Chapter 3
Delivery of Mental Health Services to American Indian and Alaska Native Adolescents

There is no single system for delivering mental health treatment to Indian and Native youth. Rather, there are a series of agencies and institutions with different responsibilities that create a patchwork of resources that varies from community to community. This chapter describes, to the extent information is available, the agencies relevant to the mental health of adolescents. It also describes the way in which contemporary mental health treatment approaches and settings have been adapted by Indian communities. The chapter makes clear that mental health services for Indian adolescents appear to be inadequate, given the mental health needs described in chapter 2.

AGENCIES INVOLVED IN THE DELIVERY OF MENTAL HEALTH AND RELATED SERVICES TO INDIAN ADOLESCENTS

The agency most directly responsible for providing mental health services to Indian adolescents is the Indian Health Service's Mental Health Programs Branch. IHS'S Alcoholism/substance abuse Programs Branch, the Bureau of Indian Affairs, tribal health programs, urban Indian health programs, and State and local service agencies also play a role in providing mental health services.

Indian Health Service[1]

Mental Health Programs Branch

The mission of the Indian Health Service Mental Health Programs Branch (MHPB) is to provide access for all Indian persons to high-quality and culturally appropriate mental health services that are appropriate to the nature and severity of their mental illness (355). The MHPB, which is one component of the Division of Clinical and Preventive Services in the IHS Office of Health Programs, has two geographic locations. Mental health and social services staff are located in IHS headquarters offices in Rockville, Maryland. Staff responsible for field services-e. g., quality assurance, planning, data, research, community consultation, special projects, children's services, and training-are located in the IHS Headquarters West Mental Health Office in Albuquerque, New Mexico. Branch staff work closely with area and service unit personnel, and with major Indian organizations.

As of April 1989, IHS reported that 251 staff were supported by mental health categorical funds (355) (table 24). Of these, 198 provide direct care, while 53 are administrative or clerical staff or professionals who work at one of the headquarters offices. The estimated total of 200 clinical staff means that on the average, between one and two mental health direct treatment personnel are available in each of IHS'S 127 service units. In actual practice, 80 percent of the service areas have a mental health presence and 20 percent do not[2] (355) (see table 24).

The distribution of mental health resources and staff varies considerably from area to area as does the availability of mental health professionals trained to work with children or adolescents (tables 24 and 25). As shown in table 25, in fiscal year 1988 the per capita budget for mental health services for persons of all ages in IHS areas ranged from $6.00 per person in California to $23.30 per person in the Billings and Portland areas.[3] Only 17 (9 percent) of the 198 direct care professionals were trained to work with children or adolescents, while children aged 19 and younger account for approximately 43 percent of the Indian population (355). This amounts to an average of 0.43 providers per 10,000 children and adolescents. In 4 of the 12 IHS areas, there are no child- and adolescent-trained mental health professionals.[4]

Given the mental health problems of adolescents described in chapter 2, the resources to provide mental health services are clearly inadequate. IHS'S

[1]See appendix C of this Special Report and U.S. Congress, OTA, April 1986, for an overview of the IHS.

[2]Table 20 shows the distribution of personnel by IHS area office rather than by the smaller Organizational service unit.

[3]With its increased appropriation for fiscal year 1990 (see ch. 1), IHS plans to increase mental health allocations to at least $12 per capita (fOr all ages combined) in each area.

[4]Estimated mental health providers per 10,000 adolescents by area is shown in table 1 in chapter 1 of this Special Report.

Table 24-Indian Health Service Mental Health Programs Branch Staff, Apri1989[a]

Area	All staff: Combined IHS Direct and 638 programs[a]								
	Psychiatrists	Psychologists	Nurses	Social wo~ers	Social work associates	Mental health technicians	Other mental health professionals	Administration and clerical	Total
Aberdeen	2	3	2	8	—	14	4	5	38
Alaska	4	2	1	1	.	—	—	3	11
Albuquerque	1	10	—	—	.	11	—	3	25
Bemidji	—	2	—	3	—	3	—	—	8
Billings	—	2	3	12	1	2	4	6	30
California	—	1	—	—	—	—	—	—	1
Nashville	—	1	—	—	—	—	—	—	1
Navajo	10	2	—	4	—	9	8	9	42
Oklahoma City	1	2	1	15	—	—	9	4	32
Phoenix	2	10	1	1	—	3	2	8	26
Portland	1	2	—	8	2	3	5	—	21
Tucson	1	—	—	—	—	—	—	—	1
Total **Area** Direct or 638 Mental Health programs	22	37	7	52	3	45	32	38	236
Headquarters staff	1	2	—	3	—	—	3	6	15
Total IHIS Direct or 638 Mental Healthprograms	23	39	7	55	3	45	35	44	251

[a]Direct and 638 Mental Health Programs: Positions counted against Mental Health Program's position ceiling and funded with Mental Health Program dollars.

Table 24b—Child- and Adolescent-Trained Mental Health Professionals[a]

Area	Combined IHS Direct and 638 programs[a]							
	Psychiatrists	Psychologists	Nurses	Social workers	Social work associates	Mental health technicians	Other mental health professionals	Total
Aberdeen	1	—	—	—	—	—	1	2
Alaska	1	—	—	—	—	—	—	1
Albuquerque	—	1	—	—	—	—	—	1
Bemidji	—	—	—	—	—	—	—	—
Billings	—	2	2	4	—	—	1	9
California	—	—	—	—	—	—	—	—
Nashville	—	—	—	—	—	—	—	—
Navajo	2	—	—	—	—	—	—	2
Oklahoma City	1	—	—	—	—	—	—	1
Phoenix	—	—	—	—	—	—	—	—
Portland	—	—	—	1	—	—	—	1
Tucson	—	—	—	—	—	—	—	—
Total	5	3	2	5	—	—	2	17

[a]Program indicates number of professionals specified who are trained to work with the mental health problems of children or adolescents.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Mental Health Programs Branch, "A National Plan for Native American Mental Health Services," IOth draft, unpublished report, Rockville, MD, June 26, 19S9.

own draft National Plan for Native American Mental Health Services concluded:

> While Native Americans suffer from the same types of mental disorders as other Americans, the prevalence and severity of these disorders appear to be greater, the availability of services lower, the cultural relevance of treatment plans more challenging, and the social context more disintegrated than in almost any part of American society. Failure to address these issues will result in more severe emotional problems for future generations of Native American individuals, families, and communities.

What constitutes an adequate number of mental health professionals for children and adolescents? The question is difficult to answer. IHS'S draft Plan's major recommendations included more than doubling the current number of direct treatment staff and assuring that trained staff are available to "provide services to Native American populations with special needs, especially children" (355).

OTA has attempted to estimate the number of child-and adolescent-trained mental health professionals that would optimally be available to serve Indian children and adolescents, Such an estimate is made difficult by the fact that both the total number of such specially trained mental health professionals in the United States and standards for provider-to-population ratios are generally not available.[5] In 1981, the Graduate Medical Education National Advisory Committee (GMENAC) recommended to the Secretary of the U.S. Department of Health and Human Services that 8,000 to 10,000 child psychiatrists be available by 1990 (339). A GMENAC panel estimated, however, that psychiatrists would be needed to treat approximately 25 percent of the mental health needs of children and adolescents, with the other needs being treated by primary care physicians, pediatricians, and other mental health professionals.[6][7] Since then, the advisability of primary care physicians' treating mental disorders has been questioned (260). Thus, OTA concludes that

Table 25-IHS Mental Health Programs Branch User Population, Budget Per Capita, and Mental Health Providers Per 10,000 Population by IHS Service Area, FY 1988

IHS service area	User population	Budget per capita 1988a	Mental health direct care providers per 10,000 population
Aberdeen	78,677	$18.14	4.2
Alaska	88,511	9.86	.9
Albuquerque	62,284	16.83	3.5
Bemidji	44,837	9.83	1.8
Billings	49,800	20.30	4.8
California	39,866	6.00	.2
Nashville	25,022	14.84	.4
Navajo	167,741	10.29	2.5
Oklahoma	217,211	6.15	1.5
Phoenix	75,522	15.34	3.4
Portland	54,059	20.30	3.9
Tucson	19,877	12.56	.5
Totals-all ages	923)407	11.89	2.1
Totals-ages O-19[c]	397,065	NIA	0.4

[a]Calculated on basis of $10,983,340.
b~table 24 for numbers of provders, Ratio of mental health providers to population by area is for all ages,
[c]Figures are not available for ages 10-19.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, Indian Health service, Mental Health Programs Branch, "A National Plan for Natwe American Mental Health Serwces," IOth draft, unpublished report, Rockville, MD, 1989.

GMENAC'S recommended total number of child and adolescent mental health professionals can be increased to between 32,000 and 40,000 in 1990. This estimate remains somewhat conservative in that an oversight panel of GMENAC reduced an original recommended projection of child psychiatrists from 25,000 to between 8,000 and 10,000 in part because of a lack of capacity to train adequate numbers of professionals to treat the large unmet need by 1990" (339).

With an estimated total U.S. child and adolescent population aged O-to 19-years-old of 89.6 million in 1990 (328), OTA concludes that a provider-to-population ratio of 4 to 5 child- and adolescent-trained mental health professionals to every 10,000

[5]One available estimate is from the American Academy of Child and Adolescent Psychiatry, which approximates that 5,000 child- and adolescent-trained psychiatrists alone are currently available in the United States (67). In 1981, the USDHHS NIMH had proposed a survey to determine the number of available mental health treatment professionals in 1981, but the request was refused by the U.S. Office of Management and Budget as having no practical utility for the Federal Government (187).

[6]The panel estimated psychiatrists should see nearly all children with psychoses and those in hospital settings, but only 25 percent of children with neuroses, personality disorders and other nonpsychotic mental illnesses (339). Because very few children and adolescents suffer from psychoses, and because children and adolescents in hospital settings are also treated by mental health professionals other than psychiatrists (323), OTA used an overall estimate of 25 percent of children and adolescents with mental health problems being seen by psychiatrists. The issue of the appropriate professionals to treat adolescents will be addressed in OTA's adolescent health assessment,

[7]The GMENAC panel also attempted to correct for the percentage of child mental health care provided by "general" psychiatrist and for the percentage of adult mental health care that child psychiatrists would provide (339).

children and adolescents is needed. Within IHS service areas alone, this would translate to an increase in child- and adolescent-trained mental health professionals from 17 to between 160 and 200, or at least 1 to 2 for every 1 of the 127 service units.[8] OTA's conclusion concurs somewhat with the IHS's recommendation, except that it substantially more than doubles the current number of direct mental health treatment staff for children and adolescents.

As for a standard percent of expenditures for child and adolescent mental health problems (see table 25), few data are available. Few States are able to disaggregate expenditures for children from those for other age groups; those that were able to do so estimated spending $9 per capita for services specifically for children in 1985 (231). For all ages combined, average per capita expenditures by States averaged $25.30 in 1985 (231). It is important to note that most State spending is for inpatient mental health care,[9] but that private and third-party expenditures for outpatient and inpatient care are not included in State per capita expenditures.[10]

Primary Health Care Services

Most of IHS's budget is devoted to the provision of primary acute health care services (see app. C). Because of the paucity of mental health professionals, primary care practitioners may be the principal source of detection and treatment of mental health problems for Indian adolescents. The extent of such screening and treatment is not known, however. In every IHS service area, medical providers are scarce (323, 324, 87). The ratio of providers to population is well below accepted standards (324,87). This overextension is due to a combination of widespread needs among Indians for physical health care, the fact that II-Ms' financial resources have not increased relative to inflation since 1978, and difficulties in recruiting clinical personnel to IHS service areas.

Even if there were a sufficient number of primary care physicians to treat adolescents with mental health problems, the delivery of mental health services by non-psychiatric physicians is a problem of sufficient magnitude that the 1990 objectives for the health care of the Nation focused on improving this facet of the health care delivery system (333). The National Institute of Mental Health is devoting substantial resources to this problem on a national level (see 260). Yet, little coordinated effort has been brought to bear to meet this objective within the II-M. One exception has been the recent training, funded through the 1986 Drug Omnibus Act, of IHS physicians and other allied health personnel in the awareness, recognition, and treatment of substance disorders (350). However, no systematic evaluation has been undertaken to determine if such training has improved actual practice nor have provisions been made to continue in-service education to reinforce the lessons learned. In addition, these efforts are focused on substance abuse disorders, not other mental health problems. This may be particularly serious with respect to the treatment of adolescents because most physicians report that they do not understand adolescents' problems (43). While this problem is not specific to IHS physicians, IHS physicians come from the same pool of practitioners trained nationally.

Alcoholism/Substance Abuse Program Branch

The Alcoholism/Substance Abuse Program Branch (A/SAPB) of the IHS, originally known as the Office of Alcohol Programs, was established in March of 1978. Title II of Public Law 94-437 (Indian Health Care Improvement Act) authorized the transfer of mature (6 years of operation) Indian alcoholism projects from the administrative jurisdiction of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) to the II-IS. The transition of all (158) Indian alcoholism programs funded by the NIAAA was completed at the beginning of fiscal year 1983. Presently, the IHS funds 309 Indian alcoholism service contracts in Indian reservations and urban communities.

A/SAPB was situated in the Office of the Director until April 1984, when it was placed in the Division of Clinical and Preventive Services in IHS's Office of Program Operations. Organizationally, the A/SAPB consists of seven headquarters positions. three located in Rockville, Maryland, and four in Albuquerque, New Mexico. The administrative staff link with IHS service areas and programs through

[8] The actual number would depend on the child user population in the service unit.

[9] As a result, ambulatory care is believed to be inadequate in publicly funded settings (323).

[10] OTA's adolescent health assessment will estimate the total cost of mental health problems among U.S. adolescents, a figure that will include an estimate of expenditures for mental health treatment services for adolescents.

area alcoholism coordinators. Area alcoholism coordinators, in turn, relate to local-level alcoholism and substance abuse programs through project officers, who may be members of an IHS service unit or area staff.

The most extensive summary of IHS alcoholism programming efforts can be found in Peake-Raymond and Raymond's (249) report that identifies and assesses a series of model projects. Peake-Raymond and Raymond and other reports (e.g., 5,6,57,343) found that virtually no alcoholism services were designed for Indian adolescents and that there was little coordination or continuity of care among alcoholism, social service, and mental health programs.

The A/SAPB is responding to these deficiencies (345,349) (table 26). Recent initiatives, made possible through 1986 Omnibus Drug Act funding, led to the development of a youth services component that began in fiscal year 1987 (349). IHS reports three elements to its A/SAPB youth services component: prevention, outpatient treatment, and residential treatment. In fiscal year 1987, 445 Indian youths were treated as outpatients, and 147 were treated in residential facilities (349). Two 24-bed regional adolescent substance abuse treatment centers were providing services by fiscal year 1988.[11] By the time all residential treatment facilities for substance abuse have been opened, there will be one in each of eight areas (350).[12]

In 1988, IHS reported a commitment to providing services to all Indian adolescents diagnosed as needing alcohol and drug abuse treatment, to providing community-based aftercare to all adolescents and adults hospitalized for alcohol and drug abuse treatment, to fully integrating alcohol and drug abuse treatment services into the IHS health care delivery system, and to funding and evaluating five demonstration projects for innovative Indian alcohol and drug abuse prevention projects (349). IHS concluded, however, that community commitment to change held the key to reducing Indians' alcohol and substance abuse.

Table 26-Overview of IHS Aicoholism/Substance Abuse Program Branch

hh8dS ***identified:***
- ***New,*** more reliable diagnostic tools
- New discharge classification system
- New program models for treatment and prevention
- More specific contract requirements
- Eligibility criteria for services
- Education/training program to ensure competence
- Overall plan to improve program operations

Objectives developed to address deficiencies:
- Standardize development of prevention programs, with emphasis on Indian youth and families
- Standardize and develop a network of community-based treatment services for alcoholics and family members
- Develop a series of research projects on alcohol abuse among Indians
- Develop a system that meets the needs of IHS and Indians for alcoholism data
- Establish standards of care and staffing resource methodology
- Develop evaluation and quality assurance measures
- Provide technical assistance to staff of alcoholism programs, and to all IHS professional staff
- Provide additional resources to projects with the greatest need
- Integrate alcoholism treatment into the overall IHS health care delivery system

SOURCES: **Needs: M.P. Peake-Raymond and E.V. Raymond, "Identification and Assessment of Model Indian Health Service Alcoholism Projects," contract No. 240-083-0100, unpublished report submitted to the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, Rockville, MD, 1984; Objectives: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, Office of Health Programs, "IHS Alcoholism/Substance Abuse Prevention Initiative" (Rockville, MD: 1985).**

Bureau of Indian Affairs

The Bureau of Indian Affairs (BIA) was established in 1824 as part of the War Department and became apart of the U.S. Department of the Interior (DOI) in 1849, when DOI was created. In 1977, DOI established the position of Assistant Secretary for Indian Affairs for the supervision and direction of the BIA.

The BIA works with Indian tribal governments and Alaska Native village communities. It provides educational programs to supplement those provided by public and private schools. BIA assistance also is available for Indian college students, vocational training, adult education, gifted and talented stu-

IITh= were located at the ACL Hospital in San Fidel, New Mexico, and the Cherokee Nation of Oklahoma in Tahlequah.

12Three areas (Bemidji, Billings, Portland) decided to continue to purchase care on a contract basis, some because no Federal facilities that could be renovated existed (350). The Office of General Counsel for U.S. DHHS had advised IHS that funds provided by Public Law 99-570 could only be utilized for renovation or construction of Federal facilities. The Phoenix and Tucson areas will share a facility.

In total, $8.6 million was made available to IHS, and through IHS, the tribes, for renovation, construction, and staffing of residential treatment facilities in fiscal years 1987 and 1988, In fiscal year 1987, a Model Staffing Pattern for a 24-bed facility was developed and distributed to each IHS Area Director for use in approving applications; in fiscal year 1988, because funds were more limited, approximately $350,000 was distributed to each area to develop, with tribal consultation, a mechanism to provide residential treatment to youth in their Areas (350).

dents programs, and single parent programs. Finally, the BIA collaborates with tribal governments to provide a variety of social services, police protection, and economic development efforts.

In recent years, two major laws have resulted in a restructuring of mental health-related BIA programs. In 1975, the passage of the Indian Self Determination and Education Assistance Act (Public Law 93-638; amended in 1988 by Public Law 100-472) facilitated contracting for the operation of education programs by tribal groups. The passage of Public Law 95-561, the Education Amendments Act of 1978 with technical amendments in Public Law 98-511 (Education Amendments of 1984) and Public Law 99-89 (Indian Education Technical Amendments Act of 1985), mandated a major change in the operation of both BIA-operated and tribally contracted schools. The implementation of Public Law 95-561 (Education Amendments of 1978) resulted in decisionmaking powers for Indian school boards, local hiring of teachers and staff, direct funding to the schools, and increased authority for the Indian education programs within the Bureau.

In the 1987-88 school year, the BIA funded a total of 182 education facilities (table 27). BIA education programs furnish BIA-funded schools with curriculum materials and technical assistance to develop and implement alcohol and substance abuse programs, with special emphasis on identification, assessment, prevention, and crisis intervention through the use of referrals and additional counselors at the schools. Boarding schools also depend on a number of BIA personnel, typically social workers, educational psychologists, and special educators, to screen for, intervene with, as well as monitor students who experience social and mental health problems. Much of this effort takes place within the context of the local Intensive Residential Guidance program. In 1988, the BIA reported that 19.2 percent of all Indian children were in BIA-funded schools (359).13

The BIA also funds Indian Child Welfare Act programs that provide a wide range of human services. These services, which are managed by tribes, often address the social and mental health problems of Indian adults seeking to retain or reassume parental responsibility for their children as well as of Indian children subject to the stresses inherent in foster care and adoption. Although the ultimate disposition of the cases is not well documented, Indian Child Welfare workers are known to play a role in identifying abused adolescents in need of mental health services, and in attempting to see that these needs are met (table 28). However, a lack of treatment resources for children and their families was among the barriers identified in a 1989 BIA/IHS Forum on Child Abuse (362) (table 29).

Table 27-Overview of U.S. Department of the Interior, Bureau of Indian Affairs (BiA) Educational Programs

***8/A* operates directly?**
. 57 day schools
. 40 on-reservation boarding schools
. 6 off-reservation boarding schools
• 9 dormitories (to facilitate attendance in public schools)
Operated by tribes with *BIA contracts?*
. ***54*** day schools
• 10 on-reservation boarding schools
. 1 off-reservation boarding school
• 5 dormitories (to facilitate attendance in public schools)
Under Johnson--O'Malley *Act of 1934 (46 Stat. 596), the BIA provides funds:*
For special education for 201,162 Indian students in public schools
Under Education for All Handicapped Chiidren Act* (Pubiic Law 94-142), the BIA *provides funds:
For handicapped Indian students in approximately 25 facilities

[a]Figures for FY 1987-88.

SOURCES: Development Associates, "Final Report: The Evaluation of the Impact of the Part A Entitlement Program Funded Under Title IV of the Indian Education Act," Arlington, VA 1983; and U.S. Department of the Interior, Bureau of Indian Affairs, Report on *BIA Education: Excellence* in *Indian Education Through Effective School Process* (Washington, DC: U.S. Government Printing Office, 1988).

The BIA also plays a major role in the law enforcement and criminal justice systems in many reservation communities. These systems frequently encounter mental health-related issues, such as the detention and diversion of Indian adolescents involved with alcohol and substance abuse, and those who experience serious emotional disturbance. This involvement is likely to increase, as outlined in the joint BIA-IHS Organizational Management Action Plan (361).

Tribal Health Programs

As a consequence of Public Law 93-638, the Indian Self-Determination and Education Assistance Act, many tribes have assumed administrative control of local health programs, either partially or in their entirety. Scopes of work and monitoring are negotiated on an individual basis, leading to consid-

[13]In 1938, approximately 39 percent of Indian children were in BIA-funded beading schools (359).

Table 2&Responsibilities of Local Child Protection Teams

Prow/de oversight:
. Monitor child abuse and neglect activities to ensure adequate preventive, protective, and corrective services are provided
. Review and track alll child abuse and neglect cases which have been referred
. Investigate cases to determine whether the best interests of the children are being met
• Review case plans for their adequacy
. Maintain confidentiality of information
. Send local CPT data to area CPT

Facilitate provtsion of services:
. Receive child abuse and neglect referrals, assign case managers to track cases
. Identify available community resources, programs, and services
• Provide recommendations to various pertinent agencies
. Promote cooperation, communication, and consistency among agencies
. Provide a forum for debating what actions would be best to promote the well-being of Indian children
. Respond to inquiries from the community, area CPT, and other individuals and groups

Provide technical assistance:
• Develop procedures to provide effective and efficient preventive, protective and corrective child abuse and neglect services
• Develop standards to determine which cases are to be investigated
• Provide information and technical recommendations to decisionmaking agencies
• Educate communities about child abuse and neglect problems and solutions
• Identify danger signs which prompt intervention and/or preventive actions
• Assist in the development and implementation of plans to promote long-term well-being of children and their families
• Assist in the development and implementation of strategies bv communities to create environments which provide opportunities-ties for community members to lead meaningful, productive, self-fulfilling, and rewardinag lives

SOURCE: U.S. Department of the Interior, Office of the Secretary, Assistant Secretary, Indian Affairs, and Director, Indian Health Service, Washington, DC, "Establishment **of Child Protection Teams and Mandatory Child Abuse and Neglect Reporting and Referral Procedures," memorandum to ail BIA Area Directors, all BIA Area Education Programs Administrators, and all IHS Area Directors, signed Apr. 2, 1987.**

Table 29--Barriers to Effective Chiid Protection Services

Prevention Is not a priority:
. health promotion/disease prevention are low priorities
. alcohol substance abuse prevention lacking
• worker time is consumed in crisis management

Community barriers:
. lack of awareness/denial
. lack of community education
• Prevalent alcohol ldrug abuse
. lack of alcohol/drug abuse prevention treatment
. voice from tribal leadership for child advocacy missing
. lack of treatment resources
. interference in tribal court proceedings

Disorganized chiid abuse management:
• suspected cases are not always reported
• register and tracking system not in place
• mutually agreed procedures are not established
• unauthorized release of confidential information
• lack of agreement on definitions
• no local interagency memorandum of agreement
• lack of communication between workers; no team case manager not identified
• delayed investigations
• delayed prosecutions
• cases submitted to tribal courts after Federal declination
• inconsistent and unsympathetic investigators/prosecutors
• inadmissible evidence
• unclear team leadership
• dysfunctional team
• uncertain information exchange
• decisions not clearly documented
• failure to develop and mandate treatment plans for dysfunctional families
• violations of Indian Child Welfare Aot (ICWA)
• statistical surveillance is inconsistent/cumbersome

Inadequate chiid protection services:
. ***lack*** of foster homes (especially Indian/Native) in home communities
. lack of emergency shelter for children
. unacceptable foster homes
. ICWA grants are competitive
. unavailable treatment in home community
• insufficient staffing due to: lack of funds, unfilled positions, staff turnover, staff burnout
• inadequate staff expertise: lack of appropriate specialists, lack ongoing training programs
• excessive staff workfoads
• insufficient mental health treatment resources

SOURCE: U.S. Department of the Interior, Bureau of Indian Affairs, and U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, National Oversight Committee on Child Protection, "Forum on Child Protection in Indian Country: A Report," unpublished report, April 1989.

erable variance in reports of program activities and services. A recent analysis by the IHS Office of Health Program Development (OHPD) provides one of the few, albeit limited, overviews available of this system of care (344).

OHPD identified 174 tribal health programs that received substantial IHS funding under Public Law 93-638 in fiscal year 1985 programs. Eighty-five percent (148) of the existing programs completed and returned the profiles. Approximately 42 percent of the tribal health programs reported providing mental health services, but only 3 percent of tribal health staff worked in mental health services, indicating limited provision of such services (table 30). Ten percent of the tribal health programs reported that mental health services were not available at all. Programs were not asked about mental health services specifically for adolescents, but the paucity of mental health staff suggests that adolescents would not be provided adequate mental health care.

Table 30-Overview of Tribal Health Programs[a]

Eligibie population:
. Total IHS support was $206.5 million
. Tribes received another $31.6 million from other sources
• $23.7 million from IHS **was** earmarked for alcoholism programs
c $28.5 million from IHS was dedicated to community health programs

Percent of tribai community heaith programs providing specific services:
. ***75.2%:*** alcoholism
• 64.7°/0: drug abuse
. 50,50/.: social services
• 85.7°/0: outreach and referral
• 64.9°/0: health education
• 54.8°/0: home health
. 50.0°/0: community health nursing
. 41 .7°/0: mental heafth

Maental heaith services:
• Are reported as totally not available by nearly 10°/0 of programs
. 22?% of the programs provide mental health services through IHS
. 10.2% of the programs provide mental health services through contract care

Staff (fuii-time equivaient):
. 13.5% work on alcoholism/substance abuse programs
• 3.10/0 work in mental health
• 2.9°/0 Work in social service

aFigUreS repre~nt self-reporting by 148 tribal health programs; this represents 850/. of all tribal health programs in the United States.

SOURCE: U.S. Department of Health and Human **Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, Office of Health Program Development, "Final Report: Descriptive Analysis of Tribal Health Systems,' May 1987.**

Urban Indian Health Programs

In 1972, the IHS began to fund urban programs through its community development branch under general authority of the Snyder Act. Since then, 42 different projects have received financial support from IHS. The Indian Health Care Improvement Act of 1976 authorized urban Indian organizations to contract with IHS to operate health centers and to increase Indian access to public assistance programs. There are currently 35 urban Indian health programs that encompass 40 urban areas in 20 States. A recent study by the American Indian Health Care Association (AIHCA) (11) provides insight into the nature and scope of these programs, although the data are not specific to adolescents (table 31).

Urban Indian health projects are different from IHS reservation-based clinics in their emphasis on increasing access to existing services funded by other public and private sources rather than providing or paying for services directly. However, their single largest source of funding is the IHS Urban Indian Health Program. This source of funding is followed by some IHS funding for categorical services such as alcohol and substance abuse services. Urban Indian health programs have not been eligible for mental health funding through IHS, however, because such funds are used only to provide mental health services to Indians remaining on or near reservations. This creates a problem for the large percentage (estimated to be about 50 percent [322,355]) of American Indians who live in cities, as they have severely limited access to culturally specific mental health services.

Many smaller urban Indian health programs offer mental health services as part of primary medical care; mental health problems that cannot be managed by the primary care provider are referred to outside resources. Other urban programs receive categorical funding for substance abuse or child welfare problems, and address mental health problems within the context of these services. Still other, larger urban programs are able to provide a range of onsite mental health services with funds received through such sources as mental health Block Grants and community mental health center funds. On average, expenditures for mental health services represent about 3.8 percent ($600,000 per year) of all ambulatory health services provided by urban Indian health programs.

As is evident in table 31, the mental health counseling needs that urban Indians present are not those which respond to short-term, crisis-oriented counseling. Among these needs are child abuse and child behavioral problems. Each of the 35 urban Indian health programs surveyed by AIHCA identified mental health needs among their client populations that could not be addressed for lack of staff, funding, and referral sources. Between 1985 to 1987, the total number of onsite mental health providers ranged from 15 to 20 for all urban programs, representing less than 4 percent of the entire staff. During this period the average number of users per full-time provider more than doubled, and the number of visits per provider also increased. Several of the respondents in the AIHCA study reported that available services are of poor quality and that waiting periods for services are excessively long.

Table 31-Overview of Urban Indian Mental Health Programs

Mental health expenditures:
. Have remained about 4°/0 ($600,000 per year)
. Expenditures were up in 1986 due to one-time grants to three programs
c Per person expenditures declined by almost 50%from 1985 to'1987
. Per visit expenditure declined about 10% in that same period

Usageof mental health services
. Ranged from a low of about 10,000 contacts in FY 1985 to a high of about 22,000 in FY 1984
. In 1987, there were 12,000 mental health encounters
• Follow-up declined from 6.2 per user in 1985 to 3.8 per user in 1987
. While usage was up dramatically, funding and staff did not increase; this may explain the decline in follow-up visits

Mental *health services offered (in descending orderof frequency):*
• Referral to outside agencies (most frequent)
. Drug and alcohol abuse services
. Child counseling
. Community outreach
. Marital counseling
. Domestic abuse counseling
. Various group counseling services
• Group support
• Psychological testing
. Family counseling
. Crisis intervention

Mental health problems encountered, in descending order of tiequency
• Drug and alcohol abuse
• Cultural adjustment issues
• Family problems and dysfunction
• Child abuse, depression, and low self-esteem
• Domestic violence
• Spousal violence
• Poverty
• Anxiety
• Child behavioral problems
• Suioidal tendencies
• Unemployment
• Stress
• Grief
• Racism

Staff (in descending order of frequency):
• M.S.W. social workers
• Drug and alcohol counselors
. B.S.W. social workers
. M.S. psychologists
. M.S. counselors
. Ph.D. psychologists
. Psychiatrists
• Prevention specialists
. Indian Child Welfare counselors
. Interns

SOURCE: American Indian Health Care Association, "Mental Health Services Delivery: Urban Indian Programs," St Paul, MN, 1988.

State and Local Service Agencies

Very little information exists about the extent to which such local agencies as community mental health centers and State psychiatric facilities serve Indian communities. It seems fair to assume that numerous Indian people obtain care from these settings, especially in urban communities. However, the diverse points of entry into this system—e.g., State hospitals, day treatment centers, Social Security Administration, the criminal justice system, detoxification facilities, and vocational rehabilitation centers—yield a confusing and often unmanageable set of service use data. For exampie, in the State of Oregon alone, there are over 30 service agencies that potentially may see emotionally disturbed Indians (244). A recent survey by Denver Indian Health and Family Services, Inc., an urban Indian health program, revealed that 71 municipal, county, State, and private agencies offered mental health services within the immediate metropolitan area (75). Less than 40 percent of these agencies' patient information systems track ethnicity, although virtually all of them (91 percent) answered affirmatively when asked if they could recall having had an Indian patient in care during the month prior to the survey. This is not, of course, an indication of the extent of care available to Indians from non-IHS agencies.

Though established in part for the purpose of reaching high-risk minority populations, community mental health centers (CMHCS) tend to underserve them (386). This occurs even in catchment areas that have significant numbers of non-White residents. American Indians, in particular, appear to use these facilities far less frequently than other segments of the American population (302,303,381). Sue (302), in a 3-year survey of 17 community mental health centers in Seattle, Washington, reported that 55 percent of the Indian patients seen were highly unlikely to return after the initial contact. This was a much more significant non-return rate than that observed for Black, Asian, Hispanic, or White patients. Information specific to adolescents is not available.

MENTAL HEALTH TREATMENT SETTINGS AND SERVICES AS ADAPTED TO AND BY AMERICAN INDIANS

Treatment Settings

There is a consensus that a well-integrated, community-based continuum of services could improve the mental health of children and adolescents (301,323). This consensus applies as well to Indian and Native communities. An array of treatment settings is needed to promote more rapid movement to less restrictive environments and to decrease reliance on more expensive forms of treatment. Graduated, transitional aftercare programs in the community can sustain and enhance therapeutic improvement.

In discussing the array of treatment settings, however, it is important to distinguish between the needs of the community as a whole and each individual. Communities may require the full array of treatment settings in order to meet the diverse needs of individual adolescents. Only the most disturbed individuals will require the full array of treatment settings, from psychiatric hospitalization to aftercare services. If treatment is effective and made available in time, less restrictive alternatives such as outpatient care may be sufficient, although they may be required on a continuing basis. A general principle of mental health care, especially for children and adolescents, is that it be provided in the least restrictive setting (323).

From the community perspective, and sometimes from the perspective of the individual, a continuum of settings includes, at a minimum, inpatient treatment in a psychiatric hospital, a residential treatment center, a partial hospital program, and an outpatient service. Conceived more broadly, the continuum encompasses a wider range of services, especially those involving child welfare, such as therapeutic foster and group homes and home-based interventions. Other possibilities include structured recreational activities, before- and after-school programs, case management, and respite programs. *4

Each element in the continuum performs a special function and employs different admission criteria. For example, typically psychiatrists and nurses in psychiatric hospitals diagnosis and treat patients who are extremely disturbed and require intensive mental health intervention. Hospitalized patients often attempt, threaten, or contemplate suicidal or assaultive behaviors, although adolescents may be hospitalized for much less serious disturbances (e.g., running away from home, experimentation with drugs). Hospitalized patients may also suffer from severe cognitive, behavioral, and/or affective disorders that preclude independent functioning in the home, school, or community. The psychiatric hospital can provide specialized diagnostic services, facilitate the stabilization of medication regimens, and introduce therapeutic leverages that are lacking in less restrictive settings.

Residential treatment centers also provide 24-hour supervision, but usually serve more chronic patients who are either less severely disturbed or already stabilized in their treatment. Limited psychiatric or nursing care is available; neither close observation nor individualized care are typical. Patients are not actively suicidal or homicidal, though the potential may exist. They generally do not pose a significant danger to themselves or to others.

Partial hospitals offer special schooling and a structured, intensive, therapeutic milieu to patients who are able to live at home. Such settings are not designed to manage assaultive or suicidal adolescents, or those who may need seclusion or restraint. Families or guardians are expected to support the child's treatment and provide transportation on a daily basis.

Outpatient care enables children to remain in or return to their families, schools, and communities while continuing to progress or maintaining gains achieved through other therapeutic settings. Outpatient care can be provided in publicly funded clinics, the offices of private practitioners, and in comprehensive, youth service centers (e.g., 73).

For adolescents, a recent innovation has been to provide mental health services in or immediately adjacent to schools, thus making the services more immediately available and accessible (59,90,227). Because of limited funding and the wide range of services that school-linked youth services centers attempt to maintain, the mental health services available are often limited. However, when pro-

[14]For more detail, see U.S. Congress, OTA (323).

vialed, they have proven to be one of the most sought-after of the school-linked health services, and through them, schools have uncovered numerous mental health problems that previously had gone undetected.

A comprehensive continuum of care also augments more traditional mental health programs through ancillary services. Therapeutic foster homes are operated by specially trained and clinically supported couples who serve in parental roles for several foster children. Such homes offer a highly structured living environment that is well suited for younger children whose major needs include stability, security, and nurturance.

Therapeutic group homes are better suited for older adolescents. They live together with perhaps 10 to 12 peers and a trained couple, who function as adult role models and staff. Like therapeutic foster homes, group homes provide a living environment that falls somewhere between institutional and family care. Both foster homes and group homes may serve as the child's or adolescent's primary form of treatment, or may work in tandem with partial hospitalization or outpatient care.

Home-based interventions introduce treatment directly into the family setting. Generally supportive, directive, and practically oriented, home-based interventions are usually indicated for highly disorganized, hard-to-reach families who will not participate in office-based therapies. Home-based interventions may be used alone or in concert with other elements of the continuum.

Although the continuum of care just described is the ideal, the general paucity of treatment options for Indian children has been a recurrent theme over the last two decades. Schools and social service programs seem to play more prominent roles than in non-Indian communities but the major setting for treatment is clinic-based outpatient care. Innovative home-based and group home interventions are much less common, but still in evidence (276). Intensive care in residential treatment centers and partial as well as full psychiatric hospitalization is almost nonexistent. Such intensive care requires the mobilization of extremely scarce resources, poses significant transportation problems, and almost always removes the child or adolescent entirely from family, community, and the other supports.

An equally serious problem in these communities is the fragmented and discontinuous nature of care within and across treatment settings, regardless of their scope. In part, this lack of coordination springs from the rural, isolated environments typically associated with Indian communities. However, disciplinary, institutional, and jurisdictional barriers may pose even greater barriers. Within the IHS, for example, collaboration between mental health and alcohol programs is rare, because of different perceptions of illness and competing philosophies of care. Well-coordinated efforts among IHS, BIA, and tribal agencies are also the exception. Interagency rivalries, differing views of accountability, different eligibility requirements, and incompatible program goals often undermine necessary working relationships. Mistaken assumptions about jurisdiction and governmental obligations impede ready access to the treatment settings. Perhaps one of the toughest challenges that faces any attempt to develop a coordinated continuum of care is to blend and coordinate community resources and talents with those of the mainstream systems of care provided directly by II-IS and other agencies. None can stand alone in meeting the mental health needs of Indian children; together, they hold considerable promise for maximizing the impact of the available care.

Therapeutic Interventions

A wide array of types of therapeutic interventions is in use in American Indian and Alaska Native communities today. In planning for a broadly based mental health program, it may be helpful to understand the major categories of approaches to therapy, some typical forms of each, and their relative strengths and liabilities. Unfortunately, despite increasing efforts to offer much needed care to Indian youth, very little is known about the availability or effectiveness of these services. Systematic evaluation is virtually nonexistent; even careful description of content, form, and related aspects of process is rare. In order to get a sense of the range of therapies being used in Indian communities, OTA searched the social, behavioral, and health sciences literature, including fugitive documents such as program reports and organizational newsletters. Descriptive information obtained from these sources is included in the following discussion. A more general treatment of these therapeutic interventions can be found in the reviews by the U.S. Congress, Office of Technology Assessment (323) and the Institute of

Medicine (144).1s Where the effectiveness of specific treatments has been evaluated, it is noted in the discussion.

Psychopharmacology

In their comprehensive review of recent developments in psychopharmacology for children and adolescents, Campbell and Spencer (54) concluded that many questions remain unanswered in regard to the efficacy and safety of numerous medications (also see 144,323). Much work needs to be done with respect to optimal drug choices for treating such illnesses as schizophrenia and depression. Nonetheless, psychopharmacological forms of intervention are being employed with increasing frequency among adolescents in the non-Indian population. Though potentially beneficial, the use of medications with Indian adolescents deserves close study especially since Indian patients taking psychotropic drugs frequently receive their prescriptions from primary care physicians and often are not seen by mental health and/or social service providers (124). Medication is most effective when taken in the context of a psychotherapeutic relationship (323).

Individual Psychotherapy

If any single therapeutic modality can be said to be the mainstay of mental health treatment, it is psychotherapy. The relationship between a therapist and client or patient is the best known means of treating mental health problems, although there is a great diversity in the approaches psychotherapists use. These include psychoanalytic, behavior and learning theory-based approaches, and supportive and client-centered approaches. A great variety of approaches or schools of psychotherapy can be found in Indian and Native communities.lb

Psychoanalytic Therapy—Devereux's description (77,78) of his work with Plains Indians, though dated, remains the most significant discussion of the psychoanalytic approach to individual psychotherapy although it was not specific to adolescents. He focused on issues pertaining to transference, to dreams and visions, and to therapeutic objectives. Devereux recalled examples of each of these issues from his own practice and demonstrated how the correct interpretation of, as well as the response to, transference behavior among Plains Indians requires an understanding of their familial roles and patterns of social interaction. Boyer (45), Jilek-Aall (149), Duran (91), and others have written more recently about various aspects of psychoanalysis with American Indian patients, sometimes adolescents, but they do not approach Devereux's description and explanation of the inherent therapeutic dynamics.

Psychoanalytic thought has given rise to a number of other schools and techniques of psychotherapy, including transactional analysis, gestalt therapy, and existential therapy. These approaches are practiced, usually infrequently, in Indian communities. None, unfortunately, has occasioned any written accounts of their application with Indian adolescents or adults.

Behavioral and Learning Therapies—Several well-known interventions with Indian adolescents have been based on behavior modification. Goldstein (114) described a program implemented in a BIA boarding school that employed dormitory counselors to reshape problems of student living using reward, mild punishment, desensitization, discrimination learning, and extinction techniques. His experience underscored the need to understand culturally meaningful contingencies and to draw on natural reinforcers that are specific to the social ecology. Galloway and Mickelson (110) reported another school-based program that sought to modify North Carolina Indian children's "passive resistance to adults, withdrawal in the face of threat, and peer orientation with a subsequent lack of attention to adults" (p. 150). They recognized that such behaviors are deeply rooted in the cultural rearing of the children, but argued that their academic success depends on the ability to act in accordance with mainstream classroom expectations. The highly structured intervention, which used material and

[15]These sources do not separate children's services from adolescents' services. The U.S. Congress, Office of Technology Assessment will be addressing mental health services specifically for adolescents in its forthcoming full report on adolescent health.

[16]There is wide diversity of opinion about the effectiveness and fundamental characteristics of psychotherapy. A decade ago, studies appeared to demonstrate that the process of psychotherapy depended not on the learning and formal training of the therapist, but on personal characteristics such as genuineness, warmth, and empathy (172). Therapeutic orientation seemed to make no discernible difference in the overall course of treatment. Indeed, studies of the time supported the contention that formal training makes little or no difference to therapeutic outcome, and that untrained people with warmth, genuineness, and empathy produce, overall, as good or better results than trained therapists. The last decade has modified these conclusions; a number of psychotherapeutic interventions have been shown to be effective for specific problems (323,374). However, considerable work remains to be done on the effectiveness of individual psychotherapy with adolescents (144,323). Almost no systematic research has been done on the effectiveness of individual psychotherapy with Indian adolescents.

social reinforcements, extinguished the undesirable behaviors and gave rise to behaviors valued by the teachers. The authors, however, highlighted another major issue that may arise in using behavioral therapies with Indian adolescents. They found reason to be concerned that such changes may extend beyond the situations for which they were originally intended, thereby engendering conflict in other social arenas such as families and communities.

Thus, there are potential disadvantages, as well as advantages, to using behavioral and learning theory-based therapies with Indian youth. Behavioral therapies tend to pay little attention to internal states or feelings, usually require a high level of motivation and activity, and are seldom satisfying intellectually. Consequently, some clinicians report that such behavioral techniques meet marked resistance with many Indian patients who hold strong cultural beliefs that will and intellect can master mood and behavior. For these reasons, cognitively based therapies tend to be more easily accepted by Indian adolescents. The relatively new school of cognitive therapy (see ref. 323), for example, assumes that internal thought models about people, relationships, and events give rise to actions and feelings. The therapist and the patient attempt to develop new ways of conceptualizing events and relationships in order to counteract cognitive models that lead to maladaptive thought and behavior.

Supportive and Client-Centered Psychotherapy— Supportive and client-centered therapies are linked more by their use in the field then by their ideological roots. Supportive psychotherapy evolved in the context of the psychoanalytic movement, as a vehicle for caring for patients too ill or incapable of forming the relationships necessary for psychoanalytic or insight-oriented psychotherapy. Client-centered psychotherapy, in contrast, was developed by Carl Rogers, a psychologist, as a reaction to the "medical model" of mental health espoused by behaviorists, psychoanalysts, and some psychiatrists (130).

Supportive and client-centered techniques tend to merge in practice. Supportive psychotherapy is not intended to produce change in the patient through the therapist. Instead, the objective is to make the patient feel better about him-or herself, and to provide gentle help and advice about activities of daily living. The therapist assists the patient's return to a prior functional level, and helps him or her to learn to tolerate difficult situations.

Client-centered or "Rogerian" therapy is predicated more explicitly on the relationship between the client and the therapist. Unlike psychoanalytic psychotherapy, the aim is for the patient to experience the therapist as a genuine, accurately empathic, caring person, who reflects the patient back to him-or herself. Rogerian therapy is built around a number of concrete interviewing techniques that almost all trained therapists learn at some point.

Taken together, these two forms of therapy are often employed by beginning therapists and those who practice in difficult and uncertain situations. Those most likely to respond to supportive and client-centered therapies typically are at risk for deterioration as the result of more severe illnesses, or suffer from situational problems and normal grief.

Clinical observation suggests that supportive and client-centered therapies are probably the most common of all the different techniques in use in Indian mental health programs. An overwhelming number of young Indian people experience situational problems and grief. Consequently, these techniques may be initially appropriate for most of them who are seen in Indian mental health programs. In addition, relatively little training is required to provide either type of intervention. However, supportive therapies by themselves may be ineffective for some patients, and some clinicians believe that political safety may be one of the more disconcerting reasons for the popularity of these therapies in Indian communities. In some other therapies, a patient may become angry with his or her therapist as a normal part of the therapeutic process. The supportive therapist is not required to do anything that might endanger his or her standing in the clinic or in the community.

Group Psychotherapies

As Edwards and Edwards (93) noted, the use of group therapy is growing in programs that serve Indians and Natives, as it is in many public mental health settings. One explanation of this trend is that it is an outgrowth of the natural emphasis on groups in the social ecology of most Indian communities. Another explanation is the low cost of group psychotherapy compared to individual psychotherapy.

This relatively new movement contrasts sharply with prior assertions that group psychotherapy is inapplicable with American Indians and Alaska Natives. These assertions stemmed from three assumptions. First, Indians have been stereotyped as being stoic and silent. Second, it was presumed that an unspoken solidarity among Indians would preclude the involvement of non-Indians as either fellow patients or group leaders. Third, it was believed that Indians' social norms, which disapprove of setting oneself apart from others, would repress the therapeutic expression of fear, weaknesses, or problems. An increasing number of examples of the apparently successful adaptation of group approaches in the treatment of young Indian and Native patients suggests otherwise. As with other forms of mental health treatment for Indian adolescents, group psychotherapies have not been systematically evaluated. It may be important to note that most of these group psychotherapy described here is not group psychotherapy in the traditional sense, but consists more of support and self-help groups.

Single Issue Groups—Probably the most common form of group therapy in Indian communities is the support group organized around a single issue or topic. The format is often mixed, incorporating lectures on various aspects of the primary topic, testimonials, and support for troubled members. The group provides a context for mutual help and protection even outside of formal meetings, a tendency that is often discouraged in non-Indian therapy techniques. This model is one of the most rapidly growing therapeutic movements in Indian mental health today, and assumes a variety of forms in these communities.

A large number of single-issue support groups currently focus on parent-child relationships (table 32). Adolescent parents and parents of adolescents can participate in the more generic groups (193), but few groups are focused specifically on adolescents, either as parents (except see Salt River Pima-Maricopa) or children (except see United Tribes Educational Technical program for parents of students at tribal boarding school).

There are also therapeutic groups organized around specific problems such as sexuality abused adolescents, rather than general psychosocial issues. Ashby, Gilchrist, and Miramontez (13) chronicled the development of a therapeutic group for Indian females who were experiencing problems of self--esteem and difficulties in relating to peers and/or adults. Wolman (385) described and analyzed the interpersonal dynamics of group therapy with late adolescent and young adult male and female Navajo alcoholics at a treatment ward in the Gallup (New Mexico) Indian Hospital. Merrill (224) systematically tested the effects of group therapy with Indian teenagers who exhibited significant symptoms of depression, anxiety, and substance abuse. Other popular types of support groups can be found in school settings and involve Indian youth at risk for a range of mental health problems (see table 33).

Currently the greatest impetus for single-issue groups among American Indians and Alaska Natives stems from the rapid growth of alcoholism programs. Anecdotal observations attest to the value and utility of these techniques. Systematic outcome research to determine the nature and extent of their efficacy has yet to be conducted and very few of them have been extended to Indian adolescents.

Self-Help Groups

Unlike other mental health interventions, self-help groups do not use a therapist. Rather, the group is organized and directed by its members, often helped initially by someone with a mental health background. Group members generate their own therapeutic movement and support, usually according to a set of known rules or principles. Self-help groups of many sorts operate in Indian communities around a wide variety of problems. Sexual abuse victims, children of severely mentally ill parents, and surviving relatives of suicide victims are among the most frequent types of local self-help groups. The Navajo Nation supports peer self-help groups which include tribal youth aged 12 to 25 many of whom have histories of abuse and/or neglect. The purpose of groups is to enhance the participants' self-esteem and to help them to feel more confident, but these groups have not been evaluated.

Family Involvement in Therapy

Family therapy is common in non-Indian mental health programs. It is a way to help disruptive families and thus their adolescent children or to help adolescents or their own families. However, family therapy is not nearly as common in Indian communities (15,101,1 36). Clinicians have observed that it is difficult to obtain the participation of all relevant family members or couples in the treatment process,

Table 32-Single Issue Groups for Parent-Child Relationships

Tribe/agency	Program	Participants	Focus	Format
Salt River Pima-Maricopa	Teenage Parents Support Group	Teen parents and significant relatives	Well being of teen parents and their children	Individual/group counseling and group activities; parent instruction
Yavapai Prescott	Parenting Education	Parents and children	Non-abusive child behavior management	Behavior management; Self-esteem/actualization
Colorado River Indian Tribes	Parental Support	Parents	Family management, parenting, job-search skills, goal development	Support groups and parent aides
Fort McDowell Mohave/ Apache	Parenting Skills (Two-part program)	Parents	Part One: Home/ Behavior Management Part Two: Parenting skills training	In-home parent aides and classroom instruction
Pima/Maricopa	Parents Are Teachers	Mothers and children	Self-reliant mothers being a positive force in children's lives	Twelve-week training that both mothers and children attend
Shasta County Schools	Child Care Referral and Education	Parents	Parental control and involvement in schools	In-home outreach workers and support groups
Cook Inlet Native Association	Parents in Need of Special Services (Two-part program)	Parents	Decrease parental neglect and abuse	In-home family aides and weekly group meetings
Fort McDowell Mohave/ Apache	Titie II Child Welfare Program	Parents	Recognition and reduction of child behavior problems	Six-week course and monthly community education meetings
Michigan Indian Child Welfare Agency	Intensive Parent Aide Program	Parents and foster care parents	Promote family stability and basic parent education	Parent aides and support groups
Minnesota Souix	Group Parent Training Program	Parents	Parenting skills	"Systematic Teaching of Effective Parenting" (STEP)
Phoenix Indian Center	Parent Support Groups	Parents	Parenting skills	Weekly sessions incorporating traditional values
Red Cliff Band Lake Superior Chippewa	Parent Training Program	Parents	Parenting skills	Support groups using local tribal members as facilitators
Shoshone-Bannock	Parental Training for Pre-school Children	Parents	Child development and behavior modification	In-home and group meetings dealing with social and traditional values
United Tribes Educational Technical	Parent Effectiveness Training (PET)	Parents of students at Tribal boarding school	Parenting skills	Twenty-hour/twelve-week group training
Urban Indian Child Resource Center	Positive Parenting	Parents	Parental communication	Two-hour/six-week group sessions
Vern Jackson Receiving Home: Warm Springs	Basic and Advanced Parenting Skills	Parents	Culturally relevant parenting skills	Eight- and six-week group sessions

SOURCE: Office of Technology Assessment, 1990.

especially adult men. Yet, as summarized in table *34*, at least five programs have adapted such techniques to local Indian families as part of their services to families at risk. Two of the programs focus on troubled adolescents (Warm Springs, Navajo Area Office), but none of the programs have been evaluated for their effectiveness.

Network Therapy and Related Techniques

Attneave (14) was the first to suggest that therapy with American Indians and Alaska Natives ought logically to proceed within the context of the extended family. The family and kin relationships of Indians and Natives represent their most potent and lasting socializing influence (257,281).

Table 33~Single Issue Groups for Indian Youthat Risk

Tribe/agency	Program	Participants	Focus	Format
Indian High School	Support for teen girls at risk	Pregnant adolescents	Child care/parenting with parent and roles	Classes/experience in day care, etc.
Various	Counseling for children at risk	4th, 5th, and 6th graders from dysfunctional alcoholic families	Dealing with feelings of abandonment	Individual and group counseling
Tohono O'odham	Reservation school group therapy program	Potential school dropouts	Decrease arrests, school absences, and dropouts	Paid to participate in group therapy
Navajo, Zuni, Oglala Sioux, Great Lakes Inter-Tribal Council	Foster grandparents	Tribal elders and needy, troubled, disturbed, and disabled Indian youth	Retention of culture	Individual and group instruction in native songs, danoe, crafts, and customs

SOURCE: Office of Technology Assessment, 1990.

Network therapy is useful in precisely the kind of complex social networks that exist among the agencies and extended families that occur in Indian/ Native communities. It is particularly appropriate for troubled, multiple problem families.

Several recent efforts to apply family-network intervention with American Indians stand out. One, described by John Red Horse (258), involved mobilizing the extended families of Indians in crisis to assist in problem-recognition and problem-solving, to work through role conflicts, and to provide a collective form of therapeutic support. Other examples of the application of family-network intervention with American Indians can be found in Yvonne Red Horse's work (259) with young, pregnant, unmarried Indian adolescents. Neither of these programs have been evaluated. The difficulties with this form of intervention include expense arising from the number of professionals that it takes to accomplish the therapy and the fact that few therapists are trained in this technique.

Recreational and Outdoor Therapy

Recreational and outdoor therapy provide good opportunities for older children and adolescents to confront relationship issues with their peers, to master new and unfamiliar situations, and to establish constructive relationships. Recreational therapy is practiced in a variety of ways.

One distinction is between competitive and noncompetitive forms of recreation. Competitive sports teach some lessons about adulthood and the need to work cooperatively with others. However, unless great care is taken, competitive sports can tend to diminish the self-esteem of children and adolescents who are uncoordinated, or who are inept at acquiring group membership. Noncompetitive sports and outdoor programs offer several therapeutic advantages over competitive activities. By challenging one's self or nature, the adolescent learns valuable lessons about personal mastery and self-efficacy.

Examples of both competitive and noncompetitive recreational therapy are numerous in Indian communities (30). There is little evidence, however, to document the outcomes of these forms of therapy. Generally, recreational and outdoor therapies are nonspecific in their effects and are not central to the treatment of seriously emotionally and mentally ill adolescents. Such programs can, when used improperly, exacerbate an adolescent's problems and may provide the greatest benefit to those least in need (297). However, in the context of an overall treatment plan there may be a place for them to improve the functioning of children and adolescents, and as a tool for promoting physical health.

Traditional Indian Therapeutic Interventions

Many traditional Indian and Native healing practices are gradually being incorporated into contemporary approaches to mental health treatment of Indian adolescents (81). Indeed, there is increasing collaboration between health care providers and traditional healers. However, this collaboration has not been without the kinds of problems that one would expect from any cross-disciplinary effort (189). Several traditional therapeutic strategies have received considerable attention and invited attempts at integration into approaches to intervention with Indian adolescents: the four circles, the talking circle, and the sweat lodge (196).

The four circles refers to a symbolic process that uses a series of concentric circles to visualize and analyze the significant relationships in one's life. This approach is commonly used in counseling troubled youth among Northern Plains communities.

Table 34-Family Involvement in Therapy

Tribe/agency	Program	Participants	Focus	Format
Minneapolis Indian Health Board	Family Mental Health Program	Traditional elders; representatives of major tribes; families in crisis	Prevent breakup of families by Child Protective Services	Rituals, ceremonies, traditional healing practices, POW WOWs; routine crisis Counseling/case management; use of extended family for child placement; comprehensive network review model
Yakima	Nak-nu-we-sha	Indian paraprofessionals, abused children and their families	End inappropriate removal of abused children from their kinship system; halt adoption of children off the reservation; increase community awareness of child *use/ neglect; develop positive alternatives to abuse/neglect	Foster care, medical counseling and receiving home services; case management; coordination of community resources and services with focus on the family. Intensive casework and advocacy services
Warm Springs Confederated Tribes	Whipper Man	Troubled children and adolescents	Reduce adolescent jail time; reduce off-reservation referral for foster care	Tribally operated group home; short- and long-term placement counseling; intensive outreach family counseling; out patient followup and case management
Salt River Pima/Maricopa	Family Support Program	Parents from community acting as parent advocates	Family crisis intervention. Providing culturally appropriate role models to families	During crisis, advocates spend time in homes of in-need families, doing counseling and assessment
Navajo Area Office, Indian Health Service		Depressed Navajo adolescents and their extended families	Treatment of depression and family dynamics	Weaving together of traditional. Navajo medicine with typical therapeutic tasks of family-based interventions

SOURCE: Office of Technology Assessment, 1990.

The talking circle is a unique form of group therapy and is a part of many Indian treatment programs. For example, in 1984, the Phoenix Indian Center began to use talking circles to help urban Indian families cope with child abuse and neglect (128). Between 1984 and 1988, more than 5,000 persons participated in the Indian Center's circles, and demand increases steadily. Other well-known examples include the Seattle Indian Health Board's program for street youth and the Native American Rehabilitation Association's youth alcoholism treatment program in Portland, Oregon.

The sweat lodge, best likened to a sauna that combines individual prayer and group therapy, has been incorporated into a number of IHS alcoholism and mental health treatment programs (127).

The IHS has not fared well in past efforts to admit traditional Indian psychotherapeutic interventions into its daily operations, Thus, such interventions are more characteristic of tribal programs contracted through the 638 mechanism.

Approaches Integrating Traditional and Western Techniques

A relatively new and apparently promising approach to improving the mental health of Indian adolescents (and Indian adults) is to combine both western-style professional mental health care with traditional Indian approaches. Written materials, although no rigorous evaluations, are available concerning programs implemented on the Salish-Kootenai Indian Reservation in western Montana (62,100,101). Three components distinguish the Salish-Kootenai approach:

- . a strong clinical component using mainstream mental health care providers;
- . a cultural program using tribal elders, meetings in long-houses, and a cultural specialist; and
- • coordination with other community programs (62).

In an earlier youth-specific component of the program, young Indians chosen from the local mental health program participated in a class organ-

ized around cultural activities such as beading. Tribal elders taught traditional values and an experienced psychologist provided client-centered psychotherapy (100,101).

The Salish-Kootenai program is regarded highly by both the tribe (62) and the IHS (236), and similar approaches have begun to be used around the country (102). Such techniques may play a major part in Indian mental health programs of the future, especially for adolescents at high risk of mental health problems as a consequence of alienation and cultural adjustment problems. However, clinicians have expressed concern that efforts like this represent a highly sophisticated form of intervention that should not be confused with the extensive array of cultural heritage classes and traditional value groups that perform important, but not necessarily therapeutic, functions in many Indian communities.

PREVENTIVE AND PROMOTIVE INTERVENTIONS

Overview

Debate continues about the most appropriate set of terms by which to distinguish the broad domain of prevention from other approaches to or activities in mental health (161). The tripartite division of primary, secondary, and tertiary prevention, each with separate methodological emphases, enjoys the greatest currency (55). As Bloom (41) noted, the goal of primary and secondary prevention is to reduce the prevalence of disease or disorder in a given population, whereas the object of tertiary prevention is to ameliorate the discomfort or disability that attends an existing disease condition. Bloom (41), Wagenfeld (369), and others have argued that the latter actually falls outside of the realm of prevention since such efforts are not designed to decrease the occurrence of disease.

Primary prevention, which seeks to lower the prevalence of disease by reducing its incidence, can be accomplished in three ways: health promotion and enhancement, disease and disorder prevention, and health protection (42). Health promotion and enhancement involves building or augmenting adaptive strengths, coping resources, survival skills, and general health. In addition to focusing on the capacity to resist stress, health promotion and enhancement require an understanding of the conditions which generate stress and may negatively affect psychosocial functioning. There is very little research of this nature in the Indian mental health literature (188). Exceptions include work by Dinges, Yazzie, and Tollefson (82) on developmental task accomplishment among Navajo parents and children. by Kleinfeld (163) in her study of the characteristics of successful boarding school parents for Alaska Native students, by Lefley (178) in her research on the familial and social correlates of psychological health among Miccosukee children, and by Goldstein (1 15) in the Toyei model dormitory project.

Disease and disorder prevention encompasses a much narrower spectrum of concerns. It targets a specific disorder and, based on an analysis of risk factors, attempts to manipulate one or more conditions to forestall the occurrence of the disease. The vast bulk of primary prevention research in Indian mental health is of this type, but seldom moves beyond the identification of risk factors. Hence, the literature is replete with profiles of the "typical" Indian alcoholic, delinquent, addict, and suicide, and lacks data on the effectiveness of potential responses.

Health protection techniques employ regulatory and legislative action to reduce the probability that the disease agent and host will come into contact. Bonnie (44) discussed health protection in terms of four legal strategies: establishing the conditions of contact (availability), deterring undesired behavior through punishment, symbolizing an official posture toward the behavior, and influencing the content of messages in the mass media. With respect to Indian communities, the classic ''experiment" in health protection has been the federally imposed (and in many places now tribal) prohibition of liquor sales and liquor consumption on reservation lands. Levy and Kunitz (182) and May (201) clearly demonstrated that the prevalence of ''problem drinking' and of associated phenomena (accident, arrest, and homicide rates) are not necessarily lower and may be even higher on "dry" reservations than on "wet" reservations. [17]

Secondary prevention seeks to reduce the prevalence of disease or disorder through early case finding and treatment. A reduction in the duration of

[17] However, the more recent IAHS found a lower prevalence of alcohol use among Indian adolescents on reservations with more restrictive drinking laws (see ch. 2 of this Special Report).

a case consequently. decreases the total number of active cases at any given point in time. Research of this nature is extremely sparse in the American Indian and Alaska Native mental health literature. To permit earlier intervention and more appropriate treatment, researchers have begun to identify the relationships among psychophysiological symptoms, indigenous categories of illness, and research diagnostic criteria for depression within various tribes (e.g.,195). McShane and Plas' (220) study of the psychoeducational impact of otitis media, specifically of parent reports of the number of a child's ear infections as a means of early detection of psychoeducational problems, is another example. However, as with primary prevention efforts, these are not evaluations of the effectiveness of secondary prevention strategies.

Preventive and Promotive Efforts Specific to Indian Adolescents

A recent review of the published literature revealed approximately 45 articles that specifically describe prevention and/or promotive programs targeted to Indian adolescents (193). The interventions reported in this literature largely represent examples of promotional (65 percent) and primary prevention (73 percent) programming. There were no studies of how effective these efforts have been in accomplishing their respective intervention goals.

In an earlier review for the IHS of school- and community-based alcohol and substance-abuse prevention programs, counseling and referral, workshops and training, self-help and support groups, and driver education were the most numerous types of activities found (346). Adolescents were the most frequently mentioned target groups. This review also reported infrequent evaluation of program outcomes. Objective measures were employed in fewer than 30 percent of the identified preventive interventions. The greatest gains included increased participant involvement in outreach programs and increased reporting of abuse, family violence, and other forms of antisocial behavior. Actual decreases in such alcohol and substance abuse problems as arrests, suicide, abuse and neglect, and chemical dependency ranged from minimal to negligible.

Unfortunately, the published record does not reflect the extent to which preventive and promotive activities are currently underway in Indian communities. In order to get a sense of the range of such interventions, the NCAIANMHR contacted tribal agencies and community-based organizations requesting the following information: program sponsor, title, participant characteristics, intervention focus, and format. As of May 9, 1988, 194 programs were identified with significant preventive intervention activities. Nearly one-half of these programs were operated or sponsored by local tribes or native organizations; one-third were managed by private nonprofit groups, and one-quarter were administered by IHS. Of the actual preventive interventions, two-thirds involved counseling or psychotherapy and one-half provided education and training or case and program consultation. Roughly one-third emphasized recreational or cultural events. Programs were asked about the effectiveness of their approaches to which many responded affirmatively, but few acknowledged having gathered empirical data to support such conclusions. Clearly, additional work is needed to determine the characteristics of effective prevention programs.

CULTURAL SENSITIVITY IN INDIAN MENTAL HEALTH PROGRAMS

"Mental health" and "mental illness" can be controversial terms, involving as they do implications for the way a person thinks and the ways in which he or she interacts with others. In their effort to help meet the goal of the U.S. DHHS National Institute of Mental Health's (NIMH) Child and Adolescent Service System Program (CASSP) that services to minority children be appropriate, the CASSP Technical Assistance Center at Georgetown University recently published a monograph geared toward developing a' 'culturally competent' system of care (68). The needs of Indian children were among those considered when the CASSP team developed its report.

The CASSP analysis suggested that problems related to cultural variation can arise at several levels in the intervention system for mental health problems: policy. resources, training, practice, and research. At the *policy* level, the most important problem is that States have not had a specific focus in the area of services to children of color. Indians theoretically have their own source of health care in the II-IS, but, as described previously, *resources are scarce.* In general, according to the CASSP team, minority-controlled programs and agencies continu-

ally struggle for survival: "With scarce resources it is difficult for such programs and agencies to develop culturally-specialized approaches or materials for use with their clients. Consequently they remain underdeveloped. " The ***training*** of mental health professionals is troublesome in that there is a shortage of trained minority persons to work in the field, and the existing curricula for mental health providers inadequately address the needs of minority communities. When minority persons have successfully completed training, they sometimes find that the education offered by the nonminority institution serves to alienate them from their community rather than make them a resource (e.g., see 171).

Some of the *practice* issues uncovered by the CASSP analysis are cross-cultural issues, while others are applicable regardless of the service provider's identity. Cross-cultural issues include such areas as historic distrust, language and communication barriers, and culturally biased assessment techniques. Value conflicts, stereotypes, and unrealistic fears of minority clients can arise regardless of the service provider's identity. Many of these issues are of longstanding concern in the provision of mental health treatment and prevention services to Indians, and the need for cultural sensitivity is repeated whenever an evaluation of services is conducted (e.g., 355). These issues are of particular concern to adolescent mental health. One characteristic of adolescence is the experience of an 'identity crisis" (97), and thus Indian adolescents may be more likely than Indians of other ages to experience distress as a result of feeling caught between two cultures (368). Problems with policy, training, and practice may be due in part to an inadequate *research* base on the characteristics and mental health needs of minority children and adolescents. According to Cross and his colleagues, current research too often fails to consider culture as a variable, and funding sources for research historically have not been sensitive to minority needs and thus do not follow direction from minority communities.

With the support of Congress, IHS has made an effort to bring more Indian mental health providers into the system. One hundred nine of the 198 mental health providers are Indians. However, most are social workers and mental health technicians (355). only 4 of the 37 clinical psychologists are Indian. No psychiatrists are Indian.

Even Indian heritage does not guarantee "cultural competence. There is considerable diversity in language and heritage among the more than 500 Indian tribes (355). For example, differences among Alaska Native tribes can be as great as between Native and non-Natives. The Oklahoma City region serves members of more than 60 tribes who were originally from different areas of the North American continent but who were induced or forced to resettle in the Oklahoma area.

Thus, there is a long-recognized need for enhanced cultural awareness and training among health care providers of all kinds. The draft IHS MHPB National Plan recommended that:

> A more systematic program for orienting new mental health providers and for upgrading the skills of mental health staff and of other human service providers regarding mental health care and relevant cultural issues should be developed and implemented. New mental health staff should be fully oriented to the mental health program and to the cultural traditions and community of the tribe/tribes which are served: Such orientation should emphasize that Native Americans often fail to acceptor respond to western mental health treatment procedures because of inherent socio-cultural factors, and that these factors must be taken into account and integrated into planning treatment strategies at all levels (355).

COMMUNITY INVOLVEMENT

Throughout the Nation and abroad, consumers are becoming increasingly involved in planning mental health services (19), and providers of services for young people are beginning to seek their continuing assistance. Not only is community involvement consonant with the spirit of Indian Self-Determination (Public Law 93-638 as amended), but it can enhance the feelings of self-efficacy and control that may be important to improved mental health (e.g., 18a).

Specific to Indian adolescents, the Laguna-Acoma Teen Center in rural New Mexico was developed with community participation (73). Teenagers themselves were involved in the planning and design of the Center, and continue to serve as an ongoing Teen Advisory Group, consulting with the adult program directors. The teens also prepare a peer-targeted, teen health-oriented newsletter, produce videotapes and skits, help teach fellow students and elementary school children, and are involved in

evaluating the Center's programs. As part of the United National Indian Tribal Youth (UNITY) organization, Indian youth have been involved in needs assessments and have provided testimony to Congress on their views of the needs of Indian adolescents. One of the most pressing concerns identified by UNITY members at a May 1987 UNITY Conference was to improve communication between themselves and tribal government officials (306).[18]

Recognizing the importance of youth involvement, II-IS and BIA are developing a plan to promote the involvement of youth in community actions involving alcohol and substance abuse, including encouraging the selection of youth as members of Tribal Coordinating Committees (361). It is important to note, however, that mental health treatment is a health care specialty like any other. In addition, Indian communities are unusual in that it they may be host to two mental health approaches: western-oriented psychotherapy and traditional medicine. Thus, conflicts concerning approaches to treatment among mainstream mental health professionals, traditional medicine specialists, and communities may be inevitable (19).

HOLDING THE SYSTEM TOGETHER

In planning a mental health system, it is not adequate simply to know the mental health needs of Indian people in a particular area and to be aware of available treatment and prevention. Treatment plans for patients often require that several interventions be used simultaneously. Patients need to be able to have access to services, or the services will not work.

Overview

In planning the development of a comprehensive mental health system, it is useful to consider the system as a continuous whole. Several types of deficiencies may exist. Test (308) described them as: a) "gaps" in the system—places where the components to meet some unmet need are inadequate or non-existent; b) "cracks" in the system—spaces between existing system elements resulting from a lack of communication, coordination, or clearly defined responsibilities; and c) difficulty in keeping the patient or client involved in the system.

All of these problems exist in the health care delivery systems in Indian communities, as Manson and Neligh (194) have noted. There are a variety of barriers to good care for the patient who must receive services from an array of different providers and agencies.

Bachrach(18) urged thinking of continuity of care as having several dimensions:

1. a temporal or longitudinal dimension that implies a course of treatment, unencumbered by the patient's having to put together discrete, unconnected episodes of service;
2. an individual dimension in which care is planned with and for the patient and his family;
3. a cross-sectional dimension consisting of comprehensiveness and continuity of care.
4. flexibility such that a patient is relieved of pressures to exhibit "progress" or to move "forward" along a continuum;
5. a relationship dimension in which contacts with the service system are, ideally, of a primary nature and are characterized by familiarity and closeness;
6. an accessibility dimension that ensures one the ability to reach the services ystem when needed; and
7. a communication dimension such that different agencies and individuals may be responsible for a patient's helpers.

McArthur (210) and Albaugh (7) provide concrete, practical examples of how these dimensions can be incorporated into local programming of services for Indian adolescents and their families.

Coordination Efforts Among Indian-Serving Agencies

Recently, IHS and other agencies in the U.S. Department of Health and Human Services have begun to address the issue of inter-and intra-agency coordination. These efforts primarily address the problem of alcohol and substance abuse among Indian people, including adolescents, and were stimulated by Public Law 99-570. Among these

[18]More than 300 Indian youth representing 53 tribes from 21 States participated in the UNITY conference, which was sponsored by Youth 2000, a joint U. S. Department of Health and Human Services and U. S. Department of Labor campaign. The Indian youth identified their most pressing needs as: 1) alcohol, drug, and other substance abuse; 2) suicide; 3) teenage pregnancy; 4) preservation of tribal culture and traditions; 5) communication between themselves and tribal government officials; 6) funding for higher education; 7) motivation and self-esteem; 8) school dropout; 9) lack of recreational facilities; and 10) unemployment.

coordinating efforts are a U.S. DHHS Inter-Agency Task Force consisting of IHS, Office of Human Development Services, the Administration on Aging, the Alcohol, Drug Abuse and Mental Health Administration, and the Office of Minority Health (349). Memoranda of agreement (MoAs) have been signed between the IHS, these agencies, and others (i.e., Administration for Native Americans, Administration for Children Youth and Families) resulting in coordinated Discretionary Grant Programs to provide support to Indian communities which face alcohol and substance abuse problems. In addition, BIA and IHS have signed MoAs on child protection and alcohol and substance abuse (356,357). As a result of the Child Protection MoA, IHS and BIA formed a National Oversight Committee for Child Protection; the Committee is attempting to work more closely with tribes, the FBI (222) and the Office for Victims of Crime on child abuse (51). The purpose of the alcohol and substance abuse MoA was to develop a management framework for implementation of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (Public Law 99-570) resulted in an OMAP (361). In response to longstanding concerns about lack of coordination, IHS MHPB and A/SAPB also signed an MoA dated October 31, 1988 (353).

CONCLUSIONS AND POLICY IMPLICATIONS

Very little systematic research has been conducted on the effectiveness of specific therapies with Indian adolescents, Where success has been noted in the literature, it often reflects the judgment of the clinician providing the treatment rather than the conclusion of an objective observer conducting rigorous research. This situation is true of much research on mental health services (144,323). Nonetheless, OTA and others have concluded that, overall, more is known about how to provide mental health treatment to children, including adolescents, than is generally put into practice (323). Thus, it is unfortunate that even in the Nation at large, children and adolescents represent an underserved population. Among Indians, the situation is more critical, with only 17 child and adolescent-trained mental health professionals in the IHS mental health system and extremely limited access to inpatient care, residential treatment centers for emotionally disturbed children, and the other forms of care that constitute a desirable continuum of care. Tribally run programs such as parent groups are available to adolescents but few are specifically designed to meet their special needs.

OTA concludes that approximately 160 to 200 mental health providers especially trained to treat children and adolescents are needed in IHS service areas. OTA was unable to calculate an increase for urban areas because the number of Indian children and adolescents in urban areas is unknown. However, a ratio of 4 to 5 mental health professionals per 10,000 children, including adolescents, seems warranted.