Chapter 1
Executive Summary and Policy Options

The Senate Select Committee on Indian Affairs is considering legislation to enhance and improve mental health services to Indians.[1] The Committee asked the Office of Technology Assessment to assist them in this effort by reviewing the mental health needs of Indian adolescents and the services available to them, and to provide options that Congress might consider when designing its legislation. This chapter summarizes the findings of OTA's review, suggests options that Congress might consider, and provides an overview of the remainder of the Special Report.

FINDINGS

Scientifically acceptable information on the extent of mental health problems among Indian adolescents and on the availability, accessibility, and effectiveness of mental health services specifically for Indian adolescents is scarce. The information that does exist makes clear, however, that mental health services for Indian adolescents are inadequate. The data that do exist on mental health problems suggest that Indian adolescents have more serious mental health problems than the U.S. all races population with respect to:

- developmental disabilities, such as mental retardation and learning disabilities;
- depression;
- suicide;
- anxiety;
- alcohol and substance abuse;
- self-esteem and alienation;
- running away; and
- school dropout.

While the causes of mental health problems are not known with certainty, the life situations of many Indian adolescents are filled with stressors that can lead to emotional distress and serious mental and behavioral problems. These stressors include (in addition to those listed above):

- recurrent otitis media and its consequences for learning disabilities and psychosocial deficits;
- fetal alcohol syndrome and its consequences for mental retardation and less severe forms of developmental disabilities, as well as psychosocial deficits;
- physical and sexual abuse and neglect;
- parental alcoholism;
- family disruption; and
- poor school environments.

In addition, because of their developmental need to establish their own identities, Indian adolescents often feel particularly caught between two cultures.

The resources to cope with these serious problems are clearly inadequate. While there are at least 397,000 children and adolescents in Indian Health Service (IHS) service areas, II-IS funds only 17 mental health providers trained to treat children and adolescents, a ratio of less than one-half a mental health provider to every 10,000 children and adolescents. In total, approximately 1 to 2 percent of EM's budget is allocated to mental health services for Indians of all ages. Only 3 percent of tribal and urban staffs are mental health providers. Publicly funded State and local services are either unavailable or unacceptable to Indian people.~

Further, the distribution of the 17 mental health providers trained to work with children or adolescents varies considerably by IHS service area (see table 1). The Bemidji area; California

[1] In this Special Report, the term Indians is used to refer to American Indians and Alaska Natives.

[2] This Special Report is the second publication from OTA's full assessment of adolescent health. The full assessment will be published in late 1990.

[3] Services may be unacceptable for a number of reasons. One of the longstanding concerns in providing mental health treatment and prevention services to Indians is the need for cultural sensitivity. Currently, there is a shortage of trained minority mental health providers, and sometimes those who have completed training find that the education offered by nonminority institutions serves to alienate them from their community rather than make them a resource.

Table I<hild- and Adolescent-Trained Mental Health Care Providers for Indian Adolescents by IHS Service Area

IHS service area	Reservation States included in service area	Estimated adolescent user population	Number of child- and adolescent-trained mental health care providers	Child- and adolescent-trained mental health care providers per 10,000 adolescent population
Aberdeen	ND, SD, NE, 1A	9,969	2	2.0
Alaska	AK	10,922	1	0.9
Albuquerque	NM, CO	15,434	1	0.6
Bemidji	MN, WI, MI	11,272	—	0.0
Billings	MT, WY	12,012	9	7.5
California	CA	8,388	—	0.0
Nashville	AL, MS, LA, FL, NC, PA, NY, CT, ME	5,342	·	0.0
Navajo	AZ, NM, UT	42,657	2	0.5
Oklahoma	OK, KS	48,090	1	0.2
Phoenix	AZ	17,642	—	0.0
Portland	OR, WA, ID	12,617	1	0.8
Tucson	AZc	5,077	—	0.0
Total adolescents aged 10-19 in IHS service areas		199,422	17	0.8
Urban areas	States with urban programs			
Various	AZ, CA, CO, IL, KS, MA, MI, MN, MT, NM, NV, NY, OK, OR, SD, TX, UT, WA, WI	160,000d	N/Ae	N/A

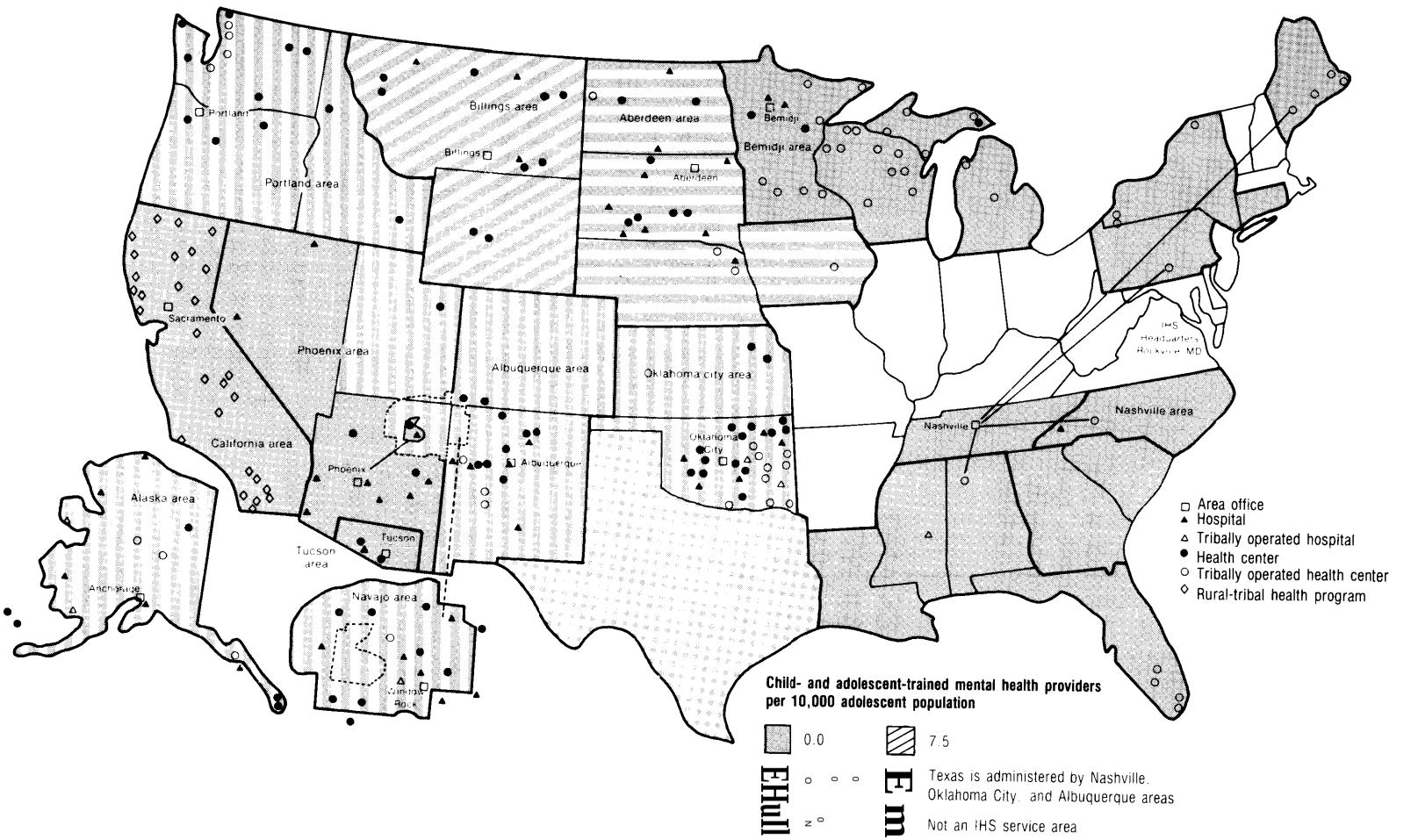
Calculated from percent distribution of adolescent population for IHS service areas by age based on 1980 U.S. Census Data (347). May not be current.
bIn some ways, these data Overestimate the number of mental health providers for adolescents. For example, the 17 IHS-funded providers are to serve both adolescents aged 10 to 19 and children younger than 10. Older children are more likely to require and seek therapy, however.
'South-central Arizona only.
dThe number of Indian adolescents living in urban areas sewed by Lhban Indian Health Programs is not known. OTA's estimate is based on an estimated total Indian population of approximately 1.5 million (estimate for 1985; 322), approximately 24 percent (360,000) of whom are estimated to be between 10 and 19 years old (see footnote b). If approximately 200,000 of these adolescents live in IHS service areas (see above), 160,000 would live in areas not served by II-IS. This estimate is consistent with 1980 census figures showing that 50 percent of Indians live in metropolitan areas. However, not all of these Indian adolescent live in urban areas with Urban Indian Health Programs, so this is probably an overestimate of the adolescent population sewed by Urban Indian Health Programs. In addition, some Indians living in metropolitan areas are served by IHS (322).
eThe number of child- and adolescent-trained mental health providers in urban areas is unknown. In any event, the number would be small because fewer than 3 percent (15 to 20 providers total) of urban program staffs are mental health providers.
SOURCE: Office of Technology Assessment, 1990.

area; Nashville area; Phoenix area; and Tucson area have no mental health providers trained to work with children or adolescents. The Alaska, Albuquerque, Oklahoma City, and Portland areas have one each. The Aberdeen and Navajo areas have two each. The Billings area has nine. Note that in terms of provider to population ratios, table 1 presents a conservative estimate of the proportion of child- and adolescent-trained mental health providers available to the Indian population by assuming that adolescents aged 10 to 19 would be more likely than younger children to seek mental health care.

There are no comparable data about the full range of child- and adolescent-trained mental health providers (i.e., including psychiatrists, psychologists, social workers, and other mental health professionals) for the U.S. all races population, although some data, as well as a recommended ratio of providers to children, are available regarding child psychiatrists. These data can be extrapolated to suggest that there be a ratio of between 4 and 5 specially trained mental health providers to every 10,000 children 19 and under. If this ratio were applied to the II-IS service population, there would be an increase from 17 to approximately 200 specially trained mental health providers for reservation-based Indians alone.

In addition to the expansion of services, important needs are to make any such expansion responsive to the particular needs of Indian adolescents and their communities and to improve coordination among service agencies. Evidence for the effectiveness of mental health treatment adapted to Indian adolescents is lack-

Figure 1—Child- and Adolescent-Trained Mental Health Care Providers for Indian Adolescents by IHS Service Area



SOURCE: Office of Technology Assessement, 1990.

ing, although several promising models exist. There is considerable evidence to suggest that, in general, mental health treatment for children and adolescents can be effective. OTA therefore concludes that in order to meet the unmet mental health needs of Indian adolescents mental health services must be expanded in ways sensitive to the needs of Indian adolescents and their communities.

These and other needs are addressed in the following section on guiding principles and options for a community-based, comprehensive, mental health services system for Indian adolescents.

GUIDING PRINCIPLES AND OPTIONS FOR A COMMUNITY-BASED, COMPREHENSIVE, MENTAL HEALTH SERVICES SYSTEM FOR INDIAN ADOLESCENTS

OTA's evaluation of American Indian and Alaska Native adolescents' mental health needs and the services available to them suggests a number of principles for Congress to consider as it designs legislation to improve the mental and emotional health of American Indian and Alaska Native adolescents. These guiding principles were agreed upon by an OTA panel of experts and are consistent with principles derived by similar groups (e.g., 33,145,253,301,336,341). First, the guidelines are summarized. Then, obstacles to implementation of the guidelines are discussed. Finally, options for congressional consideration are presented.

Guiding Principles

A consensus exists that mental health services for American Indian and Alaska Native adolescents should adhere to the following principles. Mental health services for American Indian and Alaska Native adolescents should:

- be accessible to all American Indian and Alaska Native adolescents, regardless of geographic location or socioeconomic status;
- be adequately funded and staffed;
- be provided within a continuum of care, to include, at a minimum, inpatient treatment in a psychiatric hospital, a residential treatment center, a partial hospital program, and an outpatient service;
- be comprehensive, to include preventive services, treatment, and community education;
- be coordinated within and between service agencies, including non-mental health system agencies, and State, local, and other Federal (non-IHS and Bureau of Indian Affairs (BIA)) agencies;
- be provided in the community to the extent possible;
- include the affected community (including adolescents) in the design, management, and evaluation of services to the extent possible;
- be consonant with the cultural, spiritual, and religious values of American Indian and Alaska Natives;
- be appropriate for adolescents;
- be family-based to the extent clinically possible;
- be based on valid data about the extent of need and availability and effectiveness of services;
- be of high quality; and
- be provided on a timely basis.

Obstacles to Implementing Guiding Principles

Numerous obstacles exist before the guiding principles listed above can be implemented. This brief description of obstacles represents a summary of the service conditions in IHS and in other service systems (e.g., BIA, local, State, and other Federal agencies) described in the body of this report. Several of the conditions described in this section present obstacles to implementing more than one of the guidelines described above. Not every obstacle may be amenable to change through legislation.

Obstacles to Accessibility, Adequate Staffing, Continuous, Comprehensive, and Appropriate Services

Little headway in improving services to adolescents can be made with a total categorical II-IS budget of $13 million for mental health services.[4] Only 198 IHS staff members are mental health professionals; only 17 of these are specially trained to treat children and adolescents. There are only 21 inpatient psychiatric beds for Indians; none of these are designated for adolescents. Virtually no partial hospitalization, transitional living, or child residential mental health treatment facilities exist in IHS direct or tribal operations.

Obstacles to Providing Continuous, Comprehensive, and Coordinated Services

Primarily because of funding disputes or inadequate resources, local, State, and Federal programs that are not based in IHS or BIA are unlikely to serve Indians (322). Because they have different objectives (e.g., education and criminal justice for the BIA versus health for the IHS), BIA and IHS programs often are not coordinated. Within the II-IS, alcoholism, primary health programs, and mental health services are often not coordinated.

Obstacles to Providing Services Consonant With the Cultural, Spiritual, and Religious Values of American Indians and Alaska Natives

At present, few mental health service providers are Indian, and cultural-sensitivity training of providers is inadequate. Few opportunities exist to train additional Indian mental health providers. Western-trained mental health services providers may be insufficiently sensitive to cultural issues to work effectively with Indian communities. Indian communities may resist some of the prevention and treatment recommendations of Western-trained mental health professionals.

Obstacles to Services' Being Designed by the Affected Community

Many service programs originally under the control of the Federal Government are moving toward community control by Indians themselves. However, numerous problems have beset the full implementation of Indian self-determination (322).[5] Issues common to all health services, including mental health, include the extent to which the IHS contracting process either allows or undermines Indian control. Another generic issue is whether Indian communities have developed the competence to design, manage, monitor, and evaluate their own programs. For mental health services, and the coordination of mental health with other health services, a particular problem is presented by the sometimes different interpretations (by tribes and IHS and BIA professionals) of mental health and emotional problems and their appropriate treatment.

Obstacles to Services' Being Information-Based

With adequate information on the epidemiology and etiology of mental health problems, and on the value and extent of services available to help Indian adolescents with mental health and emotional problems, Indian communities and Federal agencies would be much better equipped to provide appropriate and effective mental health services. Such information is not currently available to Indian communities (322). Epidemiologic, etiologic, and clinical research is needed (88). Such research should be culturally sensitive (see 269).

[4]The 101st Congress voted a total appropriation of $21.5 million for IHS mental health programs for fiscal year 1990 (Public Law 101-121). Of this amount, $3.2 million was set aside by Congress for specific activities, $2.5 million was set aside by IHS for specific activities and reserves (including $75,000 for regionally planned training to serve children and adolescents), and the remainder was allocated to area mental health programs to achieve an approximate allocation of $12 per capita (McCoy, G., U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, personal communication, Dec. 21, 1989).

[5]Some of these issues were addressed in the recent amendments to Public Law 93-638 (Indian Self-Determination and Education Assistance Act Amendments of 1988 [Public Law 100-472]).

Obstacles to Assuring Mental Health Services of High Quality

Evaluations of mental health and related services to Indians have been few and far between. Without such evaluations, it is difficult to determine whether services of high quality are being provided.[b]

Congressional Options

Many of the steps Congress could take to improve the mental health of Indian adolescents are expansions of legislation passed in the IOOth Congress (e.g., aspects of Public Laws 100-297, 100-472, 100-713) or of changes already begun in the Federal agencies serving Indians (353). Others require substantial infusions of resources.

Options to Increase Both Dollar and Staffing Resources for Mental Health Services for Indian Adolescents Within IHS

- Option l—Increase categorical funding for IHS for mental health services. IHS'S internal deliberations have determined that H-IS needs at least twice the amount of funds currently allocated to mental health. If child and adolescent mental health services are to be increased, more funds than that may be needed.
- Option 2—Provide categorical funding for mental health services specifically for Indian children and adolescents.

  Increases in categorical funding would help to ensure that the mental health needs of Indian adolescents are met. However, without an overall increase in funding for IHS, these increases would decrease the flexibility of IHS to meet the other health and mental needs of Indians of all ages. Further, any expansion of services should be teamed with a qualitative change in the service approach, to provide a culturally competent, continuous system of care for children and adolescents.
- Option 3—Provide for a specific level of full-time-equivalent mental health professionals, a portion of whom are to be for children and adolescents. OTA concludes that at least one to two child-or adolescent-trained mental health professionals in each service unit seems necessary, at least initially. Ideally, child- or adolescent-trained professionals would also be available in youth services centers and schools.
- Option 4--Provide for training of non-mental health professionals (e.g., primary care physicians) nurses, and nonprofessional mental health providers (e.g., mental health technicians) to be better observers of the need for mental health sources and better providers of mental health care.
- Option 5—Mandate that a specific portion of Indian Health Professions scholarships (see 25 U.S.C. 1613a) be for students who pledge to work with adolescents.
- Option 6-Expand retention bonuses (25 U.S.C. 1616j) to mental health professionals other than physicians and nurses, and improve retention bonuses for physicians and nurses.
- Option 7—Ensure that the Indian Health Care Improvement Fund (25 U.S.C. 1621) is allocated at least in part to mental health services.

  Currently, it is "approved" but not required for the Secretary to spend Indian Health Care Improvement funds[7] for mental health services.
- Option 8—Provide a mechanism to use underutilized IHS hospital general medical beds for adolescent psychiatric patients.

Options to Increase Funding for Mental Health and Related Services for Indian Adolescents in Non-IHS Programs

The amount of mental health care received by Indian adolescents from non-IHS sources is not known, but it is believed to be very small.

[6]The quality of services can also be determined in part by the extent to which services adhere to standards (325). IHS has recently developed national mental health program standards as part of its quality assurance efforts (355); OTA did not evaluate these standards.

[7]In fiscal years 1990 and 1991, $19 million for the Indian Health Care Improvement Fund was authorized, and $29 million for fiscal year 1992 (25 U.S.C. 1621).

Congress could help Indian adolescents receive services from non-IHS sources by providing set-asides for Indian adolescents in general legislation. However, these may not be sensitive to Indian cultures, and so may not be used by Indian adolescents unless some provision is made to increase the sensitivity of non-IHS service providers.

Precedent for set-asides for Indians, including Indian adolescents, exists. For example, recent legislation designed to combat alcohol and drug abuse (the Drug-Free Schools and Communities Act [Section 51 12(a)(2) of the August F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (Public Law 100-297)][8]) reserved 1 percent of the authorized funds for drug education and prevention programs for Indian youth. As another example, the Indian Education Act of 1988 (Title V, Part C, of Public Law 100-297) provided financial assistance to local education agencies to develop and carry out elementary and secondary school programs specially designed to meet the special education and culturally related academic needs of Indian students. Vocational rehabilitation legislation allows for the making of grants to Indian tribes (29 U.S.C. 750). Set-asides and mandated funding would ensure that Indian adolescents are included in innovative programs available to non-Indians.[9]

- Option 9—Provide set-asides for Indian adolescents in general legislation, such as the Alcohol and Drug Abuse and Mental Health Block Grant (Public Law 100-690), Juvenile Justice and Delinquency Prevention Act (Public Law 100-690), Vocational Rehabilitation Act, Sec. 130, and Maternal and Child Health (MCI-I) Services Block Grant (Title V of the Social Security Act).[10]
- Option 10-Clarify the intent of Public Law 98-509, which permits the United States Department of Health and Human Services (U.S. DHHS) to provide alcohol, drug abuse, and mental health (ADM) block grant funds directly to Indian tribes.

  Public Law 98-509 permits U.S. DHHS to provide ADM block grant funds directly to Indian tribes (42 U.S.C. 300x-la(b)(l)). However, paragraph 2 of the same section of the U.S. Code limits the amounts to be so distributed to Indian tribes to ''the amount which bears the same ratio to the State's allotment for the fiscal year involved as the total amount provided or allotted for fiscal year 1980" (42 U.S.C. 300x-la(b)(2)). Thus, unless tribal organizations applied for and received such grants in fiscal year 1980, they are ineligible to take advantage of this provision (245).

- Option 11—Mandate services to Indian adolescents under Federal programs such as Medicaid (Title XIX of the Social Security Act).

  There are already precedents for this in other acts. For example, States are required to provide vocational rehabilitation services to American Indians with disabilities residing in a State to the same extent as the State provides such services to other significant segments of the resident population of individuals with disabilities residing in the State (29 U.S.C. 721(B)(20)). States are also required to consult with Indians in the development of State plans (29 U.S.C. 721(B)(20)).

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[8] legislation permitted the Department of Education (DoEd) t. contract with Indian tribes, using the provisions of the Indian Self-Determination Act. (Section 5133 of Public Law 100-297).

[9] For example, the ADM Block Grant mandates that at least 10 percent of mental health funds be used to provide services and programs for seriously emotionally disturbed children and adolescents (Public Law 100-690, Sec. 2033(A)). Half of this amount is to be used to provide new or expanded services and programs (Public Law 100-690, Sec. 2033(B)).

[10] The Maternal and Child Health (MCI-I) Services Block Grant provides health services to mothers and children, particularthose with low income or limited access to health services. The purposes of the block grant include reducing infant mortality; reducing the incidence of preventable disease and handicapping conditions among children; and increasing the availability of prenatal, delivery, and postpartum care to low-income mothers. Mothers and children whose incomes fall below the poverty level may not be charged for services. States determine the services to be provided under the block grant. In fiscal year 1987, $478 million was appropriated for the MCH Block Grant.

Options to Provide for, and Evaluate the Effectiveness of, Alternative Models for Access to Mental Health Services

Even if overall resources and staffing were improved, small community sizes and wide geographic distribution of Indian populations would make the provision of professional mental health services difficult. Some Indian communities are located in rural areas where mental health services are not available from anyone. Thus, alternative models for access are needed, such as mobile practitioners, additional use of the village support worker model, consultation and technical assistance to indigenous mental health workers, and transportation to available services. In general, the effectiveness of these alternative methods has not been evaluated A precedent exists in legislation providing for grants to local educational agencies (LEAs) for the cultural enrichment of Indian children; this legislation allows for funds to be used for pilot projects to demonstrate effectiveness of these models (Title V, Part C, of Public Law 100-297).

- Option 12—Provide for demonstration project- for alternative models for access to mental health services, such as mobile practitioners, additional use of the village support worker model, consultation and technical assistance to indigenous mental health workers, and transportation to available services.

Options to Support Intra- and Inter-Agency Coordination for Mental Health Problems

. Option 13—Mandate coordination of child and youth services at the highest levels of the IHS, the BIA, other Federal youth services programs, and States in which Indians reside.

The programs to be coordinated could include, but not be limited to:

—II-IS mental health, maternal and child health, alcohol and drug abuse, community health nursing, CHR, and health education programs;

-Child Sexual Abuse Treatment Demonstration Programs (25 U.S.C. 1680i);

—BIA Juvenile Detention Centers (25 U.S.C. 2453 [4220 subsection b])[12];

—BIA Model Indian Juvenile Code (25 U.S.C. 2454);

—BIA Office of Alcohol and Substance Abuse Indian Youth Programs (25 U.S.C. 2413(c));

—IHS regional youth detoxification and treatment programs (25 U.S.C. 2474(a); 25 U.S.C. 2474(b));

—IHS community-based rehabilitation and follow-up services for Indian youth who are alcohol and substance abusers (25 U.S.C. 2474(d)) .13

Precedent for such coordination exists. For example, Public Law 99-570 required that a memorandum of agreement be developed between IHS and the BIA that would identify the scope of alcohol and substance abuse problems among Indian youth; identify relevant resources and programs of the BIA, the IHS, and other Federal, tribal, State, local, and private resources; develop and establish appropriate minimum standards for each agency's program responsibilities; and coordinate BIA and IHS alcohol and substance abuse programs (25 U.S.C. 2411; 25 U.S.C. 2431; 25 U.S.C. 2433; 25 U.S.C. 2441).[14]

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[11] Public Law 100-690 authorized funds for Community Health Representatives, but did not require that their effectiveness be evaluated.

[12] For example, Public Law 100-690 legislated that the IHS "sh~] not refuse to provide necessary interim treatment for any Indian youth referred pursuant to subsection(a) who has been charged or is being prosecuted for any crime unless such referral is prohibited by a court of competent jurisdiction or the youth is determined by a court of competent jurisdiction to be a danger to others" (Public Law 100-690, Title II, Sec. 2210).

[13] Includes a provision that mental health professionals are to run services.

[14] Another provision required immediate medical examination by IHS (direct or contract care) of juveniles arrested for alcohol or substance abuse to determine the juvenile's mental or physical state (25 U.S.C. 2452(a)).

Options to Provide for Community Involvement in the Design and Implementation of Mental Health Services and to Increase the Ability of Indian Communities to Design and Implement Mental Health Programs Responsive to Their Own Needs and Consonant With Their Community Values

Indian participation in the design of services is a major theme of recent legislation, but such control primarily takes the form of turning over responsibility for the delivery of services to Indian tribes themselves. Indians could also increase their participation in the design of services delivered directly by the II-IS. In this way, Indians could gain experience in designing and delivering programs at the same time the programs would become more responsive to Indian needs. Precedent for such participation exists, for example, in legislation providing for grants to LEAs for the cultural enrichment of Indian children (Title V, Part C, Section 5314 of Public Law 100-297, The Tribally Controlled Schools Act of 1988). This legislation requires that programs be developed and operated with the participation of parents of Indian children, teachers, and where applicable, secondary school students themselves.[15] Public Law 99-570 authorized $1 million a year (for each of fiscal years 1989, 1990, 1991, and 1992) for BIA grants to tribes for development of Tribal Action Plans to coordinate available resources and programs to combat alcohol and substance abuse among tribal members (25 U.S.C. 2412(d)). In general, U.S. DHHS is to provide technical assistance directly to tribes and to make grants to tribes for obtaining technical assistance from entities other than IHS (Public Law 100-472).

An example of legislation that goes further in helping to train tribal leaders is the provision in Public Law 100-713 for demonstration projects for tribal management of health care services (25 U.S.C. 1680h). Importantly, during the demonstration period, the Secretary was to award all health care contracts (including community, behavioral, and preventive health care contracts) to the Indian tribe in the form of a single grant (25 U.S.C. 1680h(b)), and was permitted to waive provisions of Federal procurement law.[16] An evaluation of the demonstration project is required.

- Option 14-Mandate a mental health programs advisory board in every service unit and area office of the IHS, and at the IHS headquarters level. It would be important that the Mental Health Programs advisory board integrate its activities with advisory boards for other health and social problems.

  The 1984 IHS Ad Hoc Group on Mental Health recommended that a standing IHS Mental Health Council be formed but the IHS and the Health Resources and Services Administration (HRSA)[17] rejected that recommendation (265).
- Option 15—More adequately specify the mental health aspects, if any, of the evaluation component of the tribal management demonstration project authorized in 25 U.S.C. 1680h.

Options to Improve the Sensitivity of Mental Health Providers to Cultural, Religious, and Spiritual Considerations in Mental Health Services Delivery

Precedents for implementing this option include the Indian Education Act of 1988, which authorizes grants to prepare teachers, social workers, and ancillary personnel to serve Indian students (Public Law 100-297). Public Law 100-713 requires the IHS to establish a program to provide educational instruction in the history and culture of ''particular Indian tribes' to appropriate employees (25 U.S.C. 1616f). A similar provision requires training for Community Health Representatives to ''promote traditional health care practices of the Indian tribes

[15] In introducing the need for tribally controlled schools, Congress stated that ''true self-determination in any society of people is dependent upon an educational process which will ensure the development of qualified people to fulfill meaningful leadership roles" (25 U.S.C. 2501).

[16] Provided that any such waiver ''does not diminish or endanger the delivery of health care services to Indians. '

[17] In 1984, II-IS was part of the HRSA; it has since been elevated to agency status.

served consistent with the [Indian Health] Service standards for the provision of health care, health promotion, and disease prevention" (25 U.S.C. 1616(b)(2)(B)(6)).

- Option 16-Require that training under the tribal culture and history program of Public Law 100-713 (25 U.S.C. 1616f) be provided to all mental health professionals, particularly those who work with children and adolescents.

Options to Make the Delivery of Mental Health Services to Indian Adolescents Information-Based

More efficient collection and sharing of information by IHS and BIA would assist Indian communities, the IHS, and BIA to design programs and evaluate their effectiveness. Epidemiologic, service, and effectiveness data are necessary. For example, the BIA is required to provide IHS, affected tribes, and Tribal Coordinating Committees with data relating to ''calls and encounters, arrests and detention, and disposition of cases by BIA or tribal law enforcement or judicial personnel involving Indians where it is determined that alcohol or substance abuse is a contributing factor' (25 U.S.C. ***2455),*** and with data on child abuse and neglect cases (25 U.S.C. 2434(b)).

- Option 17—Mandate the regular collection of epidemiologic data about the mental and emotional health status of Indian adolescents, perhaps beginning with demonstration projects.
- Option 18—Mandate the timely sharing of IHS and BIA service data with tribes.
- Option 19-Expand the provision of information required in 25 U.S.C. 2475 and 25 U.S.C. 2455 from information about alcohol and substance abuse to information about other mental and emotional health problems.
- Option 20-Mandate and support evaluation studies of IHS and BIA programs related to the mental and emotional health of Indian adolescents. Precedent for this approach is included in Public Law 99-570, which required that pilot programs monitor the effectiveness of summer youth programs in furthering the prevention of alcohol and substance abuse (25 U.S.C. 2431(a)).
- Option 21—Provide for involvement of Federal research agencies in basic and applied research on mental health problems and service needs of Indian adolescents. For example, issues relevant to Indian adolescents could become part of the National Plan for NIMH-sponsored Child and Adolescent Mental Disorders Research (144).

There can be no doubt that the mental and emotional health problems of Indian adolescents need to be addressed, and that the potential exists for helping Indian adolescents to improve the quality of their lives and reach a satisfying and productive adulthood. The discussion above of precedents for congressional options suggests that the Federal Government has shown its willingness to commit resources to mitigating the problem of alcohol and substance abuse among Indian youth. However, alcohol and substance abuse may be symptoms of other severe problems among Indian youth. A similar commitment to the mental and emotional health needs of adolescents and their families before they are manifested as alcoholism and substance abuse may be equally effective.

ORGANIZATION OF THE SPECIAL REPORT

This Special Report focuses on current knowledge about the mental health problems of American Indian and Alaska Native adolescents and the service systems that have evolved to treat such problems.

Chapter 2 considers mental health problems of American Indian and Alaska Native adolescents along a continuum ranging from diagnosable mental disorders through serious mental health concerns to stressful life events. Where possible, underlying causes have been highlighted and rates compared to those of the

general adolescent population. The chapter closes by outlining the most pressing information needs and the challenges that to be faced in addressing them.

Chapter 3 focuses on the nature and scope of mental health care that is available to Indian adolescents. It opens with a synopsis of the Federal, tribal, urban Indian, State, and local systems that play major roles in the delivery of services to adolescents. The report then outlines the various treatment settings that constitute a continuum of care, which represents the optimal framework for organizing and coordinating the necessary array of interventions. It next describes the spectrum of treatment modalities, considers their current status in Indian programs, and provides specific examples.

The report subsequently turns to preventive and promotive interventions, and summarizes the salient characteristics of those reported in the published literature as well as those identified by a field survey of actual practice. The related needs for sensitivity to the variety of Indian cultures and values and to community involvement are also addressed in this chapter. This section closes on the need to develop a more articulated, responsive, and comprehensive system which capitalizes on the best of all available means of intervention and personnel. Appendix A summarizes a number of earlier evaluations of the mental health needs of Indian adolescents.

The primary focus of this Special Report is on Indian adolescents from 10 to 19 years of age. Younger children inevitably have been included in some areas of discussion, largely as a function of antecedent conditions that become manifest as mental health problems in adolescence. Notable examples include developmental disabilities and fetal alcohol syndrome.

The Special Report is somewhat limited in that some areas of mental health concern have engendered surprisingly little research and even less published material. Consequently, information sources are limited and often difficult to access. In addition, understanding of the mental health problems of childhood and adolescence is in flux. There is not the same clarity about such phenomena among youth as there is among adults. Finally, and perhaps most important to an analysis of Indian mental health issues, with rare exceptions the IHS, BIA, tribal, and urban Indian health care program utilization data do not lend themselves to ready analysis of mental health problems.