

# *Cherokee Nation of Oklahoma*

Tahlequah, Oklahoma



## *Healthy Nations Program*

*December 1993 – December 2000*



## **“The Rising of a Generation of Prevention Initiatives Born from Strong Ambition and Faithful Vision”**

Cherokee Nation narrative

Historical Context:

The Cherokee Nation is a non-reservation site that covers approximately 9,200 square miles in Northeastern Oklahoma. Due to government-sponsored auctions and land-grab settlements, the tribal land currently covers only two percent of the land set aside prior to 1907. Such actions severely fractured the sense of community. Unlike most reservations, the tribal lands are known as the Cherokee Tribal Jurisdictional Statistical Area (CTJSA). This geographical entity is comprised of all or part of fifteen Oklahoma counties: Cherokee, Adair, Sequoyah, Delaware, Mayes, Nowata, Craig, Rogers, and parts of Ottawa, Bartlesville, Washington, McIntosh, Wagoner, Tulsa, and Muskogee. The CTJSA also overlaps into parts of eight other counties. The tribal seat, Tahlequah, is the historical end of the “Trail of Tears” and is where the tribal government manages services, laws, and intergovernmental relationships. This tribal seat and these administered lands are not the historical home of the Cherokee.

The Cherokee history is replete with forced relocations and loss of ancestral lands, broken treaties, and forced marginalization from the dominant culture. Although one of the original civilized tribes and unique in the development of written language, education, governmental structure, and social functioning, the Cherokee were subjugated and denied basic liberties and sovereign rights until the 1930s. Today, the Cherokee area has an undefined

intersection with the non-Native population and is diffused among numerous communities—many with fewer than 500 people.

The interruptions of culture, community, and traditional lifestyle created and perpetrated by land loss have, like other American Indian and Alaskan Native groups, posed burdensome disadvantages for the Cherokee Nation as they respond to modern society. Responsible for over 102,000 American Indians, of which 87,000 reside within the Cherokee TJSAs, the tribal government faces tremendous challenges in providing services. The tri-partite government consists of the Principal Chief and the Deputy Chief, who make up the Executive Branch; fifteen council members, elected from the population, who constitute the Legislative Branch; and a Judicial Appeals Tribunal. Four main service divisions of the government provide daily operations of the tribe: Health Services, Social Human Services, Community Development, and Marshal Services and Law and Justice. At the beginning of Healthy Nations in 1993, there had been only three Principal Chiefs in history since the official tribal government reorganization in 1975.

The Cherokee Nation has faced and experienced the devastation of alcohol and drug abuse. Although recognized for decades as a serious problem, physical survival and tribal existence consumed leadership attention and tribal resources. A few outside agencies and programs, primarily Indian Health Service, existed prior to 1986. Their distribution of services and effectiveness were quite uneven and lacking in community support. These programs were, at times, of questionable quality. As the tribal government grew more sophisticated

and more organized, needed attention to the substance-abuse problem increased. In 1986, the Omnibus Drug Act focused resources and governmental action on this pressing problem. The following year, 1987, the Cherokee Nation published their Tribal Action Plan, a blueprint for development, growth, and health that proved an historical turning point for the tribe and the communities. Substance abuse and alcoholism were being recognized as significant factors in many of the problems on the reservation and were demanding resources.

The extent of the problems were intuitively understood by tribal leadership and confirmed by numerous research and survey projects. The data reflected the pattern of unchecked personal and collective damage wrought by substance abuse. During the early 1990s, the American Drug and Alcohol Survey conducted with 9th-12th-grade Oklahoma students revealed that Cherokee students had nearly a double rate of reported use of alcohol and illicit drugs. In 1992, the tribal marshal services indicated that 90 percent of calls were related to substance abuse. The Community Health Service data noted that a significant portion of the severe injuries reported were alcohol- and drug-related. Lastly, research cited that four of the five leading causes of death of Cherokee Nation's tribal members were connected to alcohol.

Complicating the assault of substance abuse was the diffuse nature of the catchment area and the lack of cohesiveness in some of the communities. Over time, many communities had accepted substance abuse as normative. This further challenged the growing but rather centralized cadre of services. Having documented what was commonly known, the tribal government established an

outpatient counseling program with substance-abuse-specific outreach services. Added to the group of services was the Jack Brown residential treatment center. This youth-focused center acted and continues to serve as a primary mental health and substance abuse facility in the area. The staff provided ongoing training for professionals working with Indian Youth. The tribal programs, situated within a greater matrix of Community Health Services, continued to be fragmented and without sufficient personnel or resources to adequately service all the rural communities.

Partnering with the state social services departments, the programs for women and children, and the housing authority, the concerned providers and leaders acknowledged that the magnitude of the problems outstripped their limited resources. The rapid deployment of services, the conflicting demands of different funding sources, and the lack of coordination added to service fragmentation and uneven effects. In response to the Robert Wood Johnson Foundation call for proposals, three committees representing different tribal programs were formed. Staff from the Children, Youth, and Families Committee, clinical staff from Jack Brown Treatment Center, and representatives from the tribal health services gathered to write a Healthy Nations proposal. Members of these three committees acted as an advisory board during the early stages of the Cherokee Nation Healthy Nations program. They established the direction and philosophy of the Healthy Nations that paralleled existing tribal programs. The proposal reflected many of the trends and structures found in the tribal health system. The submitted proposal embraced greater community participation in

prevention as well as more local access to services. Culture and coordination were strong components in the proposed model. Cherokee Nation was awarded the Phase I planning and development grant. The tribe began structuring the program and hiring staff.

#### Phase I:

The advisory committee had composed a proposal positing greater coordination and access to services as the central tenet of their efforts. They theorized that such connections and coordination would stimulate consumer usage, provide greater support to families, and increase efficiencies. The proposal writers envisioned stronger community involvement and, therefore, increased mobilization against substance abuse. Traditional family values, cultural ceremony, and traditional recreation formed the foundation philosophy for the Cherokee Nation Healthy Nations program. Early challenges to this ideal of integrating and mobilizing the diverse communities within the Cherokee Nation catchment were manifest in the logo development and early Phase I activities. Disagreement of a stylized logo representing modern depictions countered the more traditional and ceremonial images. The resolution of the logo issue foretold of the strength of tradition. The energies necessary to reconcile and accommodate the various sub-populations and their traditional beliefs would be evident and surprising throughout the life of Healthy Nations.

Organizational placement in the Behavioral Health Unit of the Tribal Health Division exerted pressure on the direction and philosophy, both positive

and restrictive, of the developing Healthy Nations program. Many associated tribal programs viewed Healthy Nations as a source for expanding their services. Leadership and management of the new grant were central in the jostling for responsibility and control. A vibrant young director was hired. This director of the Healthy Nations program at Cherokee Nations dedicated herself to the program and concepts while thrown into negotiating the tribal and intra-agency politics. She was the only director of the program at Cherokee Nations during the entirety of the Initiative. This was a unique feat and produced prodigious outcomes. As the Healthy Nations program matured, many of the initially supportive tribal agencies and programs systematically shifted away from direct association and coordination.

The loss of internal support and relationship fostered greater outreach and association with non-tribal agencies. These relationships consisted of working with the Housing Authority of the Cherokee Nation, community health clinics, and community public school systems. Healthy Nations leadership divided the task of negotiating these relationships between the coordinator and the health educator. The coordinator was responsible for the intra-tribal relationships while the health educator attended to the outside collaborations. These assignments reflected the strengths of the staff's individual styles and capabilities. The arrangement functioned well in mobilizing resources and communities in the early phase, but this leadership arrangement was not without conflict. Personality differences created stress. The health educator eventually left the position, and hiring a replacement posed the first of many important negotiations with the advisory

committee and identity development for Healthy Nations. The coordinator's concept of job qualifications embraced the natural leaders and empowered the community through informal connections, while the advisory committee was more committed to the professional qualifications and IHS model of hiring.

This early tension set the stage and philosophy for the rest of the Healthy Nations programming. The resolution leaned in the coordinator's favor, supporting the qualities of identifiableness, community savvy, and non-threatening status. A compromise was struck. The new hire had previous tribal agency experience while having positive community rapport. This left the advisory committee with dissonance and doubting the wisdom of the coordinator and the philosophy of Healthy Nations.

Fortuitous events came together to provide Cherokee Healthy Nations the position and strength needed to complete their tasks. Tribal administration reorganized the Tribal Health Division and created the Health Promotion and Disease Prevention Department of the Health Division. Eventual placement of Healthy Nations in this organizational slot virtually halted the advisory committee's recommendations to have it subsumed under an ongoing CSAP grant. Tension between the advisory board and the Healthy Nations staff continued throughout Phase I. Attempts to quell the tension included accommodating the committee's choice of communities for the initial pilot projects. It soon became clear that this chosen community lacked enthusiasm and acceptance. The community was not ready. Lessons about community readiness and willingness were presented early. Worries about the flexible nature

of the grant, the dedication to community response, and the unorthodox hiring requirements manifested the advisory committee's ongoing discontentment with the direction of Healthy Nations. They attempted to micro-manage the program application and consistently over-analyzed the coordinator's decisions. This arrangement consumed much of the coordinator's energies and did little to present a united philosophy to the communities. Fortunately, the executive director of the Health Department was quite supportive and provided resources and permission to the coordinator. This relationship allowed the pilot programs to advance and take hold. It also saved the coordinator from abandoning the position.

Following the first grantee meeting, the Healthy Nations staff returned more dedicated to the community empowerment model, which represented a significant and crucial turning point in the trajectory and mission of Cherokee Healthy Nations. The staff made deliberate decisions to approach receptive communities and capitalize on existing staff/community relationships. They targeted Adair County, a significantly Cherokee area. Invitation to provide curriculum in the schools and coordinate culture activities with the students was gradually accepted. This success garnered attention and, ultimately, a strong coalition with the area Housing Authority of the Cherokee Nation. Together they sponsored the "Nativefest" or "Native Games," aimed at 8<sup>th</sup> graders in Adair County. The many contributing agencies—including Cherry Tree Community, the Crime Prevention League, and others—felt that the event was quite successful. The effective and positive reputation of Healthy Nations increased visibility and,

therefore, increased requests to help other communities. The strength and desirability of Healthy Nations was augmented by their ability to respond to the community with both time and resources. This was different from most tribal and governmental programs.

Accompanying this early success was a sore personnel issue that pulled energies from the program and added to the stress of the young coordinator. Besides nagging personnel issues, there were the impending tribal elections. Supposed association with a successful program like Healthy Nations carried into the election rhetoric. The Healthy Nations staff decreased visibility and remained neutral to avoid the divisive nature of politics. Notwithstanding the staff's effort, Healthy Nations was co-opted into candidate debates and platforms.

The net effect of the elections was a new Principal Chief and the consequential changes in leadership in the major divisions of the tribal services. Fortunately, the coordinator survived, but one of the early programs was permanently disrupted due to perceived political alliances of Healthy Nations, severely detracting from fulfilling objectives in Phase I. This period of development proved that the philosophy of "community first" and supportive listening by the program staff leads to success and influence. The construction of a strong Healthy Nations program going into Phase II implementation confirmed the vision and dedication of the staff. The barriers and challenges had shifted the composition of the advisory board and created greater outside alliances. The transition into the implementation stage of Phase II was prepared on solid footing.

Transition:

Phase II began where Phase I left off. The implementation proposal expanded the pilot programs into six counties and then to all Cherokee communities. A strong public awareness component, in-school education and traditional teaching, along with resource allocations to communities and continuing attempts to bolster the treatment and aftercare community defined the objectives and energies of Phase II. The transition was not completely seamless or without disruption. The election had installed a new health director with a different stance toward Healthy Nations. The previous supportive relationship of the first health director gave way to a stance of toleration and increased supervision. The new management had changed the financial reporting and request process, which posed a problem and roadblock in the flexibility of spending and responsiveness to community requests.

This change in internal support and the disruption of the election had negatively impacted the Healthy Nations effort and reporting. The accumulation of these factors and the nature of the transition process necessitated a NPO site visit. This meeting was interpreted as edgy and threatening. The coordinator was suffering from burnout and over-commitment. The ecology of the organization was undergoing shifts, and demand for Healthy Nation services grew. Reporting had suffered and the complicated financial requirements strained, appearing as non-compliant. The site visit provided a clarification of the grant demands and a

strong message of meeting the proposal components. This meeting both stressed and supported the Healthy Nations staff.

#### Phase II:

The coordinator described Phase II as “going from pushing down walls to being pulled on roller skates.” The Phase I internal detractors had diminished in influence, and Healthy Nations enjoyed a strong identity. Healthy Nations was growing in reputation; demand for support was accelerating; activity planning and implementation was brisk; and the staff was working 70 hours per week. The tribal reorganization posed challenges but failed to deter the direction and expansion of Healthy Nations. Even Healthy Nations physical space demanded adjustment when they moved from the central Health Services office to a new location. Initially thought of as a political carryover, the move allowed a more casual environment and provided flexible hours and greater public access. The move corresponded in time to a summer fitness camp sponsored by Healthy Nations, which taxed available resources. However, the staff rose to the occasion, and this initial camp set in motion a defining activity of Healthy Nations.

Early Phase II saw changes in financial accounting as well as a new attitude and vision of the Health Department director. This new health director was supportive but failed to produce promised resources and personnel, although the Healthy Nations staff was maintained on the tribal payroll and not financed through the grant. For example, a problem arose around purchasing tee shirts for participants. The director thought such items were superfluous and

wasteful; the program staff thought they were essential and productive. The Healthy Nations staff, through persistence and negotiating various administrative demands, continued to send the message of traditional pride and health via tee shirts and giveaways.

Phase II was extremely busy—a period of tremendous expansion, including a successful public awareness campaign, involvement in numerous schools, and sponsorship of both traditional and health-related activities. The coordinator matured further and found boundaries to her dedication. Difficulties in addressing all of the grant objectives again caused NPO concern. Successes were insufficient to balance the weakness in addressing early identification and enhanced treatment options. Notwithstanding the holding of monthly coordination meetings, the intra-tribal collaboration continued to be rocky and created barriers to fulfilling these components. The Healthy Nations staff was hesitant to refer individuals to treatment, considering it outside their expertise. The coordinator recognized this gap and addressed these grant objectives through training for the Healthy Nations staff on substance abuse recognition and assessment, and the latter years of Phase II reaped benefits from this decision. Healthy Nations staff became more involved in identifying at-risk community members through participation in community activities. The relationships and reputations built on these successes allowed referral and better coordination with some of the treatment facilities.

The grant experienced one more structural shift with another change in health directors. It resulted in thwarting some goal attainment and causing delays

in new program efforts; however, the coordinator effectively addressed and resolved these problems. Healthy Nations continued steadfast in its dedication to community empowerment and traditional activities as essential to prevention and wellbeing. Weathering numerous internal and external storms, the staff demonstrated the courage and belief to endure. The successes and legacies of Healthy Nations witness to these attributes.

#### Highlights:

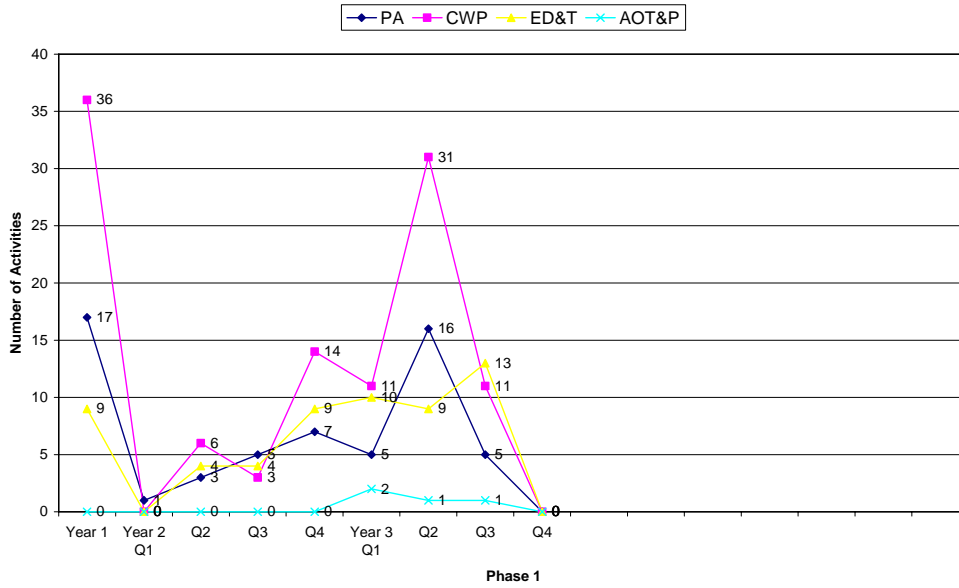
In-school education and prevention is one hallmark of the Cherokee Healthy Nations project. The original success in Adair County expanded to numerous other schools. The school acted as the cultural and community gathering place, and alliances with teachers, principals, and students facilitated entry into other functions and groups within the different communities. The Healthy Nations curricula and programs disseminated health messages, taught parenting skills, identified at-risk kids, and instituted a fitness program. These relationships continued to provide an entrance into the community. Following the end of the grant, the in-school prevention and skill development programs were assumed by a HUD grant for drug-free communities in collaboration with the now-tribal-operated Healthy Nations. Other agencies and cultural committees have been invited into classrooms to teach and support the teachers and students. Youth groups, video clubs, fitness groups, and cultural committees all take their beginnings from this hallmark program. Today, teachers and school administrators inquire if Healthy Nations support is still available.

Cultural activities and the revisiting of tradition served as preventive and restorative factors in the stomp dances and other tribal events sponsored by Healthy Nations. Powwows and gatherings were supplied with measured resources and materials to augment the participation of sober youth and adults. One of the most notable successes is the “Wings” program. Many health indicators showed that the Cherokee people were physically at-risk because of lack of exercise, depression, and substance-related complications. Historically, running was practiced as a traditional activity and spiritual ceremony. The Wings program set out to reestablish the running tradition and, consequently, improved health status. From humble beginnings and marginal participation, the Wings program has engaged 1,300 tribal members in routine and frequent physical activity including running and walking. Healthy Nations strongly promoted and sponsored this activity, organizing and funding Wings events. It organized competitions and even supported individuals to run in state races. Tee shirts, trophies, mugs, and posters all encouraged both young and old to take to the roadways and run. When Healthy Nations funding ended, the Tribal funds, local schools, clubs, and businesses continued to sponsor this program. Today, it remains a vital community activity.

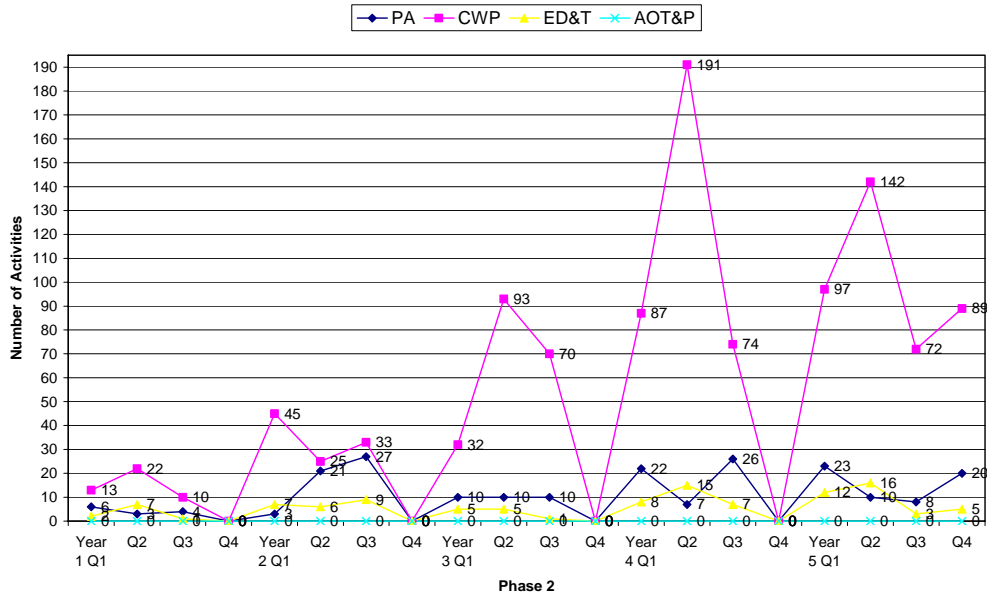
Each success at Cherokee seemed to be counterbalanced by some detraction from the goals and its full realization. The lessons learned in addressing these challenges promoted increased flexibility, leadership maturity and a more measured set of expectations. The development of the identity of Healthy Nations as a community-friendly and responsive organization became a

model for other service department reorganizations. The focus on prevention and the community collaboration philosophy remain central factors of associated service agencies and in the professional activities of those staff connected with Healthy Nations. Program personnel have continued to exert influence and exhibit healthy choices in the communities and agencies. Some Healthy Nations staff have completed university studies; others have taken roles as program leaders. Community volunteers supported by Healthy Nations remain change agents in their respective communities. Principles advocated by Healthy Nations have found resonance and a place in ongoing tribal and non-Native programs. Communities still call inquiring about support for healthy activities. Even the name retains power, recognition, and hope. Today, the Cherokee Nation Healthy Nations program is a health movement touching untold lives through fitness, education, information, and tradition.

### Cherokee Nation Activities



### Cherokee Nation Activities



Key: PA = public awareness  
 CWP = community-wide prevention  
 ED&T = early identification and treatment  
 AOT&P = accessible options for treatment and relapse prevention