

Norton Sound Health Corporation

Nome, Alaska



Healthy Nations Program

December 1993 – November 2000

“Growing Individuals and Communities at the Arctic Circle”

Norton Sound Health Corporation Narrative

Historical Context:

The Norton Sound Healthy Nations project was the farthest north of all grantees, located in Nome, Alaska. Nome is poised on the tip of the Seward Peninsula, some 560 air miles north of Anchorage—accessible only by air travel. A unique and varied topography defines the communities, cultures, and services provision structures within the region. Covering some 44,000 square miles, this combination of treeless tundra, rugged mountain coasts, and islands in the Bering Sea is home to roughly 10,000 residents. The population centers are fifteen established villages and two seasonal campsites—home to twenty distinct groupings of people. The weather also defines the region and life therein. Severe winters often disrupt the required small plane travel (there is one village to which there is a passable road). Ice and snow routinely challenge communications, travel, and services. Long winter darkness and manic summer midnight sun define activity levels as well as availability and access to target populations.

The combination of geography and weather pose a challenging scenario to provide services in the region. The area is the crossroads of three Native Alaskan groups: the Inupiaq, Central Yupik, and Siberian Yupik. These three major language groups are dispersed throughout the region. This confluence of different ethnic groups presents a history of tension, shifting political alliances, and remarkably diverse cultural behaviors.

Nome, the largest city in the area, is the regional hub. Most cash-based economies, health and social services, and federal and state programs operate from Nome. Known as the “white man’s town,” Nome is famous for the gold rush and romanticized frontier mentality of the turn of the twentieth century. It is the terminus of the Iditarod sled dog race. Nome, a community of 3,500 residents, is the home of the Norton Sound Health Corporation (NSHC). The largest employer in the region, NSHC provides a continuum of health services including medical and emergency services, medical itineration and community health aids, and mental health outpatient and substance abuse inpatient programs. Public health nursing, pre-maternal residential care, and health education make up some of the different services. NSHC exists under charter from the fifteen representative villages. Each village is a second-class city under Alaska statute with a city council government. Correspondingly, each village is an incorporated Native corporation with an attendant tribal council or Indian Reorganization Act government. NSHC is the collective health arm of the villages and is a nonprofit corporation currently functioning as a public law 638 entity.

The region has long been under the siege of alcohol abuse and related problems. Most of the villages are considered dry except for the porous, illegal importation of alcohol and drugs. Nome is notably a wet town. Thirteen bars line the famed Front Street, and daily demonstrations of the extent of alcohol abuse are witnessed on this central artery of Nome. Although limited systematic surveys have been conducted, common knowledge and observation document the severity of the damage. The resistance to being surveyed takes many forms.

Principally, the lack of anonymity in the very small communities or fears that the survey would underestimate the real problem has conspired to silence the data. Some indicators that support the acknowledgement of problems with substances came from a 1991 student survey. Sixth through twelfth graders responded to questions about inhalant abuse, revealing a 48 percent lifetime prevalence and a current-year rate of 11 percent.

A 1990 review of court documents showed an 81 percent rate of alcohol involvement in the crimes brought before the bench. A random sample of police logs from 1993 indicated that 43 percent of all calls were related to alcohol. The Nome ambulance calls revealed that a majority of responses involved alcohol contrasted with the NSHC emergency indications that a mere 11 percent of emergencies treated had a primary or secondary alcohol diagnosis. The Bering Strait Women's Group, a nonprofit organization dealing with battered women, estimated that over 50 percent of all domestic violence and sexual assaults attended to by their agency were alcohol related. The region is identified as exceeding the national and state levels of suicide. Substance abuse is cited as a pre-disposing factor in the disproportionate level of incarceration of Native males. Further evidence substantiating the endemic nature of substance abuse is that there existed sixty agencies and programs addressing alcohol and substance abuse at the time of the Robert Wood Johnson Foundation Healthy Nations project call for proposal.

The Interagency Child Advocates of Norton Sound formed following a meeting in 1988. Native and non-Native programs, state agencies, and volunteer

groups convened to address social needs and program gaps including substance abuse. Over a period of three years, this group evolved into the Bering Strait Community Partnership. Early in 1991, the Bering Strait Community Partnership successfully competed for a demonstration grant from the Center Substance Abuse Prevention (CSAP) agency. This event defined the context of the next five years in addressing substance abuse. Also, in 1988, Nome community members formed “DAWN,” an acronym for “drugs aren’t wanted in Nome.” They sponsored youth activities, lobbied for tougher laws against distribution to minors, and supported the national “red ribbon week.” The following year (1989), a region-wide Elders’ conference passed resolutions calling on the community leadership and Native service agencies to enhance local resources to combat the devastation caused by substance abuse.

In 1991, NSHC hosted the first Inhalant Abuse Conference, bringing together state leaders and key stakeholders. That same year, the Bering Strait Community Partnership received the notice of award for the substance abuse prevention grant. In 1992, NSHC sponsored a Fetal Alcohol Syndrome Education Conference targeting local community members and service providers about the related issues. Concomitantly, Kawerak—the social service sister Native Corporation to NSHC—obtained a grant to help the villages address the growing problems of pregnancy and drinking. It focused on developing local ordinances to encourage traditional and local interventions concerning substance abuse, particularly pregnant women’s substance abuse. Simultaneously, community visioning workshops were being held across the region. These workshops

attempted to identify needs, set goals, and establish coordination of resources. In the third year of visioning, the RWJ call for proposals was released.

Phase I:

The Bering Strait Community Partnership (BSCP) had carved out an important niche in the landscape of providers. Originally considered a small, harmless group of non-Native caregivers, the grant award changed their community stature. The 2.5 million dollar infusion into the community garnered the attention of the larger Native corporations. Previously disinterestedly supportive of the Partnership, the award incited withdrawal from and elicited resistance to contributing to the goals and purposes of the Partnership project. The rationale for the conflict cited lack of listening and responding to village needs in the proposal development. This tension clarified a long-standing inside/outside dynamic based on Nome-centered service provision and villages just receiving the program developed for them. Kawerak soon sided with NSHC in boycotting the Partnership project. Both sides counterclaimed that the other had been insensitive and deaf to the voice of the village.

In response to the tension, the BSCP established a steering committee made up of village representatives and other Nome agencies. This committee concentrated on helping the villages express their ideas, garner state development grants, and hire outreach coordinators. Resolution and cooperation were slow to emerge. One of the significant factors was a change in personnel at the Partnership. The original director left the position, and the new director, a

known community member, adopted a reconciliatory stance and convened a project reorganization meeting. The outgrowth of this effort was the joint agency creation of an oversight committee, the Substance Abuse Prevention Programs Committee. This committee negotiated the interagency relationships throughout the duration of the CSAP grant while acting as the advisory committee to the Healthy Nations proposal and Phase I programming.

A successful proposal through the Norton Sound Health Corporation landed the Healthy Nations Phase I development and planning grant. A coordinator was hired. She had experience with other NSHC programs and was well-connected to the corporation administration and greater community.

Early in proposal development, a group of 25 agency members and village representatives gathered to identify gaps in services and to address the four components of the Healthy Nations grant. The outcome was the formulation of goals and objectives to meet the community needs and address the grant requirements. Public awareness and community prevention topped the activities lists. The mission and vision of Healthy Nations was developed. A logo, somewhat detached from the mission, was developed. Pilot programs were undertaken in two outlying villages to enhance local human and information resources.

The parallel nature and target of Healthy Nations and the Partnership Project facilitated some early development of goals while concurrently limiting the Healthy Nation's identity and unique mission evolution. The old tensions, the sharing of the advisory committee, and the target of substance abuse prevention

confused early Healthy Nations efforts from the status quo. The intent of NSHC was to collaborate with the other program and create a unique presence in the region. The director attended interagency meetings, sought training outside, and relied on previous supervisors as the program unfolded. Great effort was exerted in community awareness and information dissemination carrying the name of Healthy Nations. Outreach successfully canvassed the whole region. Healthy Nations was attempting to create an individual reputation and relationship with the villages. This was interpreted by some as obstructionistic to the Partnership project; others saw it as differences in leadership style and director uncertainty, while yet others attributed it to remnants of the historical tensions. Whatever the reason, the actions to distinguish Healthy Nations from the Partnership project proved fortuitous and prophetic.

Phase I activities included media events targeting health issues, creation of resource networks, and collaboration with preexisting substance abuse programming activities. Recruitment of village-based volunteers consumed much of the coordinator's energies. Overwhelmed with travel to villages and outside trainings, learning administrative concerns, and attending or conducting meetings, the coordinator left some objectives undone. Others were significantly reduced in scope.

Office space played a role in the early development and trajectory of Healthy Nations. The first office was centrally located by other agencies outside Norton Sound. This initially helped define the influence and connection with other agencies. Toward the end of Phase I, the offices were moved to the Northern

Lights Recovery Center, the NSHC inpatient substance abuse treatment facility. This move influenced intra-agency coordination and shaped a service-oriented model. The early intervention and aftercare component of the grant was to have been easier to address through this relocation. This move did little to support the emerging identity of Healthy Nations or transcend the insider/outsider tension. Administrative oversight was located under the management of the Northern Lights Recovery Center, an arrangement which was insufficient for the needs of the grant. Changes in the Center's directorship, pressing treatment demands, and the lack of upper corporate administrative oversight hindered the grant's growth and compliance and set the stage for challenges in Phase II.

Preparation of the Phase II proposal expanding on the goals and objectives of Phase I dramatically reduced the number of initially anticipated activities. Certain grant component areas had been neglected and others proved very difficult. The planning and development phase had demonstrated some barriers and experienced internal adjustments not conceived in the original proposal. The transition to implementation and the establishment of Healthy Nations as an integral part of the region was entering a rough but defining time.

Transition:

Many inside and outside factors converged during the transition to Phase II. The resulting changes and instability evolved into long-term positives. The original coordinator had announced her intention to earn a graduate degree, and at the crossroads into Phase II, she left. The next coordinator assumed the

responsibilities without the benefit of having prepared the proposal and understanding the philosophy. Newer to the field of prevention, she brought educational experience and a less-established community presence.

At the same time, the Norton Sound Health Corporation underwent changes. Still without a vice president of Behavioral Health, the director of Northern Lights was acting as liaison to the corporation. Significant staff turnover and the ongoing void in administrative oversight led to poorly defined roles and goals. Likewise, the ending of the Partnership project created a gap that the new Healthy Nations was expected to fill. Shuffling of NSHC departments and corporate responsibilities also punctuated this period. Increasing demand for village-based resources, budget concerns, growing distance from the advisory committee, and different view of the etiology of substance abuse defined the context of the transition. Demands for the resources of the grant, incomplete understanding of the grant reporting requirements, and the lack of Healthy Nations staff compounded the instability and vacillating nature of the program. The first director had responded the best that she could but the changing structure around her negatively impacted the overall success. Notwithstanding the chaos at the transition, the seed of the future program had been planted, and the pilot programs in the two villages were evolving.

Phase II:

Healthy Nations was administratively relocated to the Community Wellness Program (CWP). This addition to the NSHC health education efforts

seemed a perfect match. The first months of Phase II saw a reorganization of the priorities and staffing of Healthy Nations. Finally, a vice president of Behavioral Health was hired, who was supportive of the Healthy Nations goals and of the new coordinator.

Early in 1997, the NPO had a site visit to address documentation irregularities and general noncompliance with grant requirements. This meeting was the inaugural experience for both the new HNI coordinator and the Behavioral Health vice president. The intensity of the meeting and the possible dire consequences got the attention of the upper NSHC administration. After quick negotiations and promises, the Healthy Nations funding was safe and more centrally located in the vision of the corporation.

A series of strategic planning meetings with the staff of CWP/HNI articulated and expanded the goals of the Healthy Nations proposal. Capitalizing on the successes in village outreach and the placement of Suicide Prevention Specialists in three villages, Healthy Nations again focused on increasing village-based resources. The Healthy Nations staff constructed a “train the trainer” model working in concert with state, NSHC, and Kawerak personnel. The goal was to train village personnel, leaders, and volunteers in prevention skills while helping to develop natural leaders. As workshops and community meetings were held, the Healthy Nations staff learned that volunteerism is difficult in economically depressed villages. Compensation as well as material provision became apparent. This increased participation and follow through. Healthy Nations forged village and agency partnerships; provided trainings, materials,

and information; and managed a village incentive grant program through the CWP. Being more closely situated and connected to the Behavioral Health Department offered cross-fertilization of programs, especially the long-awaited Village Based Counseling project. Again, at a vulnerable point, staff changes disrupted the flow. The sudden resignation of the vice president coupled with the loss of another Healthy Nations staff person created a pause in support and consistency. This would not be the last leadership change.

A new director of Behavioral Health Services (BHS), taking the role of the former vice president of BHS, was promoted from within. An outsider from the Lower 48, this psychologist initially set standards seemingly at odds with the ongoing Healthy Nations posture and model. He pressed forward with completing the Village Based Counseling program, ultimately covering fourteen of fifteen villages. His interaction with the Healthy Nations staff was cordial, but strained. Conflict in resource allocation underscored much of the tension. The perception of Healthy Nations being a stand-alone entity in the blueprint of integrated services espoused by the director interrupted completion of some goals and diminished other activities. Each party struggled to incorporate the worldview and philosophy of the other. This strain resolved over the next year.

The Healthy Nations programs in the villages, especially the Suicide Prevention Specialists, informed the design and implementation of the Village Based Counseling structure. This convergence of village-based models solidified the administrative partnership within the Behavioral Health Services unit. The Healthy Nations staff and the Suicide Prevention Specialists helped train and

support the new Village Based Counselor trainees. The Healthy Nations focus on local ability and understanding was an important contributor to the decentralization movement undertaken in the Behavioral Health Services unit. The director espoused a public health model and advocated greater inclusion of tradition and culture. The confluence of the positives of Healthy Nations and the shift in direction and infrastructure of the whole BHS unit blurred the lines between doing activities toward Healthy Nations goal obtainment and institutionalizing the philosophy of prevention and local ownership.

It was at this junction that the Healthy Nations coordinator and program manager left to assume other administrative jobs in the community. Integration and budget cuts reassigned the other staff members, and Healthy Nations was absorbed into the infrastructure of the Behavioral Health Services unit. Luckily, the first coordinator returned from graduate school in New Mexico, worked in the BHS administrative office, and re-engaged in husbanding the grant. This period defined the decentralization effort.

Village-based programming, greater collaboration, and recognition of the strength of indigenous knowledge were hallmark of the regional prevention and intervention model. Doing “with” the village instead of doing “to” the village was now the philosophy. Healthy Nations supported the Village Based Counseling training through the University extension Northwest campus in Nome. Healthy Nations funds supported rewriting the job descriptions for all service providers to include prevention and public awareness responsibilities. BHS transformed the inpatient services into an intensive outpatient program, incorporating the village

personnel in the early intervention and aftercare service models. Prevention responsibilities for all providers were increased; public awareness became an expectation. More cultural components and knowledge were added in both planning and delivery.

The last years of the grant saw expansion of the first vision of the steering committee. Then a leadership change occurred as the no-cost extension was emerging. The coordinator took an administrative position at Kawerak, complementing the previous coordinator's new vice-president status. The no-cost extension period of Healthy Nations was under the direct supervision of the BHS director. Activities continued to support the Village Based Counselors, inform new programs, and gather and make accessible all resources materials.

Finally, Healthy Nations concluded their formal existence with a region-wide healing conference featuring healthy Native role models and workshops to carry forward hope and progress. Over 600 people, representing all of the villages and Nome, attended.

Highlights:

Early focus on drug-free events and local ordinances supporting healthy lifestyles resulted in significant changes in the environment and the non-acceptance of drunken behaviors. Both the major Native corporations instituted employee drug testing even for their respective boards of directors. Corporate parties and meetings were now drug free (including tobacco). Gatherings in the communities were advertised as substance free, and the attitude toward "using"

became less normative. The evolution of this anti-drug awareness supported local ordinances that had begun increasing interventions and community actions regarding alcohol-related problems.

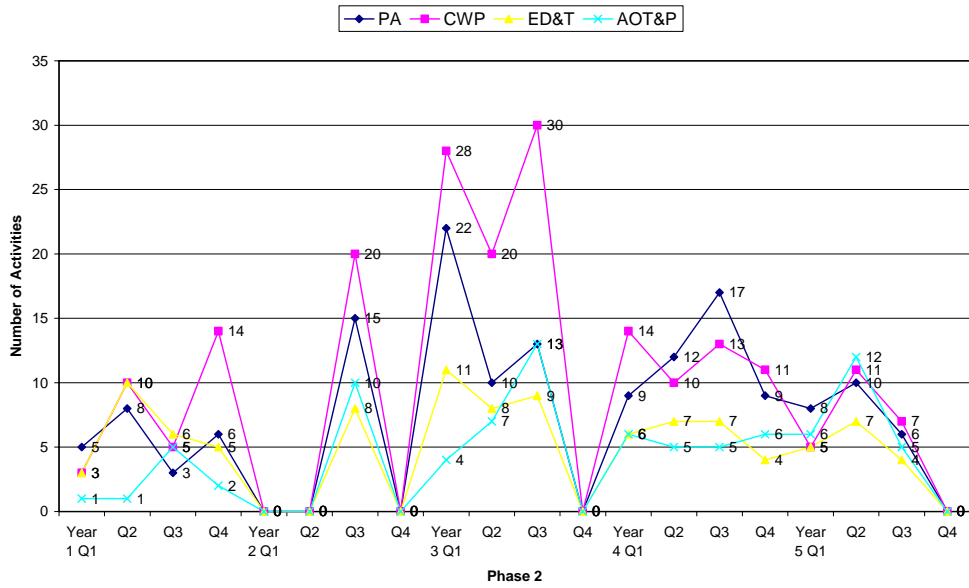
By attending to the wisdom and strength of the villages, NSHC and BHS administration made significant changes in numerous services programs informed by such local insight. Partnership with the villages became central. The creation of networks within the individual communities empowered natural leaders and community members to address otherwise taboo subjects. It helped break the silence around many secrets and wounds. The voice of the village helped form the type and frequency of services. The Village Based Counseling program and another grant program, entitled the Mobil Adolescent Treatment Team, were strongly influenced by Healthy Nations. Having local personnel shape service delivery in the villages shattered the insider/outside tension. The attitude and expectation of equal voices and dialogue infiltrated even upper management and other departments. The flexibility of Healthy Nations and the strength of its philosophy provided support for a transformation of Behavioral Health Services.

The showcase accomplishment was the Village Based Counseling program. While not funded by the grant, the Healthy Nations support, philosophy, and example enhanced its viability and effectiveness. As the grant was ending, seven of the fourteen village counselors received university certificates in the Rural Human Services. Three counselors continue toward their bachelor's and one has obtained a master's degree. They melded together the wisdom of

traditional and indigenous healing with the concepts of western counseling. They provided aftercare support for those returning from treatment. They made referrals and provided case management alongside the itinerant clinicians. They organized community events, talked with the youth, taught parenting classes, and worked with tribal leaders in addressing substance abuse and mental health issues. Three have become supervisors; others have continued to be resources in their communities.

The lasting impact—among staff turnover, regional and interagency conflicts, and failed coalitions—remains with the people associated with Healthy Nations. All staff members continue to institute shared philosophies and models in their respective jobs. Two coordinators who hold upper management positions pursue similar goals and implement Healthy Nations-like models in the region. Outreach staff and trainers continue to provide services to families, communities, and recovering men and women. The Village Based Counselors and Suicide Prevention Specialists live in and serve their communities. Most continue to set the example, provide impetus for small but significant changes in their villages, and disseminate knowledge of healthy lifestyles. Just as important are those families and individuals supported through the activities who are giving back to the communities. They are engaging with the youth, teaching traditional skills, and becoming leaders in local causes and government.

Norton Sound Health Corporation Activities



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