Eastern Band of Cherokee

Cherokee, North Carolina

Healthy Nations Program

December 1993 – November 2000

“Many Hands and Different Visions: Moving from Community-Wide to Individual Towns”

Eastern Band of Cherokee Narrative

Historical Context:

Located in the Great Smokey Mountains of the western part of North Carolina, the Eastern Band of Cherokee occupies a fraction of their ancestral homelands. The “Qualla Boundary,” or reservation, has shrunk from a historical territory of over 53,000 square miles, encompassing parts of six states in the 1830s, to the approximately 56,000 acres of the reservation today. The current reservation extends into five counties: Cherokee, Graham, Haywood, Jackson, and Swain. The “Qualla Boundary,” the most contiguous portion of the reservation, covers mountainous forests with a narrow easement along the main waterways. The rest of the tribal lands are composed of small tracts of land spread along a 60 mile corridor west from Cherokee, North Carolina, the home of the tribal headquarters and services. The Qualla Boundary encompasses ten primary communities: Big Y, Soco (Wolfe Town), Paint Town, Big Cove, Powstream, Yellowhill, Bird Town, Snowbird, Cherokee County, and a 3,200-acre tract. The beauty of the land as well as being the gateway to the Great Smokey Mountains National Park has provided the Eastern Band of Cherokee a reliable natural resource in tourism. The recent addition of a tribally owned casino has increased the draw to outside dollars.

In 1988, the total population of the Eastern Band of Cherokee members was just under 10,000, with almost 7,000 of them living on reservation lands.

These enrollees are part of the larger Cherokee Nation family who were driven from their ancestral lands in the late 1830s. Organized and executed under Congressional order and with military escorts, the “Trail of Tears” march divided this once “most civilized” tribe. The original tribe, known as “Yun-Wi-Yuh” (meaning “Principal People”) fractured into two groups: (1) those that made the trek west, or Western Cherokee of the Cherokee Nation, and (2) those who escaped into the hills, refused to go, or afterward returned home, called the Eastern Band of Cherokee. This history of distasteful relationships, broken treatises, and land losses with the U.S. government colored the development and early organization of this people. Finally, after a relatively recent amendment to the Indian Charter of the early 1930s, the Eastern Band of Cherokee became responsible for the government of the reservation.

The tribal government is modeled after the American Constitution, including a legislative branch consisting of twelve elected tribal representatives. These public figures serve two-year terms and are elected from different political subdivisions on the Qualla Boundary. The Executive Branch is composed of a Principal Chief, a Vice-Chief, and an Executive advisor. These positions are elected at-large every four years. The judicial department is a Tribal Code of Federal Regulation court system. Each community on the Qualla Boundary is governed by a Club. These Clubs have elected officers that regulate community activities and act as gatekeepers and spokespersons for the community.

Those residing on the Qualla Boundary are beset with poverty, substance abuse, and diminished health status consistent with the national trends of

American Indian communities. The Eastern Band of Cherokee (EBC) is predominantly younger than non-Native communities, with 42 percent of the EBC members younger than 25 and 23 percent under age 15. The Qualla Boundary lacks sufficient resources for many permanent jobs outside tourism and gaming resulting in 34 percent living at or below poverty level. Some 63 percent of the families are considered low to moderate income. Without tourism, these numbers would be more drastic and stark.

Education is provided on the Qualla Boundary but is funded at two-thirds the level of the state of North Carolina. The combination of poverty and insufficiently funded education generally creates social and individual problems, including increased alcohol and substance abuse. These issues have been addressed by the Tribal Health Delivery System and the tribal government.

The Health Delivery System has been managing health programs and health service funding since 1972. Under the PL 93-638, the tribe has administered the IHS services and hospital. Chemical dependency and alcohol treatment are identified problems that have garnered attention and resources from the tribe. The 1992 organization chart includes an inpatient substance abuse department and the behavioral healthy services division. The proposal for Phase I Healthy Nations funding cited an informal survey of tribal employees indicating 90 percent have been personally impacted by alcohol and substance abuse. A 1991 Cherokee Center of Family Services report showed 86 cases of child neglect and abuse with 129 referrals to Family Services parenting program. It is implied that the majority of these were alcohol- and substance-abuse related.

The youth on the Qualla Boundary experienced substance abuse at a rate greater than the surrounding non-Native communities. Based on the connection between esteem and substance use, the tribe cited a survey using the Tennessee Self-Concept Scale demonstrating that Cherokee youth scored on average one standard deviation below the national mean. This realization had prompted the tribal schools to institute a curriculum targeting substance abuse for all school-age children.

Tribal government responses to the substance abuse problems have been punctuated through the 1986 Omnibus Drug Act and subsequent revisions and tribal plans. These efforts have been in two basic directions. The first was a series of resolutions and referendums aimed at reducing substance abuse and access on reservation lands. The Tribal Specific Tribal Action Plans have successfully blocked two attempts to allow the sale of alcohol on the Qualla Boundary. The 1993 Action Plan concentrated on three areas of service coordination, health, and prevention efforts. Tribal resources and planning sought to better coordinate the services to those suffering with substance-related issues and their families, to increase prevention activities that addressed alcohol and substance abuse topics, and to integrate those agencies that work with youth. Those providing services and leading the Eastern Band of Cherokee fully recognized the negative impact of alcohol and illicit drugs on their people, culture, traditions, and general well-being. This understanding set the stage for their preparation for and solicitation of Healthy Nations funding.

Phase I:

"Project Healthy Cherokee," the title of the proposed Eastern Band of Cherokee Healthy Nations program, represented collaboration among Tribal Health Delivery System, Cherokee Central Schools, and the Rural Family Friends organizations. The submittal was supported by the tribal council through a general resolution. The composition of the proposal reflected the Tribal Action plan and included efforts to survey the communities as well as developing a coordinated system of services and prevention activities on the reservation. The intent was to enhance cultural and traditional components in the existing programs as well as to integrate strategies to bolster prevention through community participation and youth activities. The Eastern Band of Cherokee proposal was supported by most members of the National Advisory Committee and, after discussion and negotiation, approved and funded for Phase I.

Project Healthy Cherokee was housed in the Health Planning department of the Health Delivery System, which allowed for the best coordination of services. The first director was joined by a coordinator and an outreach person. The first task was a survey of the communities, demanding travel to each community, meeting with Club members, and utilizing the natural communication systems to gather information. It was not a formal survey and lacked a defined structure; it was more an intimate conversation about the community's needs and wishes. This process of community connection became a standard of practice throughout the full grant period.

Attempting to forge a greater sense of community across the Qualla Boundary, Phase I activities included the first cultural camp. This activity drew some 150–200 people who joined together in traditional games and meals. Such camps were projected to be a central mechanism for the prevention and cultural enhancement processes outlined in Healthy Cherokee goals. Other activities of Phase I included the distribution to the communities of posters and newsletters carrying anti-substance use messages. The staff undertook to calendar those reservation-wide activities that provided healthy messages and opportunities. This was the first attempt at coordinating services among the many providers and agencies.

The staff discovered that these community-wide events were demanding. This first experience exposed the complex nature of prevention programming. Organizing large community gatherings underscored the intent of Eastern Band of Cherokee's Phase I objectives and philosophy. The plan was to support ongoing activities like the women's cancer walk and other established events. Such experiences and learning were later translated into a shift of philosophy and objectives for Phase II.

Phase I also saw considerable struggles and challenges that nearly undermined their opportunity to move into Phase II. Personnel changes in both director and coordinator positions interrupted the evolution of the project. Healthy Cherokee experienced fits and starts as the community learned of the project only to witness the shuffle of personnel that inevitably changed the face of the objectives and public presentation. Other difficulties arose around the grant

reporting demands. Described as difficult and unusual, the directors were always in arrears in reporting the activities of their grant. This created a concern among the NPO and stimulated sites visits, reported to be seen as nerve racking and scary. Concern about not meeting the expectations and demands of the NPO and the grant stipulations created a tension among the staff and consumed resources and attention. The lack of reporting and the nature of the site visits overshadowed the efforts and beginning evolution of the Healthy Cherokee programs and philosophy.

Transition:

The transition into Phase II was very rocky and disjointed. The change in personnel and the panic that accompanied reporting left the proposal dangling until only eleven days before the deadline. Those who were associated with the program and had administrative oversight recruited a seasoned IHS manager from the tribe to literally rescue the proposal writing. The process was eventually completed but not without a technical support site visit. There had been discussion among the NPO and NAC about the viability of the project, but with strong advocacy from supporters, the program was maintained.

The nature of the Phase II proposal was a shift away from community-wide programs and camps to a more community-specific focus. Not formally abandoning the best of the general prevention strategies, Phase II took much of its structure and direction from the University of Washington's "Community that Cares" program. But even before a solid implementation of some of the Phase II

objectives could be initiated, personnel changes again rattled the program—the Chief changed as well as the director and coordinator. The program lacked the ability to maintain consistent management. Each director offered a different interpretation of the intent of the grant, had to learn the system and, subsequently, compounded the reporting and development problems that compromised the Healthy Cherokee viability. The transition period remained uneven well into the implementation Phase II.

Phase II:

The relationship with the different communities exposed the diversity and unique needs of each town. An outreach coordinator for Healthy Cherokee continued to visit each town, speaking with the Club members and listening at community meetings. The foundation of listening and not imposing ideas produced insights and participation at the community level. A general theme of community pride was translated into a beautification project. Utilizing a sense of ownership and encouraging self-esteem through enhancing the living environment, Healthy Cherokee sponsored community projects such as community billboards that sent welcoming and healthy messages, hanging bird houses to encourage the return of wildlife, and general clean-up projects.

Engaging the youth with community volunteers and Healthy Cherokee staff targeted their pride and self-esteem. The belief and theory was that strong self-esteem decreased the susceptibility to drug use and negative social behaviors. Although the intent of Healthy Cherokee was to involve all age groups

living on the Qualla Boundary, most of the programs addressed the youth. One such program that drew the youth was community beautification. Other efforts such as development of school-based programs, sport activities, and youth leadership were more directly related to youth and consumed a majority of the efforts for the next four years.

Trouble with personnel continued. The project in Phase II had three different directors and numerous coordinators and outreach workers. This constant turnover in leadership and staff continually interrupted many programs and decreased the effectiveness of the program in general. By the end of year two of Phase II, the staff's insecurity working in a grant environment was compounded by more financially attractive employment at the Casino.

Changes in staff dominated the Healthy Cherokee program and scrutiny of the NPO. Early year three experienced more changes in the tribe and program. Elections were held and a third Chief was elected, but the tribal government remained supportive of the program over all.

The NPO continued to work with the staff to improve the reporting system and encouraged more complete attention to the entire four RWJ components. Community-wide prevention and public awareness had received a disproportionate level of effort. This disparity was never fully remedied, but the program continued on into a fifth year of carry-over funding. The final two years experienced a relatively stable personnel corps that contributed to increased successes and the transfer of philosophy to current programs. The final director and coordinators demonstrated a dedication and level of energy hoped for in the

initial proposal. Reporting improved, programs were carried out with great success, and the intent of Healthy Nations was better realized. The final chapters were much smoother. Leadership stability as well as a different relationship with the NPO redeemed the program and set the stage for the future. In the end the program provided many viable opportunities to each community and to the youth of the area. This contribution continues to impact the lives of the Cherokee people in North Carolina.

Highlights:

Consistent with an original goal of developing youth leadership, Healthy Cherokee sponsored a very successful youth council training. Known as “Junaluska,” named after an early Cherokee leader, this program provided for 20 youth to participate yearly in tribal government. Participation was not based on grades and extracurricular activities but was open to all students willing to be drug free and to attend meetings. Junaluska taught debating skills and problem solving and included a mentoring program connecting these youth leaders with seated council members. The group would be responsible for assessing needs of their school, communities, and nation and would develop feasible plans and present resolutions to address the problems. Aimed at preparing future leaders and enhancing self-esteem, Junaluska has reaped great rewards. Most of those that participated have either gone on to the university or are productively employed. The last director stated that, to her knowledge, most remain substance free.

The community billboard project remains a visible testament to the Healthy Cherokee activities. Prominently placed on thoroughfares and entrances to each community, these signs remind residents and visitors of something unique to that specific community as well as conveying a message about wellness and sobriety. The beautification mentality has continued in many of the communities, producing a sense of pride in their environment. Many of the youth involved with these projects are about to enter into the Clubs to help direct the future for these communities. This project utilized traditional understanding about the earth, building on the philosophy of culture as protective.

Cultural and traditional messages as well as the introduction of healthy alternatives were promoted throughout the Healthy Cherokee project. The "One Feather" newsletter always carried positive acknowledgements of Healthy Cherokee sponsorship and the effort of participants. Individuals and groups were spotlighted, sending the message that respect and acknowledgement followed positive activities. These printed diaries of Healthy Cherokee speak of the strength and earnestness of the many volunteers and the staff of Healthy Nations.

Sporting events and youth soccer leagues drew large crowds of youth and their parents and were used as opportunities to present pro-social and culturally relevant messages. Direct talks and lectures about abstinence and substance abuse were not the tactics taken at these events; rather relationship building, connecting with healthy role models, and gentle teaching were the methods most culturally consistent. Education and prevention were given in small doses.

Participatory learning, reinforced with positive relationships and fun, was the model of prevention and public awareness at these gatherings. Healthy food was consistently substituted for the usual picnic fare, serving as a model and reminder of the commitment to well-being through action, eating, and culture.

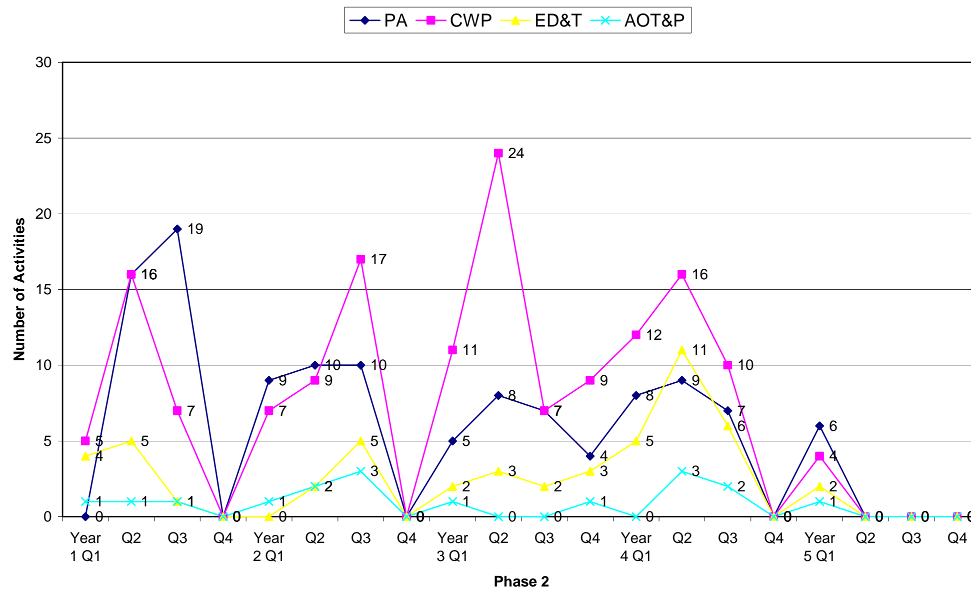
The presence of Healthy Cherokee at so many events, the joint sponsoring, and the investment of the staff's time, especially during the final two years, moved the project from a program to a common motto currently incorporated in ongoing programs. The name "Healthy Cherokee" carries a recognized power and represents the hope of the Health Delivery System.

However, not all cultural activities bore fruit. Trying to incorporate more traditional and Native components into treatment and aftercare, Healthy Cherokee encouraged the use of sweat lodges. This was only marginally accepted because Cherokee people have not historically used this ceremony. Nevertheless, the effort to expand the models of treatment to include more tradition increased dialogue and inclusion of local ideas. Traditional cooking, cultural pride, crafts, and hunting gained a place in the community and individual lives at Eastern Band of Cherokee.

The personnel turnover was excessive and extremely disruptive. However, such problems also produced a cadre of employees who were exposed to the philosophy and structure of Healthy Nations. The ideas and concepts continue, in different iterations and packages, across the tribal system and even into the private sector. Many of the directors and coordinators continued in the community and intersected with the Healthy Cherokee staff. The concept of

community and culture continue into a new Healthy Cherokee program. Capitalizing on the name and recognition of its strengths, the Eastern Band of Cherokee is conducting a diabetes prevention campaign in which most of the components of Healthy Nations are incorporated. The coordination of services and the inclusion of physical health and spiritual well-being form the foundation of this diabetes effort. The behavioral health department as well as the whole Health Delivery System contains aspects of the vision of Healthy Cherokee and Healthy Nations. The Eastern Band of Cherokee Healthy Nations program never fully matured but did generate some lasting institutions and the infusion of a community- and cultural-based philosophy.

Eastern Band of Cherokee Activities



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