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SUBJECT: Report on Health Care Delivery
1989 Blueberry Harvest
Rakers' Center Program
Washington County
Columbia, Maine

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Report on Health Care Delivery

1989 BLUEBERRY HARVEST
HEALTH CARE FOR MIGRANT WORKERS
WASHINGTON COUNTY, MAINE

SCOPE OF THE PROBLEM

The Katahdin Area Health Education Center (KAHEC) contracted for an evaluation of the health care delivery provided the migrant blueberry rakers in Washington County, Maine during the 1989 harvest. As the majority of the workers were Native Americans with Micmac tribal affiliation, ethnographic data was obtained to evaluate the sensitivity of the health care provided to this culture group. Informants were interviewed to determine the use of traditional healing practices among this group and any conflict that might have developed as it related to contemporary health care.

In addition, I observed many aspects of the care and/or assistance provided by the support personnel of the Rakers' Center relevant to the health and well-being of the migrant workers and their families.

OVERVIEW

During the 1989 Maine wild blueberry harvest, the Rakers' Center (RC) was set up at the Columbia Town Hall, Columbia, Maine. The Rakers' Center was started in 1982 and has provided

support services to migrant workers each August since that time. The numbers of clients assisted and the services provided have increased each year. Observations of client services at the 1989 Raker's Center were made and the medical staff queried. Migrant workers and their family members were interviewed at their temporary living quarters and at the harvest on the blueberry barrens.

The Health Clinic at the Rakers' Center provided an essential component of the services assisting this population. Problems were minimal in number but were representative of the need for modifications in this program in order to meet the health care needs of the migrant worker and their families.

Alterations to other support services are suggested in order to reduce the potential risk of harm to the health and well being of the migrant population.

Data was obtained from informal conversations and interviews of both local people and the rakers. Discussions took place inside and outside the Rakers' Center, at the camps set up to house the migrants and on the blueberry barrens. Administrative company representatives and other employees were interviewed. Information was obtained from the staff and students of the Harvest School.

As a trained anthropologist outside of the local network, I was able to objectively evaluate and assess a multiplicity of interactions and situations. Interviewing and documentation of responses on a questionnaire was viewed with suspicion and

concern was expressed that the answers might be construed as "complaints" placing the worker at risk of losing his/her job. Therefore, data was obtained through participant-observation and informal interviews. No tape recordings were made. Notes were make of information obtained. Names of informants are confidential.

This report focuses on factors that relate to health care and the well-being of the migrant population, the majority of which were Native American.

MIGRANT POPULATION

According to the Washington-Hancock Community Agency's statistical report for 1989, 84% of the individuals served by the Rakers' Center were Native Americans. The home locations suggest the majority were Micmac from Nova Scotia and New Brunswick, Canada. My own research concurred that the majority were Micmac. Other Native American groups included the Maliseet and Passamaquoddy.

An interesting communication problem was noted during the intake interviews and might have resulted in some inaccuracy in the figures. When asked if the applicant was "Native American", some responded "Oh, no. I am Canadian". Contrary to many contemporary "Native Americans" in the United States, the Canadian natives call themselves "Indians". The term "native peoples" was thought to represent local individuals born and raised in "Downeast" Maine.

Prejudice was clearly evident between some of the local, permanent residents of the area and the Native American migrant population. These local people thought that this population was well off financially, obtained a good deal of financial support from the Canadian government and were greedily taking additional handouts from the local agencies.

Some residents speculated that ill feelings were harbored toward the "Indians" because the Passamaquoddy Tribe had purchased many acres of blueberry barrens after the tribe settled a land claim with the U.S. Federal government. The Passamaquoddy Tribe owns and operates one of the large blueberry companies, Northeastern Blueberry Company. Of the rakers who were served at the Rakers' Center, NEBCo employed 40% and was the top employer in the region.

Prejudice and a lack of cultural relativity are clearly factors in some of the problems experienced.

THE MICMACS

Micmac migrant blueberry rakers come to Washington County every summer to rake blueberries for the potential income and because it is a cultural tradition. For many families, the income earned from this labor is the only source of cash obtained all year. Many families obtain government assistance for shelter, food and health care, but unemployment is very high on the reserves and cash income is limited. The Micmac have worked the harvest for generations.

Large extended families are an integral part of the social organization of the Micmac. The care and well-being of children are of paramount concern to the entire group. Children are highly valued. Many rakers come to Maine in order to have the money needed to purchase "Back-to-School" clothes for the children. Teenagers work to assist the family and to have the opportunity to buy "extras" for themselves.

Families consist of extended networks which include the nuclear family, grandparents, in-laws, brothers, sisters, nieces and nephews. All members take an interest and an active role in the care of the "family".

Concerns for personal health problems were minimized but great involvement was shown for other family and extended family members' health. Neighbors, too, knew when someone was ill and sought help for the ailing individual. Care for each other was a key element of this societal group.

The care and happiness of children was of concern to all members of the group. Children were not scolded or hit. There was no evidence of gross misbehavior by children. On the contrary, children were observed to be extraordinarily sensitive and caring about their peers, never teasing or acting cruel. Exuberant child behaviors of running and jumping around, playing in dirt or mud puddles was accepted by adults without comment. I mention these because of perceptions of the local people which is reported later.

SUPPORT SERVICES AT THE RAKERS' CENTER

Initial applications were primarily taken by Washington-Hancock Community Agency personnel. Others, such as myself, assisted clients with the application process when large numbers of clients were waiting to request help.

The center was in operation weekdays beginning Wednesday, July 26 and closed on Thursday, August 24. Hours were 8:00 AM to 4:00 PM with the exception of Thursday when the Center was closed at 2:00 PM. The location of the Rakers' Center was more centrally situated to the major companies' fields than in previous years although four miles from a major route.

Support services included General Assistance, Food Stamps, Pine Tree Legal, Health Clinic, Social Security Administration, Maine Migrant Education and WIC.

GENERAL ASSISTANCE

General Assistance personnel were available every day during the hours of operation, excluding lunch breaks. Temporary residents in specific townships only were eligible for assistance if they met certain income criteria. Others were required to seek help from the town halls in their respective temporary communities.

Some personnel from General Assistance openly expressed disdain for the requests of assistance. Comments were made that it was believed food vouchers were being taken by the families but were not really needed. Often it was assumed that the migrant workers had money but preferred to take a hand out.

One particular problem that arose, in which I was directly involved, was the case of a man who had severely injured his foot. The wound was infected and the Clinic physician had recommended the individual return to his home in Canada where he could receive daily treatment. If he stayed locally, he needed to obtain daily injections of an antibiotic and have sterile washes four times a day to the injury. Living in a tent on the barrens made this procedure nearly impossible to follow. He had no cash, no transportation and was unable to work. His family had left him in Maine and had continued to Vermont to work on another harvest. He tried raking berries with his injured foot and had $20 in pay coming to him. This aggravated the injury.

General Assistance was contacted for help in getting this man back to his reserve in Nova Scotia. They claimed they were unable to help except to give him a bus ticket to Calais, Maine or a $10 gas voucher. The GA staff person said this sort of thing was a problem every year, someone gets hurt and needs to get back to their home. He said they never provide the funds to get the individual home and "somehow, the problem always disappears".

Clearly, this type of emergency should have a planned response to assist the sick or disabled person. Humanitarian support should be available for the "unpredictable" emergency that "predictably" happens every year. Fortunately, in this case $50 was obtained by a local Native American who was willing to help a total stranger. The injured man was able to pay someone

to drive him home.

General Assistance vouchers does provide food for needy families who would otherwise go hungry. I personally noticed the food purchases of a number of families that used the vouchers and did not see what might be considered "abuse" of the system. Foods purchased were basic and nutritious. I noticed food supplies in a number of the camp structures. There were no "extras".

Families were large and cultural social courtesy always provided the neighbor/visitor with a meal. Appetites were good and ample quantities of food consumed.

Further study could determine if the current food voucher allotment is adequate considering the cultural eating patterns of this migrant population and the necessary caloric intake for the type of work performed.

WIC - WOMEN, INFANTS & CHILDREN PROGRAM

The WIC Program provided staff for a few days to provide nutritional information and additional food supplements for pregnant women and children under age 4.

Unfortunately, the support personnel were not available on a daily basis and potential clients had to go to the Harrington, Maine office. There was very little awareness or knowledge of this support program although there were many pregnant women and infants that could have benefitted if the resources had been more accessible.

Many living quarters did not provide refrigeration units.

Additional allocations of milk from the WIC program was in gallon quantities. The extra supply of milk and calcium products provided by WIC were left at room temperature and spoiled. Extra vouchers for ice would help to alleviate this hardship and avoid the risk of salmonella poisoning.

FOOD STAMP PROGRAM

Again, personnel were available during relatively few of the hours of operation at the center. Problems involved lack of Social Security numbers and incorrect mailing addresses. Many clients were hopeful to qualify but did not meet the U.S. guidelines for eligibility.

SOCIAL SECURITY ADMINISTRATION

Extended days/hours for Social Security would have assisted those clients needing an identification number for the Food Stamp program.

PINE TREE LEGAL ASSISTANCE

Legal Assistance was provided to migrant workers. In health issues, the staff was concerned with any problems that might have been connected with the use of chemical pesticides on the fields. I was not aware of any particular cases as all of their client information was strictly confidential.

MAINE MIGRANT EDUCATION

A Blueberry Harvest School was set up at the Milbridge Elementary School in Milbridge, Maine to operate August 2 through August 25. Children ages three through twelve were recruited from the migrant population. Bus transportation was provided from

the camps on the barrens. Three meals were given to the children: breakfast, lunch and an afternoon snack before they were returned to their home bases.

The program flier proposed Nature, Arts & Crafts, Reading Books, Dance and Music, Physical Education, Computers and Native American Culture. There was no charge to the participants.

School Health Care

Although planning for the school program had included the hiring of a school nurse, a decision was made to hire a local Emergency Medical Technician who also worked in the capacity of a teacher. If a child was sick, the teacher had to leave her class in the care of teacher aids and attend to the child.

The health room was small with inadequate ventilation. Sick children (if more than one) shared a mattress on the floor of the room. Children in need of medical attention at the Clinic were transported in a group by the EMT and teacher aides. This trip was generally around mid-day.

A potentially serious situation occurred one day when the Clinic was phoned by the school personnel seeking assistance. A three-year-old girl had a severe rash, possibly measles and needed to be seen by the physician on duty. The problem was that the child was unidentified so parental consent could not be verified. Neither the classroom teacher nor the school principal could determine the child's identity even though she had been paraded through the many classrooms in hope of recognition by other school children.

The bus driver had not remembered where she had picked up the child, although it was thought she might have come from one of the four Northeastern camps. The company nurse from NEBCO was asked to go to the school to assume responsibility for the child. The nurse went to the school but did not recognize the child from her own contact and declined to take this "unknown" child.

The child was unable to communicate with others and it could not be determined if the problem was the child's inability to understand English (Micmac children do not learn English until age 5 or 6) or shyness from immaturity. The school personnel claimed the child was not officially registered for the school program, even though this was the fifth day she had attended. Some adults at the school commented that "those people just put their kids on the bus", implying lack of care on the part of the Micmac parents. From my observations, this could not be farther from the truth and was certainly a cultural misunderstanding.

The NEBCO nurse went from camp to camp describing the child to residents in hope of finding the family. In one camp she was fortunate to find the child's uncle who directed her immediately to the mother who was understandably upset and worried. She said the child had been correctly registered on Monday of that week. The mother hurried off to the school with two cars full of concerned family to retrieve the toddler.

Other Safety Concerns

Residents of the camps told me of children being left off by

the bus at the wrong camps. Residents would then drive them to the correct "home" location. One afternoon two children were brought to the Raker's Center because the bus driver did not know where they belonged. A staff person at the Center helped to determine the identity of the children who had a surname different from their mother. The staff person then called one of the school recruiters to transport the children back to their home camp. Needless to say, the family was quite concerned when the children did not get off the bus with the rest of the school children and were missing for several hours.

Lack of adequate identification poses a serious threat to these children. Micmac children most often live on a Canadian reserve with members of their own tribal band. Their culture provides extended caregivers and an environment of trust. They are not suspicious of strangers as the children in our country have been taught. They have not been exposed to the dangers that other children here experience. This puts them at greater risk of kidnapping or abuse. Safeguards should be taken to insure the child's identity, housing location and name of parent or guardian. The school personnel did not consider this as a serious problem and did not acknowledge the potential harm to the children in their care.

Child Abuse

Reports of children being hit and pushed by the local person

hired as bus monitor by the transportation provider were given to the NEBCO nurse by several mothers. The Micmac normally have hesitated to voice any complaints about mistreatment, reluctant to be labeled a "trouble maker". However, toward the end of the raking season, after the NEBCO nurse had earned the trust of the Micmac, the mothers of several children confided their concerns to her. These incidents of alleged child abuse were witnessed by several adults and other stories were confirmed by the students. The nurse reported these incidents to the Passamaquoddy Tribal Police who had jurisdiction at the tribal owned blueberry fields.

While discussing this abuse with some local non-Indians, I heard suggestions that "perhaps they (the kids) deserved it!" and "I don't see what's the fuss. So a kid was probably slapped". Another comment was "I always hit my kids, if they needed it." Perhaps the problem stems from cultural differences in child rearing. Whatever the root cause, hitting, slapping and "man-handling" of children is against the law. Steps should be taken to insure these wrongful actions are never repeated.

School Nutrition

Meals prepared for the children at the Harvest School were prepared according to Federal Nutritional guidelines. The woman in charge of menu planning was very conscientious about nutritional adequacy and attractive meal planning.

I received many reports from mothers concerned about the lack of food the children were receiving and accounts of very

hungry children running off the bus in the afternoon, eager to eat. One mother said she had to give her daughter "two big bowls of potatoes. She was so hungry!".

When this contradictory situation was investigated it was found that much of the food served at school was "alien" to the children. One child when given a lunch of "Sloppy Joes" cried inconsolably and could not eat. She was absolutely convinced the people at the school were trying to feed her and the other children "throw-up". No amount of explanation from the staff could convince her otherwise.

This situation of cultural difference could be easily remedied. When I spoke to the kitchen manager, she was eager to obtain native recipes and was quite willing to prepare different ethnic dishes. She was disappointed to hear that the school program had observed "Indian Day" without her knowledge. She would have liked to surprise the children with some ethnic foods from their own culture.

Follow-up should be done with the cafeteria personnel to insure more appropriate dishes be given to the school children.

HEALTH CLINIC

The Rakers' Center included a Health Clinic which offered free health care to the migrant workers and their families. This service has been provided each year but many people interviewed were not aware of the facility. In the first two weeks of operations at least one-half of the people questioned did not know a Clinic with an attending physician was available. A few

women did not know that the health care was free of charge. They thought they would have to pay because "people have to pay for doctors in the U.S.".

The Clinic operated Monday, Tuesday, Wednesday and Friday from 8:00 A.M. to 4:00 P.M.. Thursday hours were 8:00 A.M. to 2:00 P.M.. Approximately one hour was taken for the staff lunch break. During evening hours or on the weekends, emergency health care was available at the Machais Hospital Emergency Room. Machais was approximately twenty-five miles away from the Rakers' Center.

The Rakers' Center Clinic was staffed with two doctors during the first seven days of operation. The remaining days saw the Clinic staffed with one physician. A local EMT served as intake interviewer and assisted the doctor(s), when necessary.

The patients were not seen on a triage basis but in the order of arrival. During busy periods, some individuals and families had long waits. Patient histories were taken by the doctor. Blood pressure, pulse and temperature were also taken by the staff physician.

Visits to the clinic nearly doubled the number seen last year. An unofficial tally given by an attending physician reported nearly 400 patient visits. (This is a larger figure than reported in the WHCA communication of 10/10/89.) The physicians treated a variety of injuries, illnesses and symptoms. Common complaints were Rakers' tendonitis, sore throats, ear aches, muscle pulls and back pain. Infected wounds, often caused

by rake injuries, upper respiratory problems and gastroenteritis were frequent ailments. Also seen were a number of skin rashes which included impetigo.

Medicine replacement was requested by individuals who forgot, lost or ran out of their daily medications. High blood pressure pills and insulin replacement topped the requests.

Broken bones and severe wounds were referred to Machals Hospital. Other patients sent to the hospital included one man with severe asthma, appendicitis, another with a possible heart attack and a woman with bowel cancer.

A number of pregnant women were seen by the physicians. Several doctors commented that the Clinic was not supplied with adequate prenatal equipment. Some women had not been having regular prenatal care and would have benefitted from this contact with medical personnel.

Problems and Recommendations

Hours of operation

The hours of operation were not sensitive to the migrant worker. Rainy days were very busy at the clinic because the weather kept people off the fields. If the weather was good for raking, few came to the center because they could not afford to take time away from the fields. They needed the income.

One family came a minute or two after the official closing time but before the staff had left and was refused treatment. The family was asked to return the next day and they did not insist on seeing the doctor that afternoon. Obviously, it was

not easy for this large family to get to the Rakers' Center at that time of the day which was clear and dry. They should have been seen.

Strong recommendations should be made to have the clinic open during evening hours, at least until 7:00 P.M. Many more could and would take advantage of this service if they did not have to lose work time. The 2:00 closing on Thursdays was problematic because a number of people came to the center after closing hours, not remembering Thursday was a special time schedule.

Intake Interviews

Patients should be seen on the basis of medical need. A triage nurse would benefit the doctor by performing preliminary routine checks, obtaining medical histories and prioritizing the order of patients. The EMT currently employed has been a key member of the team that sets up the operations of the Clinic. She transformed the kitchen of the Town Hall into a functioning clinic. She also made it possible for the doctors to experience blueberry raking, which provided information to the physicians as to the nature of the physical strain placed on the target population. Her position should be retained.

Medical Forms

Medical forms should include the present local address of the patient with particular attention to the camp's name. If a large number of particular symptoms were seen by the physician at the Clinic, the possibility of an epidemic or contaminant could

be more easily determined by correlating the incidence with the living quarters location.

Medical history information for children brought from the Harvest School was inadequate. More detailed information should be obtained from the parent(s) at the time of registration.

Medications

The majority of the migrant population came from Canada and previous medical treatment was through the Canadian health system. The Physicians' Desk Reference did not list a number of medications available and prescribed in Canada. The doctors at the Clinic would benefit from a Canadian Physicians' Desk Reference to better prescribe for the patients while in Maine.

Patients needing prescriptions were required to return the next day to obtain the medication from the Clinic. Vouchers should be given to those individuals willing to travel for the prescription. Commonly used antibiotics and other medications should be stocked in minimal quantities in the Clinic.

Orthopedic Supplies

Some patients were given crutches to use and return to the Clinic when no longer needed. Child size crutches were not available although needed.

Observation was made of two individuals who were using both crutches on only one side. When questioned, it was revealed that these people were not instructed in the correct use of crutches. They did not know to use one on each side and avoid leaning their weight in the armpit.

Staff should not assume patients understand the correct use of appliances. Instruction should always be given.

Dental Problems

Several patients were seen for acute dental problems and referred to local dentists. Problems of this nature occur each year.

Robert Massucco, D.M.D., has volunteered his services and the use of his mobile dental unit for one afternoon per week during next year's Rakers' Center operation. Details can be worked out if his offer is accepted. He resides in Jonesport, Maine.

Alcohol and Substance Abuse Problems

The Clinic physicians encountered a number of people requesting medication for alcohol problems. There were no alcohol rehabilitation support counselors available to the patients.

An AA (Alcoholics Anonymous) Meeting was planned for a weekend evening but arrangements delayed the event until many of the rakers had completed harvesting and were returning to their homes. One person told me a relative had lost six months of sobriety because of weekend boredom and the amount of drinking in the camp.

Interest was certainly evident and indicated the need for AA Meetings. Local AA members were willing to host a meeting at the Rakers' Center. A good response could be anticipated if notification was adequate in the camps, the meeting was held on a

weekend and was proposed before the end of the raking season.

Pregnancies

Many women were in the second and third trimesters of pregnancy. The Clinic lacked the equipment to adequately examine the women and assess the condition of the fetus. Proper equipment should be standard equipment. Prenatal nutritional pamphlets should be given to the women.

Emergency Services at Machais Hospital

A number of individuals who went to Machais Hospital in the evening, on weekends or without a direct referral from the Clinic physician encountered problems in obtaining treatment. One independent grower from Jonesport transported one of his injured workers to the Emergency Room. Although he claimed financial responsibility for treatment, the ER staff refused to examine the migrant worker's injury without a direct referral from the Rakers' Center physician.

The employer was forced to drive to the Rakers' Center and wait in turn for the doctor to examine his employee. The doctor recommended xrays be taken at the hospital. The employer then drove the patient back to Machias Hospital where the man was finally examined and treated. Discussions with the administrators of Machias Hospital should be undertaken to improve the procedure for treating the migrant population.

Other Health Support Services

Of the three major companies, only Northeastern Blueberry Company provided a nurse to attend to the daily medical needs of

the workers. The nurse for NEBCO visited each of the camps and all of the field work areas each day. She monitored blood pressures, administered first-aid and recommended patients see the doctor at the Clinic, when appropriate. She was also able to follow-up on the physician's instructions and monitor the patient's progress.

Wyman Company and Cherryfield Foods provided only trained first-aid personnel. This was administered for on-the-job injuries and acute conditions. The injured person was transported to a local doctor if the condition warranted. Every day health care needs were not served. Families in these company camps often were not aware of the Rakers' Center Clinic.

These major employers should be strongly encouraged to hire a company nurse to provide the daily care. Company representatives should be presented with humanitarian and practical benefits that could be provided by a staff nurse. Prompt attention to injuries could prevent infection. Other problems could be treated before an acute stage is reached.

TRADITIONAL HEALTH PRACTICES

Most Micmac interviewed said they do not use traditional remedies for health care. Upon lengthier conversations, many admitted to using herbal preparations known to their families for such common ailments as coughs and colds, aches and strains, stomach and intestinal problems. If the traditional remedies were ineffective, a western physician was contacted.

While in Maine, most had not brought any herbal remedies

with them and used over-the-counter non-prescription medications. If symptoms persisted, the doctor at the Clinic was seen. Traditional medicines were seldom used during the raking season.

Stories were told of the effectiveness of a traditional salve used for rakers' tendonitis. The doctors at the Clinic are reluctant to prescribe pain medication for this condition as it would encourage further use of the injured arm. The physician recommend resting the limb until the swelling subsides.

Of course, this would mean no raking for the individual. Some people from the Eskasoni reserve have indicated the traditional remedy was always very effective. Several demonstrated a desire to obtain the salve or the recipe to treat next year's cases of tendonitis.

SENSITIVITY TO MICMAC CULTURE

The health care personnel at the Clinic were conscious of cultural differences in their patient population. They may not be aware that the Micmac do not complain (very often) about their own problems. Native American in general and specifically Micmac seem to be a group that supports and cares for each other. Greater details about the condition of a patient could be obtained by asking questions of a family member. Rules of confidentiality may not be appropriate for this ethnic group if the well-being of the patient is the primary concern.

When an individual goes to the Clinic without some other referral, it could be assumed that the symptoms have been affecting the patient for some time or that they are very severe.

Most Micmac do not seek medical attention for themselves quickly for a physical complaint. Their tendency is to minimize their own ailments while being watchful of others' needs. Micmacs do not always volunteer information about themselves. The staff should consider this when healh information is obtained through questioning.

Verbal information to patients is essential. Written prescription or follow-up care is often unheeded. The Micmac have always been an oral tradition people.

SUMMARY

The health care provided for the migrant blueberry rakers is a necessary component of the Rakers' Center. Improvements in scheduling the hours of operation should be considered. Additional equipment is needed by the medical staff so they can adequately care for the patients, in particular pregnant women. Health forms should be reviewed for missing information that would assist the physician.

A triage nurse could assist the physician and perform routine evaluations. This would free the doctor and allow for longer verbal communication between the physician, patient and patient's family.

Attention should be given to the mental health of the workers, especially the concerns and needs of the recovering alcoholic. AA meetings should be planned for all of the weekends with adequate advance notification to the camps.

Any child abuser should be removed from his/her position and

prosecuted. Teaching staff of the Harvest School should include Micmac native teachers. The Micmac personnel should not be limited to aid positions. Micmac personnel should be employed as bus monitors. Identification bracelets should be placed on each child enrolled in school. Very young children should be provided with day care in the own camp locations, employing camp women. An effort should be made to prepare foods familiar to the Micmac students and children informed additional portions are available.

Educational opportunities should continually be sought in order to help the local population understand the Micmac and the migrant worker's culture. Cultural diversity needs to be appreciated and differences accepted. This is certainly a lot to ask. Some have been working on this process for many years. Suggestions should be made that the local adult continuing education classes offer cultural courses as a bridge to greater understanding of other people.

Conscious awareness of cultural diversity should be stressed to all of the support personnel and should be included in an orientation program for the staff. Informational meetings to explain the available support network could be held in the Indian communities. This would be especially beneficial to the participants and counselors in the drug and alcohol rehabilitation programs on the reserves. Networking should be employed.