be out on the street." While a few staff members worked well with the Indian in-group, the general feeling was one of frustration and anger.

Those ward staff who could not provide what they considered to be good psychiatric care became irritated and were vocal in requesting that the patients be discharged. This staff behavior occurred even despite evidence of benefit from hospitalization (e.g., recovery from Korsakoff's alcoholic psychosis, occupational therapy for a blind patient, repair and therapy for ulnar palsy). The rationale was that the patients "were not amenable to treatment" or "could not benefit from first class medical care." Another example serves to illustrate how "first class medical care" can affect the recipient.

> Roberta S., a 26-year-old Indian woman, was admitted to hospital for alcoholic binges following separation from her husband. She is intelligent, well-groomed, perceptive. A disposition conference with the patient, two ward staff, and the author began amiably.
>
> Fairly soon the ward staff members engaged the patient in the sort of direct, confronting approach now popular in ward meetings. Roberta quite rapidly became stone-faced, taciturn, and stared off in the distance. Despite more pressure from the ward staff, all communication was interrupted.
>
> The interaction was then discussed with Roberta and with the two staff people. The staff honestly felt they were utilizing good therapeutic techniques to "draw the patient out" and "get at the problems." They were quite satisfied with their approach, even if unsuccessful in this case. Roberta related that she preferred not to talk about anger or speak angrily, particularly with strangers.

Similar examples have been encountered in medical, surgical, and pediatric cases. I have come to regard the over-used phrase "first class medical care" as a defensive device. It is used as a shield to protect the traditional *modus operandi*, to avoid responsibility and to avoid development of innovative techniques.

High Standards in Training

Another bastion of the health worker is training standards. He has labored long to obtain his certificates and is pledged to the precept that only the "well-trained" can work as equals along side of him. The force of this obsession is illustrated by a local neighborhood clinic.

> Some three dozen professional health workers are employed in a community clinic. Fields represented include medicine, dentistry, health administration, public health nursing, clinical nursing, dental hygiene, dietetics, health education, social work, psychology, audiology, and laboratory technology. The clinic serves a low socio-economic neighborhood in which white, black and Indian people live.
>
> All of the health professionals are white. Except for one foreign-born white man, all of the professional staff live outside the clinic neighborhood. They commute into the clinic in the morning, and out again in the evening.
>
> Even supportive staff are mostly foreign to the neighborhood. Only one secretary lives in the area. One non-white aide works part-time at the clinic. The medical director avers that he would readily hire local people to fill his positions: "You bring me the qualified people, and I'll be glad to hire them." While he takes in many students from the university for training, he disclaims any obligation to train people in the neighborhood which the clinic serves.

The "high standards in training" in such cases serves only to keep the insiders in, and the outsiders out. In neighborhood clinics of this genre, health care trainees from outside areas continue to learn at the expense of minority groups and the medically indigent so that they can later provide care for the affluent.

The Long Range Effect

Experiences such as those described above, together with an extensive review of mortality statistics at the Minnesota Department of Health and of autopsy data at the Hennepin County Medical Examiner's Office, leads me to conclude that ghetto medical care (excluding preventive care, such as immunizations) for the impoverished sick has not improved the general health of minority people.[1]

While ghetto health institutions may not be of any earthly value to ghetto dwellers, we cannot ignore the role they have played in serving as subjects for medical training and research. At least there appears to be no transgression of the first principle in medicine, *primum non nocere* (i.e., at least cause no harm).

Or is there a transgression? Share a powerful lesson taught by a man whose formal schooling is limited, but whose understanding is extensive.

> When I was a boy, I thought there were three kinds of people: good people and bad people of my own race, and good white people. I saw the white doctors, white teachers, white nurses, white social worker, white storekeeper; they were able people and led good lives.
>
> When I grew up, I drank a lot. I didn't take good care of my family. I came to hate myself for being what I was. I wished I was white, I dreamed about being white.
>
> But my thinking was unbalanced, like a three-legged chair. It needed that fourth leg. Finally I found it: I found out there were bad white men, too. Then my thinking became like that four-legged chair. It became more stable and didn't tip over so easy.

With an expertise born of experience, this erudite man has recognized that the ghetto child is surrounded by people who meet his health, educational, welfare, and other needs. These people dress neatly, talk nicely, appear confident. They drive new cars. However, they do not live in his neighborhood, or visit his home, or socialize with his parents. Often they contrast in countless ways with his own parents and neighbors. Ghetto children are influenced to identify with the neighborhood foreigner whom few of them will ever emulate, and to the detriment of their attitudes toward their own parents and themselves.

Absentee educators and care givers have an even stronger message for the ghetto neighborhood. It screams wordlessly: "You cannot care for your own needs; you require that we help and direct you; you are ignorant and inept." Such a message is not wasted on the children regarding their own future.

In sum, there remains with me grave doubt whether *primum non nocere* might not be profaned in today's ghetto health activities. The long-range malignant effect on the ghetto may well counter-balance any beneficent effect the present system has for society as a whole.

We Know Better

A first principle exists in ghetto health which, while either unconscious or spoken only in seclusion, dominates the organization and the programs in the field. It is difficult to separate this strategic postulate from the tactical difficulties enumerated above. In turn, the postulate produces abortive corollaries of its own. The principle states: We Know Better.

In this era of health consumer participation, each health institution has its advisory committee. The gross incompetence of some of the health representatives would insult many of the neighborhood inhabitants, if they had any public knowledge of who was "representing" them. In other cases the committees are composed of competent people with values and education heavily skewed toward that of the health workers themselves; no pretense is even made that such groups are representative of community interest groups. In either case such committees smack of tokenism: they have no real power. They do not turn the money-spigot, approve or veto program goals, nor choose project directors. In essence, ghetto citizens are not allowed to make any significant decisions regarding their own health matters. In fact, to allow them to do so is perceived as dangerous by many health workers.

Let us look at the sequelae of this "We Know Better" principle in operation. Health becomes not a community-centered affair, but rather a clinic or hospital-centered activity. Health programs are developed to cure or prevent diseases which the local populace considers merely a normal variant, and not a disease at all. Health priorities are those of medical workers, and not of area inhabitants. The hospital or clinic becomes foreign territory to the neighborhood: as phrased by one man, "That's just another place that's not mine."

"We Know Better" has a more subtle influence on patients and on institutional statistics. The establishment of a complicated intake and care system requires a relatively high level of compulsiveness and patience, personality characteristics without much survival value in ghetto areas. As a result, a covert selection process leads then to better sta-

tistics regarding follow-up and cure as the more desirable patients (from the health worker's standpoint) receive care. It is problematical, however, whether this has any effect on mortality and morbidity statistics in ghetto areas.

How is it, then, that the "We Know Better" principle is maintained by so many bright and well-intentioned professionals? First, they keep relationships with ghetto dwellers to a minimum; non-clinic centered interactions are especially avoided. Next, they spend a major portion of the day with our professionals and absentee workers, including teachers, welfare workers, child protection people, missionaries, government inspectors, university representatives. Third, the health worker engages in self-fulfilling prophecies by excluding patients and community representatives from discussions, conferences, and decisions. Lastly, indigenous health workers are not hired or trained unless they possess middle-class norms or aspire to leave their own social group.

The Antidote

How can we remedy the present situation? Certainly, it is not simply a matter of people changing themselves. Minorities cannot suddenly become medical non-indigents. Health workers cannot willfully change their upbringing, education, values, priorities, or vested interests; indeed, these very attributes prove beneficial for other endeavors in their lives. The point is this: for individuals within each group *it is not their fault* that they are as they are. It is not reasonable to expect spontaneous alteration of the behavior patterns or intrapsychic milieu in either group. However, the following organizational changes can bring about the desired end result: better health care for all citizens.

1. *Patients' responsibility in their own health care must be recognized.* This means more than superficial "community participation" so often referred to in today's jargon. To use the Arnstein-Burke model, community responsibility for health matters means community power.[2,3] Merely telling our patients what we are going to do or bringing them into group settings where we can change their attitudes is not enough. The latter maneuvers only lead to empty clinics and indifferent service programs—in short, to community non-participation. As noted by Campbell, consumers must be involved in all levels and in all stages of planning.[4] It is most important that they be involved on the policy and planning levels; all too often they are only included as an after-thought at the time of program implementation.

A serious problem for health workers revolves around how and where to obtain organized, representative community participants. Communities vary widely in this regard. At times one or a few representative bodies are already operational. More often a variety of interest groups exist which are willing to assume shared responsibility in health enterprises. Rarely the worker might have to start from scratch in eliciting leadership. Spaeer et al. stress the need for formal organization of such consumer groups, with election of members and by-laws.[5]

2. *Health care is best rendered by people who share the sociocultural mores and values of their patients.* In practice this means that indigenous workers should fill—or preferably, flood—every available position in health facilities. Where trained indigenous people are not already available, untrained people should be hired and trained. The superiority of this method in up-grading health care has been well-documented.[6,8]

D'Onofrio notes that such training imposes an added responsibility on health professionals, who generally have varying expectations of and attitudes towards indigenous workers.[9] However, this brings the real world of the community into the clinic or hospital setting, making the health facility a part of the community rather than an island in the community.

Health workers need to know about the aspirations, idiom, and daily activities of people they serve. Indigenous workers can serve as translators for outside professionals and as *amicus curiae* for patients.[10] In recognition of the importance of this role, non-certified indigenous workers should have their own hierarchy, with representation at a level with certified personnel. At the core of this strategy lies the realization that both the professional and the local inhabitant have knowledge which the other needs to provide health care.

The eventual goal, explicitly stated, should be for all health workers to be community people. To this end, clinic personnel should strive daily to put themselves out of their particular job. Indigenous workers should receive time and expenses to cover further training so that they can replace outsiders.

3. *Professionals must seek education for themselves and educate other professionals in health care methods for minority people.* This means more than knowledge acquisition; it involves attitudinal and behavioral changes. Many professionals are threatened when consumers share in decision-making; they subvert change while averring that they act in the best interest of patients.[11,12] Only by re-education and experience with new models can professionals come to accept change and recognize that it benefits patients in addition to making their own work more interesting and productive.

One means to accomplish this re-education within our ranks is by our own behavior, yours and mine. Our peers are more influenced by what we do than by what we say. If we work in new ways and find them successful, others will emulate us.

Another means—perhaps preparatory to the first—lies in training by interaction with indigenous people, as described by Carlow.[13] At one end of the spectrum this may involve coffee breaks with indigenous health workers at a neighborhood hamburger shop. At the other end of the spectrum, staff training might include weekly didactic presentations on topics of interest to both professionals and indigenous workers (i.e., poor housing and health, rat control, etc.) followed by group discussion.[14] Besides engendering a sense of cooperation between indigenous workers and professional foreigners, such methods will allow each group to close up the gaps in communication which presently exist.[15] From such beginnings will evolve health goals and programs which can elicit community interest and support.

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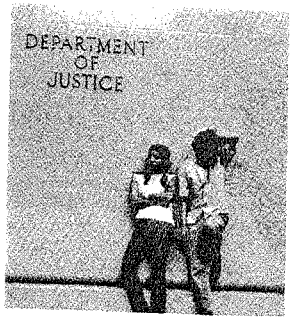
INDIAN POWERLESSNESS IN MINNESOTA

Joseph J. Westermeyer



Social institutions practice gross discrimination against Indian people in Minnesota—and they do so in the name of equality. Besides ignoring the real social needs of Indians, they often attempt to undermine Indian mores and values. Those institutions having the greatest contact with Indian people—the courts, police, welfare agencies and others—are the least adept at problem-solving and rehabilitation in the majority society. And institutions with a record of successful problem-solving have very little to do with Indians.

The incidence of infant mortality, child abuse, foster home placement, state guardianship of children, arrest (especially alcohol related arrest), imprisonment (especially property offenses), unemployment and accidental and homicidal death is many times higher for Indians than for the general population of Minnesota. Conversely, neonatal death, psychiatric hospitalization for both children and adults and suicide occur less often among Minnesota Indians. These rates are related to the degree of success or failure achieved by social institutions in solving Indian problems.

This relationship between Indian people and social institutions was the subject of a two-year investigation conducted between 1969 and 1971. Field activities concentrated on the three largest Indian reservations in Minnesota, larger towns near these reservations and the Twin Cities area. Church groups, private social agencies, federal bureaus, state departments, city police and city administration, county welfare and county sheriffs, teachers and attorneys, clinics and hospitals were consulted. Time spent with various officials and institutions ranged from a few hours, to several consecutive days, to repeated contacts throughout the study. Observations were made on the behavior of institutional workers toward Indian clients, patients, prisoners, students and parishioners.

Authority positions within the schools, clinics, social agencies, religious organizations and businesses serving Indian communities have been occupied almost exclusively by non-Indian people. The structure of these organizations has tacitly implied that Indian people are incapable of assuming responsibility for their education, health services, social welfare, religious needs and so forth. Where social institutions have included Indian people, they include them on the lowest levels.

Indian education in Minnesota demonstrated an important example of this structure and mode of thought. Minnesota society was attempting to teach majority-oriented material under the direction of majority educators to Indian children, despite the prevalent distrust of white people and disdain for middle-class values. The drop-out rate exceeded that of any other group in Minnesota. Indian students prematurely left their educational experience ill-prepared for life in either the majority society or in Indian society.

One of the factors affecting this educational experience was lack of local autonomy and control. While not an official tabulation, Table 1 shows positions held in several reservation schools in September 1969, as noted by observation and informant reporting. This sample showed the aggregation of white people in status positions and Indian people at menial tasks.

Table 1 — SCHOOL POSITIONS ON THREE INDIAN RESERVATIONS IN MINNESOTA, 1969

Position	Indian	White
Principal	1	4
Teacher	3	47
Secretaries	4	1
Bus drivers	6	0
Maintenance men	7	0

Based on observation and informant reporting (requests to the Minnesota State Department of Education for a racial categorization of employees have remained unanswered).

Indian school advisory boards have recently come into vogue both on the reservation and in urban centers. However, these boards can only advise. Unlike real boards of education, they are unable to set policy and cannot hire or discharge school employees. Thus Indian parents had, in effect, no authority over their children's education. Such administrative organization assumed that professional education was all important, while local autonomy and leadership capability had little

Photographs by Larry Frank

value. Were Indian leaders to determine goals and priorities, then professional and technical people (Indian and non-Indian) could implement them with an assurance that either success or failure would reflect on Indian leadership. But in the present context, the outcomes depend on an evermigratory series of non-Indian bureaucrats.

Another untoward finding was the tendency of Indian females to have more education than males. In the 1960 Minnesota census, the median school years completed among those 14 years of age and older was 8.6 years for Indian males and 9.0 years for females. In a 1969 survey of Indian students age 16 years and over, the number of females exceeded males. This suggested a subtle bias was operating to keep Indian males in a socioeconomic position not only inferior to non-Indian males but often inferior to Indian women as well.

High Unemployment, Low Income

As a whole, Indian people had the highest rate of unemployment and the lowest income of any racial group in Minnesota. Mean incomes averaged about one-third of income levels for the state. But it should also be noted that Indian men not only had less education than Indian women, but also more unemployment and generally lower status jobs. The male unemployment rate on reservations averaged 42 percent in 1969. In addition, these data demonstrated the trend for women's employment rates to equal and even slightly surpass those of men (58.2 percent for females, 58.0 percent for males in this survey).

Minnesota business and industry, while often glorifying "the Indian" in advertisements, have given Indian people short shrift when it comes to hiring them. Mostly Indians have worked at seasonal jobs which no one else wants—cutting pulpwood, ricing, guiding, road work and fishing.

One community psychiatrist practicing near a reservation gave a straightforward explanation of these figures, declaring that "discrimination is rampant in this town." While my own experiences in his area supported such a viewpoint, a number of fairly liberal men—mostly local businessmen and professionals—attested that such was not the case. They disavowed any malice toward Indians and considered them in no way different from other people. When they were asked the question: "But what if your son or daughter wanted to marry an Indian?" without exception a score of them admitted they would be strongly opposed (one volunteered that it would be worse if his daughter married an Indian than if his son did).

Medical services have had a major impact on Indian health in those areas where effective preventive measures are available. For example, these measures have reduced tuberculosis and other communicable diseases, as well as neonatal mortality (where prenatal care reduces infant death in the month following birth). Post-neonatal infant mortality, diarrhea and pneumonia deaths continue at an inordinately high rate, however. Deaths strongly influenced by individual behavior have increased over the last few decades: accidents, homicide, suicide, cirrhosis of the liver. Longevity is slowly increasing, but it is still two-and-a-half decades behind the general population. While mortality measures general health in a crude fashion, mortality statistics did suggest that medical care services (as distinct from preventive services) have had doubtful impact on Indian health problems.

As in the field of education, medical services also imputed to Indian people an inability to provide for themselves. Table 2 classifies Indian Health Service personnel on Chippewa reservations in Minnesota by race, sex and position. There were no Indian physicians, dentists or pharmacists. Chippewa women occupied higher status positions (nurses, medical secretaries) than did Chippewa men (janitor, maintenance work). Also, non-Chippewa Indian women tended to work at higher status jobs. Non-Indian men occupied the highest paid, most prestigious positions.

Indian people rarely used the Community Mental Health Clinic system in northern Minnesota. Staff people in those areas had a remarkably similar tale to tell. Most of their Indian referrals came from courts and social agencies; in these instances, the patient and family ordinarily gave less than willing cooperation. To the Indian citizen, the C.M.H.C. system served primarily as a way station for incorrigible psychotics and suicidal patients on their way to state psychiatric hospitals. Occasionally a patient with epilepsy or brain disease arrived for consultation. Notable by their absence were reactive or crisis difficulties, family problems, mental illness in early phases and alcoholism.

Nut Doctors

Psychiatric facilities in the Twin Cities area encountered Indian people in much the same fashion as in the northern mental health clinics. Indians did not utilize psychiatry as a first-call resource to find remedies for problems, but rather as a last resort on which to dump intolerable difficulties. As a result Indian informants perceived psychiatrists as "nut doctors" or some variant thereof. In turn, psychiatric health workers commonly described Indian patients and their families in psychiatric jargon using terms with negative connotations.

Except for occasional provision of hand-me-down clothes and secondhand refrigerators, the missionary, too, has not served significantly as a social resource among Indian people. Few Indians have attained status in church circles. Despite large numbers of nominal devotees, Catholics could not claim a single Indian priest in

Table 2 — INDIAN HEALTH SERVICE POSITIONS ON CHIPPEWA RESERVATIONS IN MINNESOTA - July 1, 1970

Position	Chippewa		Other Indian		Non-Indian	
	Male	Female	Male	Female	Male	Female
Physician	none	none	none	none	6	none
Dentist	none	none	none	none	4	none
Pharmacist	none	none	none	none	4	none
Nursing	none	17	none	2	none	7
Administration	3	4	none	1	1	none
Lab, X-ray	1	1	none	none	1	2
Dental Assistant	none	4	none	1	none	none
Clerical	4	6	none	none	none	4
Environmental Health	3	none	none	none	none	none
Dietary	5	8	none	none	none	none
Maintenance	14	2	none	none	1	1

Data obtained from Indian Health Service at Bemidji and supplemented by medical officers of I.H.S. as well as personal observation.

Minnesota; there was only one ordained Episcopal priest. A few Indian lay ministers could be found, but—like the priest—they were men well over 50 years of age.

Recently a fundamentalist evangelical sect has been gaining in popularity as Indian men have assumed ministerial roles. Of course the Native American Church (a pan-Indian religion in which peyote is used) has a long history in Minnesota. The traditional spirit religion still plays a role in the lives of some.

In both the rural counties and in the Twin Cities, police personnel possessed a wider experience with Indian people than did most other institutional workers. Complaints of police brutality suggested that the total police-Indian experience was solely a detrimental one. But such a simplistic viewpoint failed to appreciate the complexity of police-Indian relationships.

Police often played a paternal "rescuer" role to Indian people, especially when the latter were drinking. Inebriated Indians were removed from railroad tracks or highways where they had fallen asleep, rescued from snowbanks and inoperable cars in cold weather, taken off the streets when they posed a danger to themselves and traffic. As one might expect, regular "clients" dutifully acted the child's part. They even came to some jails while sober to seek a free meal or a night's lodgings when out of money. In repetitive scenarios demonstrating this police-Indian entente, officers of the law were seen cajoling their drunken, pseudo-belligerent charges into custody. The opposite reportedly occurred as well, especially in larger towns and cities—drunken Indians have been deprived of their bankrolls and obstreperous offenders have been beaten. Some officers appeared to have no patience with behavior they condemned morally and could not understand.

A private Indian organization in the Twin Cities developed an innovative cooperative program with police officials to subvert both these paternal and enemy roles played by peace officers. During the evenings, especially during warm weather, an Indian Patrol walked the streets around the Indian neighborhood. Originally started to watch the police (that is, to play the "adversary" game), it gradually developed service functions such as taking intoxicated persons home or injured persons to the hospital. Eventually police officers turned minor offenders over to the Patrol, and Patrol members assisted police in managing difficult situations.

Welfare departments ranked second only to the police in number of contacts with Indian people in trouble or distress. As with the police, their performance varied with the individuals concerned, the specific department and prevailing policy. Despite considerable range, however, certain generalizations could be made.

Lack of mutual trust and understanding marked the white social worker-Indian client relationship. Workers accused the clients of uncooperative attitudes, sloth and attempting to manipulate the worker. Clients accused workers of prejudice, excessive curiosity and superior attitudes.

Why should it be thus? Certainly differing value systems and communication skills accounted for part of it. But it went beyond that. Social workers wielded great power over Indian lives in Minnesota. Workers were restrained by laws and agency rules, yet there was much room to maneuver depending upon the elements of the case as they saw it. At one time or another the finances of virtually all Indians rested upon personal decisions made by social workers.

An even more potent cudgel was the worker's capability to take children away from Indian parents, a power which—as indicated by the large numbers of Indian foster children—was employed frequently. Many Indian

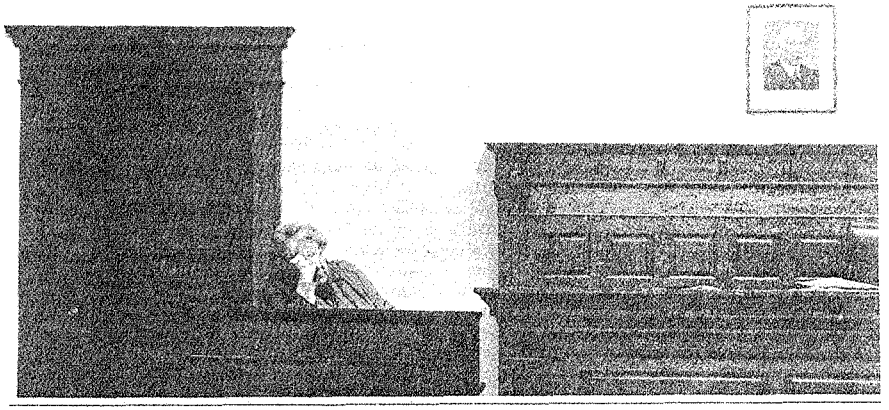
parents, considered reasonably responsible by their ethnic peers, did not hesitate to leave young children in the care of an eight- or ten-year-old child while they went shopping, working, partying or visiting. Appearance of a social worker on the scene has resulted in abandonment charges. Also, an Indian child in ordinary trouble at a good home or momentarily angry at his parents may opt to take off for the home of a friend or relative to spend a night or two until things settle down at home (a legitimate option for children in Indian families). Should the child choose a white social worker as "friend," he may be headed for a foster home.

Most Indian children were placed in white foster homes (of over 700 foster homes noted to be caring for Indian children in Minnesota during 1969, only two had an Indian parent). This fact was especially bothersome in that the rate of foster placement and state guardianship for Indian children ran 20 to 80 times that for majority children in all counties studied. An explanation for this may be found, not in humanistic philosophy, but in economics. Especially in rural communities the excessively large number of Indian children in foster care bolstered the local community, since federal funds rather than local funds paid for the foster home care and the welfare supervision. Again, this was an instance where the administration of Indian funds by state and county officials worked to the detriment of Indian people and the benefit of the nearby non-Indian community.

When the children were taken away by a social agency, the Indian couple split up immediately or soon afterwards (no exceptions to this were encountered by the author or reported by informants). Rather than working for family integration, the average worker simply took the children. And by the decision to do so, the social worker destroyed the family as a functioning unit.

Kinship ties were not totally broken for most foster children, however. Such children maintained kin ties with their defunct families as they went from one foster home to another. When they reached maturity, most of them rejoined Indian society, but without skills enabling them to live productively. That is, they were not adept at hunting or fishing or wild rice harvesting—skills useful on the reservation—nor had they obtained the skills or education necessary for a job in town. Appended to this were the psychosocial disabilities associated with the foster child syndrome (inability to trust, insecurity, free floating anxiety, difficulty in maintaining satisfying family living).

Another problem was the maze of rules and regulations governing county residence, tribal affiliation, responsible government unit (whether city, county, state or federal) and so on. Each level of government averred that another level held responsibility for Indian people.



Indian woman waiting to testify in behalf of another Indian woman seeking to regain custody of her children from the state.

Private social agencies varied widely in their services for Indian people. However, most social agencies serving Indians could be characterized as having non-Indian men in the highest positions, Indian women along with non-Indian people in intermediate jobs, and Indian men in the lowest positions. To compound matters further, Indians occupying intermediate levels often came from other tribes outside of Minnesota (sometimes from traditional enemies of local tribes).

In small towns near reservations, private social orga-

nizations were exclusively white-dominated and white-oriented in their services. Around Minneapolis a few agencies, such as the Community Information and Referral Service, assisted a sizeable proportion of Indian people. However, even in Minneapolis the services were relatively sparse when compared to the great needs. For example, the Directory of Community Services in Minneapolis included the following number of private agencies for various categories: unwed mothers, 8; Catholics, 6; Jewish, 4; Indian,2.

Indian Agencies

Those few agencies under Indian control deserve special mention. While these were few in number, their achievements were notable—especially in view of the long tradition of agency failures under non-Indian leadership. For example, a white attorney with a reservation Legal Aid agency controlled by Indians related that his clients trust him and present their problems openly:

> They need legal help badly. All reservations are crying for it. But the Legal Aid programs have been attacked by whites in reservation areas, including ours, and the Indians feel that if this is true we must be all right. They align themselves with us.

Statistical information concerning the relationships between Indians and social institutions and the resultant generalizations were, of course, important in understanding the treatment of Indians in Minnesota. Equally important were the attitudes of the people who made up these institutions. Interviews with institutional personnel abounded with surprises. Just as interactions with Indian citizen committees fractured old stereotypes of Indian incompetence, so too did these interviews disrupt many preconceived notions. Patience and frankness could be encountered in a sheriff's office, nihilism in a principal's office, rigidity in a community mental health clinic. Sufficient range of interview experiences was garnered to demonstrate that every social institution harbored entire spectrums, from nihilism to activism, from extreme flexibility to extreme rigidity. No one institutional form had cornered the market on backwardness or on enlightenment.

Many institutional leaders maintained a know-nothing attitude about Indian life, and how their institution might interrelate with and contribute to Indian life. Pressed to comment on the role of his school in the community, a white principal of a reservation school said:

> We'll tell you anything or give you any information about the school. We're the experts here. But we don't know anything about conditions outside of the school. We keep to ourselves.

Such an attitude implies that the educational function operates independently of the community whose children attend the school. In the face of such a stance (honestly and directly spoken by the principal), the high drop-out rate at his school came as no surprise.

Pseudo-egalitarianism was rife within the social institutions of Minnesota. According to official doctrine all citizens were treated equally, but in fact Indians were treated unequally by expecting all people to have the same Judeo-Christian Euroamerican system of values and behavior. Since all people in Minnesota were *not* the same in regard to their cultural mores and social problems, gross inequality in services resulted from treating everybody as though they were "the same." In effect, the true needs of Indian people were blatantly ignored or poorly handled. The argument could not be illustrated better than it was by a community psychiatrist who, when asked about statistics on Indians in his case load, spoke heatedly:

> All of the people in these counties pay for this (sic) data. If it can't benefit them, it won't be released. There aren't Indians and non-Indians in these communities. They're all citizens. They all benefit from the services here.

According to this man's staff, the Indian community did not use the services offered at the clinic. The single "preventive psychiatry program" for Indian people in this community consisted of stringently enforced school attendance, an action taken independently of the Indian community and enforced by the local sheriff's office.

A further social harm resulted from this pseudo-equal policy—the forcing of foreign social values on a minority people. In order to benefit from social institutions as constituted, Indian people were expected to behave in ways which are odious to them. This amounted to de facto attempts at ethnicide.

"Save the Indians"

Many young social and health workers openly admitted an initial messianic motivation to "save the Indians" when they began their work with Indian people. They wished to help the noble savage, fallen from grace, back to his rightful place of honor. But fatalism soon replaced their altruistic ardor. One young physician with the Indian Health Service acknowledged:

> The hard core alcoholics are irritating to the point you'd want to shoot them. They're mean and vicious when they're drunk. The police come and drop them in your lap. The medical set-up here is perfect, but you can't call this a hospital . . . . These (alcoholic) patients chew up the most time and money. Generally they die anyway. You might say our worst problems have been resolved by death.

Indians were observed to respond to such treatment by social institutions with three types of behavior: 1) open noncooperation, 2) covert passive-aggressive harassment and 3) deception. Personnel from social institutions complained that one or all of these dispositions characterized Indian-institution relationships. In my own experience with hospitalized Indian patients, each of these was indeed encountered frequently and in combination.

It should be noted that almost all such cases of noncooperative, passive-aggressive ploys and manipulation occurred in a context of majority-dominated institutions. Within Indian-dominated organizations, such unproductive mechanisms (while not altogether absent) were significantly less prominent. In the absence of such maneuvers within the ordinary Chippewa or Sioux family in Minnesota, one could not avoid the implication that these Indian people have learned or have been trained to behave this way as a result of contact with various institutions.

Institutional Mismatch

Those social institutions with which Indian people have the most direct contact emphasized neither rehabilitation of their clients nor removal of clients from the cycle of need for continued services. Courts, jails and prisons protected society. State mental institutions served to hide deviant behavior. Missionary religions wanted faithful converts. Acute medical services operated in crises, with little care for health maintenance. Educational systems were trying to acculturate Indian children into the majority society. Welfare and federal agencies served the legislative programs which created them and which annually infused fiscal sustenance; and they did this in a way which primarily benefitted non-Indian people.

Social resources with problem solving or rehabilitation emphasis had little or no contact with Indian people in Minnesota. These included business, industry, unions and co-ops; community clinics and general hospitals; trade schools, colleges and universities; city and county government; private social agencies and attorneys; self-run parish groups. They are smaller, more responsive to individual and family needs, more goal-oriented than procedure-oriented and more prone to repeated performance evaluation from within and without. These social forms tend to foster autonomy. Faced with a problem, they lend themselves to a period of mutual cooperation after which the individual or family fades as an identified "problem" and resumes status as an ordinary citizen.

Cooperative efforts between social institutions and Indian communities have been peculiarly absent. Where such cooperation does occur to some degree, problems are solved. Where non-Indian authority dominates, problems persist—problems which can only be resolved by surrendering responsibility for Indian lives to the Indian community. □

Alcoholism

Violent Death and Alcohol Use

Among the Chippewa in Minnesota

JOSEPH WESTERMEYER, M.D., Ph.D. and JOHN BRANTNER, Ph.D.

IN DOING CLINICAL work with Chippewa patients, histories of multiple traumatic events are commonly obtained. Moreover, in taking family histories with these patients, violent deaths appear to be frequent. For example, among the first degree relatives of thirty Chippewa alcoholics, 23 out of 81 deaths (28.4%) occurred by accidents, homicide, or suicide.

The literature demonstrates a high association between violent death and alcohol use. Postmortem examinations, done on single vehicle accidents in New York, demonstrate that two-thirds of the fatalities have blood alcohol above 0.05%.[1] Among car accident casualties in New Zealand, sixty percent have blood alcohol of 0.10% or higher.[2] Using the case study method, over a third of fatal accidents have been shown to involve chronic alcoholics.[3] Other violence also bears a strong relation to alcohol, as demonstrated by breathylyzer tests on victims of fights, assaults, and home accidents in a Boston emergency room.[4]

Violent death may be common among Chippewa people. Among other groups of people violent injuries or death are frequently associated with alcohol usage. We were therefore interested to see first, whether violent death is common among Chippewa; second, whether violent death is associated with alcohol use among Chippewa; and third, how the epidemiology of violent death among Chippewa differs from the general population and other Indian groups.

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Method

Vital statistics for the state of Minnesota include "Indian" as a racial category. In the 1960 census, 95.4% of Minnesota Indians were estimated to be Chippewa. Thus, the category "Indian" in Minnesota virtually means Chippewa people.

Postmortem investigations are performed for all cases of violent death by the Hennepin County Medical Examiner. Investigation includes chart review, autopsy, police report, and—where indicated—analysis of blood or gastric contents for alcohol. Again, "Indian" is a racial category in these data. Based on information from the American Indian Employment Center in Minneapolis, between 80 and 90% of Indians in the area are Chippewa. As a result, detailed autopsies are available for those Chippewa people who die in the Minneapolis area.

Methodologically, data from urban Chippewa must be cautiously applied to the state-wide Chippewa population. Supportive information suggests that such a generalization can be reasonably made.

Data

Minnesota Vital Statistics

Violent Death Among Minnesota Indians. Violent deaths comprise the most common form of death among Minnesota Indian people during 1965-67 (Table 1). While one out of four Indian people die by such causes, only one out of twenty occurs in the general population. This category ranks fourth in the general Minnesota population.

TABLE 1
Major Causes of Death
State of Minnesota
1965 - 1967

Cause of Death	Indian People					
	Rank	Number	% of all deaths	Rank	Number	% of all deaths
Accidents, violence	1	120	25.8%	4	5,205	5.3%
Heart disease	2	105	22.6%	1	37,666	38.2%
Pneumonia, influenze	3	40	8.6%	6	2,826	2.9%
Dis. Digestive System	4	36	7.7%	5	3,303	3.3%
Cancer	5	34	7.3%	2	17,107	17.4%
Stroke	6	23	4.9%	3	13,294	13.5%
Other	—	107	23.0%	—	19,208	19.5%
Total		465	99.9%		98,609	100.1%

lation. Despite the relatively small number of Indians, the differences are highly significant ($P < .005$).

Hennepin County Medical Examiner

Violent Deaths, Hennepin County. During the years 1964-69 inclusive, 3305 violent deaths came to the attention of the medical examiner. Of these 41 (1.24%) were tabulated as Indian. Table 2 indicates the individual numbers for non-vehicular accident, vehicular accident, homicide, and suicide.

TABLE 2
Violent Deaths
Hennepin County Medical Examiner
1964 - 69

Cause of Death	Total Number of Deaths	Indian Deaths Number	Indian Deaths Percent of Total
Non-vehicular accident	1411	21	1.49%
Vehicular accident	1047	11	1.05%
Homicide	229	7	3.06%
Suicide	618	2	0.32%
Total	3305	41	1.24%

Non-vehicular Accidental Deaths. Of 21 Indian cases, 15 were judged to be alcohol related based on the medical investigation. Ages for all alcohol related deaths ranged from midteens to midfifties, while deaths not related to alcohol occurred in infancy or after the late fifties. Alcohol related causes of death included: falling (seven people), acute alcohol intoxication (three), carbon monoxide poisoning (three), and drowning (two).

A comparison was made between the Indian deaths (1964-69) and "all" deaths in 1969 (Table 3). A marked difference in mean age is noted, due to the greater proportion of elderly people in the "all" sample. By excluding all persons age 70 or older, the adjusted mean ages so obtained are similar. Sex ratios for both groups are similar.

Of those blood alcohol tests having positive results, the mean level of Indian tests is higher than the "all" tests. Contributing to this difference are several cases of non-Indian people dying of intoxication from alcohol plus other drugs (barbiturates, amphetamines, analgesics). Intoxication deaths among Indian people involve alcohol only.

Vehicular Accidental Deaths. Seven of the eleven Indian deaths were judged as alcohol related. In comparing Indian and "all" deaths for age, sex, and blood alcohol, differences between the two groups are not significant.

Homicide Deaths. Of the seven homicide victims, four had elevated blood alcohol at the time of death. Comparisons for age and sex do not demonstrate significant differences between the two groups. However an age disparity may be present: mean Indian age falls two decades behind the general population. Despite the few Indians in the sample, statistical testing for age does demonstrate a significant difference at the .005 level of probability (Table 4).

Suicide Deaths. One of the two Indian suicides was alcohol related. With so few Indian suicides

TABLE 3
Characteristics of Violent Death
Hennepin County Medical Examiner

Category	Indian deaths (1964-69)	All deaths (1969 only)
Non-auto accidents		
Number	21	297
Mean age	37.5 years	53.4 years
(Adjusted age)	(35.2 years)	(34.9 years)
Percent males	62%	63%
Mean blood alcohol (pos. tests only)	0.267%	0.207%
Auto accidents		
Number	11	163
Mean age	38.1 years	36.6 years
Percent males	73%	67%
Mean blood alcohol (pos. tests only)	0.175%	0.176%
Homicide		
Number	7	40
Mean age	18.3 years	38.7 years
Percent males	86%	77%
Mean blood alcohol	0.155%	0.177%
Suicide		
Number	2	101

available for scrutiny, comparisons are meaningless. However the paucity of suicides is itself a significant finding worthy of further attention.

TABLE 4
Comparison of Homicide Victims by Age
Hennepin County Medical Examiner

Age Group	Indian deaths (1964-69)	All deaths (1969 only
Less than or equal to 25 years	7	12
Over 25 years	0	28

Fisher Exact $X^2_i = 14.3, < P .005$

Blood Alcohol Tests. Blood alcohol tests offer a fairly objective standard for comparison between the two groups. Since the number in any one subcategory of violent death is small, there is value in grouping them together. As noted in Table 1, the relative proportion of Indians to the general population varies for each category. However, the two largest categories, vehicular and nonvehicular accidents, do not vary as widely as do the two smaller categories, homicides and suicide.

Blood specimen for alcohol content tend not to be taken from the very young or the very old. Among those who survive a long time posttrauma, an autopsy alcohol specimen is of no value. So blood alcohol specimens are reserved for persons who may have recently taken alcohol. Comparing the Indian and "all" groups in Table 5, significantly more specimens have been taken from Indian persons at autopsy (at $P < .025$). Table 6 demonstrates that significantly more Indians have positive blood alcohol tests at autopsy relative to the general population ($P < .005$).

Discussion

Incidence of violent death among the Indian people of Minnesota is five times that of the general population. Based on data from Minneapolis, Indian violent death appears to be associated with alcohol to a significantly greater extent than in the general population.

TABLE 5
Comparison for Taking Blood Alcohol Specimens
Hennepin County Medical Examiner

Category	Indian deaths (1964-69)	All deaths (1969 only)
Specimen taken	26	269
Specimen not taken	15	331

$X^2_i = 5.23, \ P < .025$

Despite these disparities between the two groups, notable similarities occur as well. Proportion of males and females does not vary significantly between Indians and the general population. Mean blood alcohol levels, taken from positive tests only, compare closely. Difference in mean alcohol level among nonvehicular accidental deaths appears related to the use of other drugs in the general population and the absence of such use among the Indian deaths.

Age distributions coincide only for the vehicular accident category. However, if persons aged 70 or older are excluded from nonvehicular accidents (few Indian people survive that long), then the two groups also compare closely for age. Only among homicide victims does there appear to be a significant age discrepancy, with Indian victims being significantly younger. Of interest here also is the relatively high rate of homicide victims in the Indian group.

These observations, the young age and high rate of Indian homicide victims in Minnesota, have been noted for Indian people in general in the United States.[5] Thus, the Minnesota Indian population, while unlike other Minnesotans in these regards, resembles other Indian people.

Minnesota Indian people appear to differ regarding suicide, however. Nationwide Indian statistics,[5] as well as work done by Dizmang and Resnick among tribal groups,[6-8] indicates quite a high rate of Indian suicide. One might wonder whether Indian suicide data from an urban area such as Minneapolis might be misleading or whether Chippewa people actually have less suicide.

Paredes[9] collected vital statistics from northern Minnesota, including Beltrami and Cass Counties where Chippewa reservations are located. His records cover 20 years (1940-64) and include homicide and suicide figures by race. Using the 1960 population for Cass and Beltrami Counties, the following crude homicide rates are obtained: 7.0 per 100,000 Indians per year, versus 1.3 per

TABLE 6
Comparison for Results of Blood Alcohol Specimens
Hennepin County Medical Examiner

Category	Indian deaths (1964-69)	All deaths (1969 only)
Alcohol present	23	118
No alcohol	3	151

$X^2_i = 18.94, \ P < .005$

100,000 non-Indians per year. Again using the 1960 population as a denominator, crude suicide rates are: 6.1 per 100,000 Indians per year, and 10.7 per 100,000 non-Indians per year. Thus, for reservation areas, Chippewa homicide is much higher and Chippewa suicide is somewhat lower as compared to the general population. These rural data coincide with the urban statistics, both indicating a relatively low rate of Chippewa suicide and a relatively high rate of Chippewa homicide.

These differences in suicide rates among Minnesota Indians (mostly Chippewa) as compared to other Indian groups underscore an important point. While it is proper to look for trends and similarities among ethnic groups, it is an error in logic to assume conditions prevalent among one Indian tribal group will be present among another tribal group. The exceptions to general rules may provide clues.

There are no satisfactory explanations for the low rate of Chippewa suicides relative to the general Minnesota population and relative to other Indian groups. In fact prior clinical experience would have suggested a high rate. For example, 10 out of a series of 30 Chippewa alcoholics admitted to at least one suicide attempt, and several more reported suicidal preoccupation. In the last year at our institution, three Chippewa girls have gestured suicide by scratching or cutting their wrists during hospitalization. While one might logically argue that the "plea-for-help" gesture might inveigh against actual completed suicide among the Chippewa, we have no other data to support this contention.

The question inevitably arises: Why so much violent death among Minnesota Indians? In addition the exact nature of the alcohol-violence relationship is not clear. Is there more alcoholism among Indians in Minnesota? Do alcohol use and violence-seeking comprise a form of suicide, or perhaps function as a depressive equivalent? Or does risk-taking combined with alcohol use function as a mode of obtaining prestige? Or relieving boredom?

Conclusions

Violent death occurs five times more often among Indian people in Minnesota (most of whom are Chippewa) than among the general population. It is the most common cause of death for Indians in Minnesota during recent years.

In Minneapolis, violent deaths among Indians are significantly more often associated with alcohol use than in the general population.

In general, Chippewa victims of violent death resemble such victims in the general population with regard to sex, age, and blood alcohol level. A notable exception to this is homicide, which occurs at an earlier age among Chippewa (as it does among other American Indians). Homicide occurs particularly often among Chippewa, whereas, unlike other Indian groups, suicide is not so frequent.

Acknowledgement

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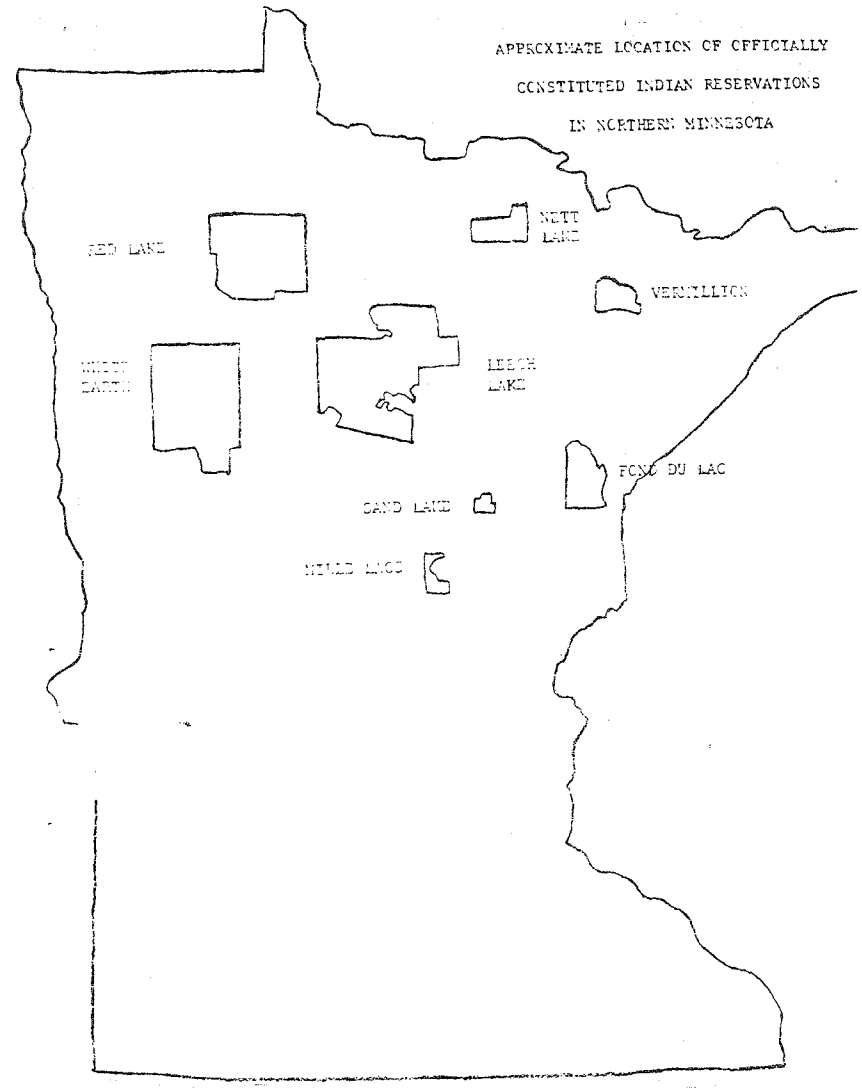
Indian Child Welfare Crisis

The Indian Youth Program, headquartered in Duluth, Minnesota, serves four reservations in Northern Minnesota, and the City of Duluth. The program is funded by the Office of Health, Education and Welfare, with a grant to the Duluth Indian Action Council and this summer will begin its third year of operation.

The program is designed to alleviate the atrociously disproportionate number of Native American youth in juvenile institutions in the target areas. The Indian Youth Program has made it a priority to exhaust all means to stop the mass theft of Indian children, (Anishinabe-Oski-neeg) from their tribe and homes.

Within the State of Minnesota, over $1,040,000.00 of BIA monies alone per year is funneled into the State to pay for this child robbery. Thirty four (34%) of all Indian children are currently in foster home placements. Indian foster placements to white homes is big business in Minnesota. Countless young Indian children are placed in white families where many sweat and toil for fifty cents a week allowance. Discriminatory child placement practices must be stopped!!! One out of every three Indian children under one year old, are adopted. We, the Ojibwe people, are a proud people, we will not permit our children being stolen from us and placed in white homes where our tribal culture and values are completely disregarded.

The following testimony and recommendations, we hope, will not fall on closed minds, but will sincerely be listened to.



This is an interview with a licensed Indian family. This was the only licensed Indian family until a few years ago.

Due to the communication of Duluth Indian Action Council and the Indian Youth Program with the agency and the Indian community we now have eighteen licensed homes.

Question. How many years have you been in Foster Care?

Answer. We've been in Foster Care for eight years.

Question. How many children have you had.

Answer. We've had 15 foster children.

Question. What was the difference between your home and a non-Indian home to these children?

Answer. As Indian parents, we could understand Indian children and their ways better than non-Indians.

Question. What type of Indian values did your home give them that they did not receive in a non-Indian home?

Answer. We practiced our Indian culture and values and made them aware of their culture and identity.

Question. Do you feel the children had lost contact with their families before coming to you?

Answer. Yes. At least half of them.

Question. How did your home differ in this situation?

Answer. As Indian parents, we encouraged them to keep in contact with family and community and also encouraged the children's family to visit our home. Many times we took the children to visit grandparents.

Question. What type of problems did the children have coming from a non-Indian home that they might not have had if they would have been placed in an Indian home to begin with.

Answer. Non-Indian parents have nothing to offer Indian children. They cannot reinforce their Indianness.

Question. Did any of the children feel resentful toward the Welfare Department or Social Worker?

Answer. Yes. They had bad feelings and felt they were not giving parents a chance.

Question. Did you feel any lack of communication between you and the Welfare?

Answer. Yes. The Welfare would like foster parents to come to them with the problems of the children. As an Indian parent I could work out the problems myself.

Question. Do you feel as an Indian Foster Parent that local welfare departments can effectively deal with Indian children?

Answer. No. Only if they have Indian input or have an Indian person on staff.

Question. Why do you feel more Indian people do not apply for Foster Care?

Answer. Indian peoples standards and ways of life do not meet the standards of Welfare Department. The Welfare Department, courts, private welfare agencies, are all complicated structures with which the Indian would rather not come in contact with.

Question. Why do Indian people feel there is not a need to use outside resources such as foster care for Indian children.

Answer. Many Indian people would rather take care of their own.

In the state of Minnesota, foster care is a program designed to insure the best possible home situation for children. However, the program lacks many elements. First is the ability of the local welfare agencies to effectively deal with minority children. The lack of communication between social workers working with the Indian natural parents and Indian foster parents. The inability of the welfare system to understand and effectively work with the local Indian community has been well documented. In the area of foster care, 31.3% of the Indian children under twenty are in some type of foster care situation. Second is the lack of Indian foster homes for Indian children. In counties surveyed by the Department of Health and Social Services with large Indian populations, there is serious lack of licensed Indian foster homes. The reasons for this are numerous, but two things standout. The first is the amount of substitute care that exists within the Indian community. This is a natural outgrowth of the culture of the American Indian. Indian tribes have always looked after the children of the tribe. There was never any need to use outside resources for tribal members. The other important reason is the license requirement. Most families do not understand the necessity for them to provide an adequate home for other younger tribe members. Third. is the bureaucracy that surrounds the entire foster care program. The

Welfare Department, the courts, and private welfare agencies, are all complicated structures with which the Indian would rather not come to grips.

DIANNA MANGAN,
Foster Home Developer.

The population of Indians in Minnesota is approximately 1%.

Of all children in Minnesota 70% of cases guardian or parents, Indian children ratio is 59%.

Commissioner of Public Welfare acts as legal guardian of 2989 children all of whom are dependent or neglected, that is 8.2% of total Public child Welfare case load.

White children 6.3% of all White children, somewhat lower than total ratio of 8.2%.

Ratio of Indian child is much higher—19.5%, as is ratio of Negroes (16.6%)

Children under state guardianship (Mental & Epileptic) 7.7% are white children, 1.3% of Negro, and 0.8% Indian.

Children in foster homes is 17.1% of total case load. Indian children foster care is largest single catagory accounts for 31.3% of all Indian children. Comparable figure for White and Negro children nearer the total figure 15.4%, 19.2% respectively.

Public number of children by race. Public and Private case loads. *Public* total case load of 36,256. Indian children were 3220=8.9%

Key Counties:

Becker—55.8%
Beltrami—47%
Cass—70%
Carlton—28%
St. Louis—11.6%
Hennipen—9.9%
Ramsey—4.4%
Atkin—7.6% (15 children)
Chicago—10.8%
Clear Water 52.9%
Cook—23.8%
Hubbard—25.5%
Itaska—13.2%
Kooching—25.5%
Manoman—72.2%
Mille Lacs—40.3%
Pine—17.5% (50 children)
Pipestone—15.8%
Roseau—8.9% (21 children)
Traverse—12.5%
Yellow Medicine—19.1%

PRIVATE AGENCY

Catholic Social Science Association (St. Paul) 45.8% case load Lutherans 4.7% is Indian.

Childrens guardianships total 36,256—3220 are Indian Parents 25,426, Indian 1904

Commissioner of Public Welfare

A. Dependent or neglected 2989 total, 627 Indian (20%?)

B. 2376 Mental or Epileptic, 26 Indian

This doesn't mean there aren't any—may not take our kids who are.

Legal custody for County and Private—Total 3154, Indian 454

Of County Welfare roles take guardianship away double the rate on Indian parents.

Hennepin County Case load 9475—White/6984, Negro/1505, Indian/934 Other/52

Foster Homes: Total 1880—White/1298, Negro/296, Indian/268

Those that stay with parents: Total 5461, White/3913, Negro/1016, Indian/510.

St. Louis County total: 2725, White/2307, Indian/317

With parents 188

Dependent or Neglected, Commissioner of Public Welfare 306 Total, white/201, Indian/89. (1/3 Indian kids on Welfare)

Legal custody—Private agency Total: 242, White/198, Indian/28 Foster families—Total: 469, White/335, Indian/105(1/3)
Rural totals of Minnesota 17,847, Indian/1695
With parents, 12,834, Indian 987
Rural Public Welfare Commissioner—total 911, Indian/283.
Legal custody or private agencies total 1959, Indian/283
Foster homes—total 2775, Indian/551

Involvement in Criminal Justice System by Indian Foster Children

My involvement with the Indian youth of Duluth has taken me into many areas. One of these areas has been the juvenile justice system and the subsequent results.

Of all the Indian youth that I have been in contact with through the justice system, 80.5% of these kids have been or are involved with foster homes or group homes. Of these youth, the large majority of them have been forced or very subtly pushed into forgetting their people and their culture. The cultural shock of being removed from their families has been devastating to these young Indian people. The forcing of alien values, beliefs and culture has produced another group of very confused and unfortunately, partially assimilated or totally assimilated young Indians.

The practice of removing young Indians from their families has become a big business for white families and a cop-out for the Welfare system. The saving of Indian youth from their own people has become the answer to the so-called Indian problem. Welfare sits by and gives white foster parents the job of raising Indian children as good Christian Americans with a sense of value and worth, instead of allowing that child to remain in his home and retain a culture of beauty, rationale and spiritualness.

Again, white people are getting rich off the Indian. The white man has used the Indian's art, handicrafts, land base, bodies and now their children to obtain the almighty dollar. The entire practice of foster placement is a disguise for further humiliation, destruction of family life, assimilation of a people and the ultimate genocide of the American Indian.

The cycle never ends for Indian youth because the child cannot relate to his white foster parents and their values. He or she builds up a resentment that can take many manifestations. Unfortunately, most Indian youth take the route of breaking the law and thus becoming involved with the juvenile justice system. This involvement only gives the courts and welfare the excuse to continue foster care. The scale of Indian flesh by Welfare to white foster parents is a poor excuse for a solution to the Indian problem. When, in fact, the real Indian problem is the whiteman himself. The young Indian never learns to cope with his new environment because the foster parents far too often see him or her as a meal ticket. He is never accepted as an Indian; he always has to change to the foster parents ideas of a young adult or child. School is a problem because the foster parents and the school have their pre-conceived ideas of the Indian as a low achiever who will never amount to anything.

The sensitivity and human care for young Indians died with the Sand Creek Massacre, the Washita Massacre and the Wounded Knee Massacre. Money has replaced humane attitudes in the whiteman's world and thus the Indian is sold on the block as a slave. He or she becomes a slave to a demoralizing, dehumanizing, ineffective and outdated set of values and beliefs.

There are no other conclusions to draw except that the Indian has been and still is being forced from his world into an alien one. The Indian is still not recognized as a human being with rights and privileges, even though he was given his life in all the major wars of this century, honored his end of the treaties, respected the flag and accepted the principles that this country was based on.

Stealing our future as a people is one of the greatest crimes the whiteman has ever devised. He justifies it with the fact that the Indian is a "pagan", a believer in the preservation of nature, a non-user of mineral resources, a non-destroyer of the land and a family man. All of which have gone by the wayside because they don't adhere to progress and civilization. The whiteman has used progress as an excuse to conquer and own all, including people of other cultures. No one asks the Indian how he feels and what he believes, because after all he is only a pagan savage with a thirst for the whiteman's medicine, alcohol.

The entire question of Indian parents rights has been violated. The Indian parents have never been consulted about their children and whether they can be

or should be removed from home. Home may only be a 2 or 3 room house, but it is a place of love and understanding, not a place of materialistic values and insensitive ideas about the darker races of the world.

The Welfare is insensitive and immoral when it comes to Indian feelings, beliefs and rights. The law has never been upheld for Indians and their fight to retain their children. A double standard exists in the Welfare system for Indians and parental rights and only the whiteman can do away with that standard. The law was created by the whiteman and is used by him to get what he wants. Too often, the whiteman uses his law to protect himself from his moral obligations to the Indian.

Only the whiteman can change and sacrifice because the Indian has done too much of both. The need for justice exists, what will the government do to equalize the whiteman and the American Indian.

Ed Howes,
Duluth Youth Worker.

Indian Foster Child

The following is testimony by Vincent Martineau, 23 years old, of the Fond du Lac Indian Reservation. Mr. Martineau spent a great portion of his childhood off the reservation and placed in white foster homes. Billy Blackwell of the Indian Youth Program questioned him.

Question. At what year were you taken from your family?
Answer. September, 1963—13 years old.
Question. Why were you taken?
Answer. My father died. They thought my mother couldn't take care of us.
Question. Were you taken off the reservation?
Answer. Yes. Twenty miles away. I was placed in jail 17 days while they attempted to find me a foster home.
Question. Were you taken to a non-Indian family?
Answer. Yes.
Question. How many non-Indians families have you and your brothers and sisters been shipped off to?
Answer. 14 families.
Questions. How many brothers and sisters do you have?
Answer. Seven.
Question. What kind of effect did moving you off of the reservation—away from your natural parents and family have on you?
Answer. They took me away from my people, from my family, all my friends, brothers and sisters, everyone. I lost all my Indianess, language, religion, beliefs, my entire sense of belonging.
Question. As you've grown up, have you felt the hurt of being taken away? Do you miss the time being away from your people?
Answer. Yes. I especially feel for the same problems for my brothers and sisters. They lost everything.
Question. Have you or your brothers and sisters ever been literally instructed to discontinue or forget your Indian People and their beliefs?
Answer. Yes. Definitely.
Question. Have you or your brothers and sisters ever been in trouble criminally as juveniles?
Answer. Yes. To a large extent.
Question. Do you attribute any of this to your being placed in white homes?
Answer. Yes.
Question. Why?
Answer. It built in me a resentment, a feeling of anger, they had stolen everything from me. I was mad at the world. I didn't care.
Question. Do you know other Indian children in this area of Minnesota who have been placed in white foster homes?
Answer. Yes.
Question. How many?
Answer. Over 80% of the children of the village I grew up in, Sawyer, on the Fond du Lac Reservation. The population is 280. Since then I have met many who were also in foster homes.
Question. Would you say, putting Indian children in Minnesota, in white foster homes by welfare is big business?
Answer. It certainly is.
Question. Do you think you will ever recover from what happened to you?
Answer. I hope so. . . . I just don't know.

PUBLIC LAW 280 STATES—CALIFORNIA, MINNESOTA, NEBRASKA, OREGON, AND WISCONSIN

"The utmost good faith shall always be observed toward the Indians; their lands shall never be taken from them without their consent; and in their property, rights and liberty, they shall never be invaded or disturbed, unless in justified and lawful wars authorized by Congress; but laws founded in justice and humanity shall from time to time be made, for preventing wrongs being done to them, and for preserving peace and friendship with them."

The language of this ordinance was reaffirmed with minor changes by the first Congress under the Constitution in 1789.

In 1953, Congress approved House Concurrent Resolution 108 which, contrary to the "utmost good faith" which is "always" to be observed toward Indians and contrary to the principles of the Indian Reorganization Act of 1934, purported to end federal responsibility for Indian affairs. Thus, House Concurrent Resolution 108 was the first formal enunciation of the termination policy of the 1950's. Public Law 280, enacted 14 days after House Concurrent Resolution 108, was part of this termination policy.

Public Law 280 provided for what seems to be a unilateral assumption of civil and criminal jurisdiction by states over Indians without the consent of Indians. Many Indian tribes and people at this time objected to the law as written and asked that an amendment be attached to the legislation which would require a referendum among Indians before the state could assume jurisdiction over them. Congress did not heed to the Indian wishes, and it became law, as is. There seems to be a serious legal question as to whether Public Law 280 has any validity in any state, regardless of how that state assumed jurisdiction because, in the absence of Indian consent, Public Law 280 as part of the policy of termination could well be an illegal attempt by the United States abrogate its responsibility to the Indian people.

Throughout the administrations of John F. Kennedy, Lyndon B. Johnson and Richard M. Nixon, administration policy has been one of self-determination by; Indian people. Public Law 280 runs against the grain of todays national policy. Therefore, it is the consensus of the Indian people of Duluth, Minnesota that Public Law 280 be abolished and new laws be enacted which would be in line of the present self-determination policy.

SPECIFIC RECOMMENDATIONS

(1) That an Indian child care agency (possibly the Minnesota Chippewa Tribe, Sioux Communities, and urban populations) be established and contract directly with the federal government for all D/HEW and BIA funds for child caring services; that is, set up their own field offices and case workers.

(2) To begin the return of Indian children to their natural homes or Indian foster or group homes, and a drastic lowering of the adoption rate of Indian children by non-Indian families.

Furthermore, that this Indian child that this Indian child care agency be given thorough supervision of all Indian children in foster and group care.

(3) That Indian parents facing termination of parental rights hearings be given thorough knowledge of their right to a court appointed attorney.

(4) That Congress authorize and make funds available for the position of the Division of Child Welfare and Family Protection Services within the Department of Health, Education and Welfare.

(5) That new laws be enacted regarding the make-up, operation, and philosophy of all juvenile treatment facilities and institutions to better ensure treatment and not punishment.

(6) Recommendation on Public Law 280 (67 stat. 588) as enacted by the 83rd Congress, 1st session, August 15, 1953. Pertaining to the original policy of the United States of America, the Northwest Ordinance of 1787 provides a oft quoted reminder of "original" federal policy toward Indians:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., April 18, 1968.

(State Letter No. 1031)

To: State Agencies administering approved public assistance plans.
Subject: Eligibility of Indians, Including Those Living on Reservations, for Medical Care and Services Under Provisions of Social Security Act.

Questions have been raised which indicate States may not be clear as to the eligibility of Indians for medical care and services provided under the Social Security Act.

The following interpretations are aimed at resolving any uncertainty in this regard:

1. Indians shall have the same rights to receipt of medical services under a State plan approved under any of the public assistance titles of the Soical Security Act, including title XIX, as do all other individuals in the State who meet the State's eligibility requirements.

2. In the case of a person who qualifies as an Indian beneficiary, the Division of Indian Health, Public Health Service, Department of Health, Education, and Welfare, may assume *residual* responsibility for medical care and services not included in the appropriate State plan, and for items that are encompassed by the plan, if such Indian chooses to utilize the Indian health facilities, without affecting the eligibility of the Indian under the State's medical assistance or other public assistance program.

3. Under the provisions of its approved medical assistance plan or other public assistance plans, the State agency responsible for such plans has *primary* responsibility for meeting the cost of the services provided therein for all individuals, regardless of race, who apply and are found eligible.

Sincerely,

STEPHEN P. SIMONDS,
Commissioner.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., March 3, 1969.

(State Letter No. 1062)

To: State Agencies Administration Approved Public Assistance Plans.
Subject: Eligibility of Indians, Including Those Living on Reservations for Assistance and Services Under Provisions of the Social Security Act.

Questions have been raised which indicate States may not be clear as to the eligibility of Indians for financial assistance and services provided under the Social Security Act.

The following interpretations are aimed at resolving any uncertainty in this regard:

1. State plan provision putting into effect titles I, IV, X, XIV, XVI, and XIX must be available State-wide to all eligible individuals. This includes State plan provisions added as a result of the 1967 legislation with reference to AFDC-Emergency assistance, unemployed fathers, and foster care.

2. Financial assistance through the Bureau of Indian Affairs, U.S. Department of the Interior (as well as medical assistance through Indian Health Service, Public Health Service, U.S. Department of Health, Education, and Welfare, (see State Letter No. 1031)), is not available to individuals eligible for assistance from any other source.

Assistance, therefore from the Bureau of Indian Affairs, Department of the Interior, cannot be considered a basic resource in determining an individual's eligibility for a federally assisted program under the Social Security Act, since that resource is not actually available to persons eligible for the public assistance programs.

3. The Social Security Act provides that Federal sharing is available, under certain conditions when a child has been removed from his own home as the result of a judicial determination. The court or other judicial authority must have jurisdiction in such matters. Indian tribal courts and courts of Indian offenses are courts of competent jurisdiction in this respect, and are so recognized by the laws and regulations of the United States.

Therefore, on Indian reservations, the authority of the tribal court to make such judicial determinations must be recognized by the State welfare agency as a proper authority for this provision of the Act.

4. This issuance does not replace or in any way modify State Letter No. 1031 which relates to medical assistance.

Sincerely,

STEPHEN P. SIMONDS,
Commissioner.

YAKIMA INDIAN AGENCY,
Toppenish, Wash., April 3, 1974.

Affidavit

I, Don James Morrison, duly swear that I am the above named person, and the foregoing is the truth to the best of my knowledge.

At the approximate age of 6 or 7 years, I noticed that my skin was brown and darker than my parents. I started asking questions of my father (referring to adoptive father) and he would tell me I was too young yet to understand. I asked my mother (referring to adoptive mother) and she wanted to know why I was asking. I told her that my skin was a brown, and darker than her's. She told me I was adopted and my natural parents were killed in a car accident.

My second grade teacher was the one that told me I was an Indian, around the ages of 7 or 8. My adoptive parents told me when I was between the age of 9 and 10 that I was an Indian, not mentioning a Tribe or where I was from.

In recalling my adoptive parents, who were of Non-Indian, some of the following incidents come to my mind of their treatment towards me during the early age, very small to 11 years of age.

I can recall at an early age that I was locked in my bedroom and the door locked, that the sky was blue and turning dark; that an old washing machine was in a closet, which to me was a monster of some kind. I started to really cry and my father (referring to adoptive father) came in and I ran to him, wanting to be picked up and he wouldn't, he started to leave and I followed, but he took me back into the room. If it was not for my mother I would probably have been left in there. I can remember at one time he dumped a barrel of around a 50 gallon drum, which contained some rain water and rocks that I had been putting in there, on top of my head because he got mad at me for putting rocks in it. Another time I have remembered and can not forget is the time I climed an old crab apple tree and he (referring to adoptive father) had me climb down and he beat me with three hoses (regular garden type) tied together. Another incident was when I used some oil that I shouldn't have on a chain, and I was told to remove my belt and I guess I did not do this fast enough, so my father went and got a big one which had a buckle on it and he used this on me for a long time, I remember rolling on the ground trying to get away; and when he got through there was blood on my back. Another time he told me to do something and I did not get up right away and he picked me up off the chair and threw me against the wall (the house had a cement foundation) and I hit the cement foundation pushing my shoulder blade out of place a little bit, and it has remained that way since.

When I was told to do something by my father, I had to do it right now and be told only once or—he would give it to me. At one time he slapped me across the face leaving a red mark where he had hit me. When I made a mistake he would let me know about it for weeks on end.

When I reached the age of 8 years I was started on doing manual labor by digging ditches, a bank on the place, digging up tree stumps, and cutting brush.

When I was a junior in high school, I wanted to go to an Indian Boarding School, and my father got real mad, I felt that I would have been better off there. I had a feeling of rejection from the kids at school and from my father.

I recall these incident as part of those that were not so bad.

There was a lot of abuse that I took mentally and physically which I just want to forget ever happened. It is of my opinion that he tried to break me down mentally and physically. He was forever putting me down in front of his friends and anybody that was around at the time. It was not until, just before he died that he realized that he had treated me very badly. He had never wanted me from the very beginning.

There was no explanation of Indian, language, culture, history, or religion after finding out that I was of an Indian descent.

My adoptive mother, was like a real mother should be, she protected and guided me through my years and life. Her protection of me from my adoptive father was what kept me going.

It is of my opinion that it is too tough for an Indian child to live in an Non-Indian Home. After they find out they are an Indian, there should be an Indian around that they can talk to.

Done and dated this date April 3, 1974, at the Yakima Indian Agency, Toppenish, Washington.

MARGARET C. GWINN,
Notary Public in and for the State of Washington. Residing in Wapato, Wn.

My commission expires February 16, 1975.

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