Appendix A

Earlier Evaluations of American Indian and Alaska Native Adolescents? Mental Health Needs and Services

Public concern for the mental health of American Indian and Alaska Native youth arose initially within the context of their education, dating to an often-quoted publication entitled *The Problem of Indian Administration,* more commonly known as the Meriam Report (223). The Meriam Report highlighted a number of serious school-related conditions that threatened Indian youth's physical and emotional well-being. Sweeping reforms were encouraged. For example, the Meriam Report recommended raising food and clothing allowances, introducing Indian culture into the curriculum, and increasing the number and qualifications of school personnel. It also urged the construction of local day schools to serve as community centers. The intent was to improve the educational environment and render it more relevant to the daily life experience of Indian youth, thereby enhancing their sense of 'personal security' and, consequently, the authors presumed, their academic competence. Many of these reforms were pursued by John Collier during his tenure as Commissioner of Indian Affairs from 1933 to 1945. However, ensuing administrations presided over the reversal of most of these advances (305).

It was not until nearly a quarter of a century later, with the issuance of the Kennedy Report in 1969, that the public spotlight returned to these concerns, and therefore to the mental health of Indian youth (326). Congressional forces, tribal leadership, and professional opinion coincided. As a result, the Senate Special Subcommittee on Indian Education reached extraordinarily negative conclusions about the impact of Federal policy on Indian adolescents in boarding schools, citing a "dismal record of absenteeism, dropouts, negative self-image, low achievement, and, ultimately, academic failure . . .' (326). Its recommendations echoed many of those advanced by the Meriarn Report, 40 years earlier. Slow, but definite progress became evident (305) as new attempts at educational enrichment were undertaken, embodied in subsequent initiatives such as the Office of Economic Opportunity Headstart, Title IV of the Indian Education Act and the remolding of Johnson-O' Malley programs **(305).**

Though education, especially boarding schools, continued to serve as a major forum for the discussion of Indian children's mental health, other areas of concern began to emerge. Kane and Kane (156) pointed out that the IHS's[1] preoccupation with infectious diseases, though important, ignored the social and psychological welfare of Indian people, and youth in particular (156). The consequences of ignoring adolescents' social and psychological problems were thought to be far-reaching and included alienation, adjustment difficulties, child abuse and neglect, alcohol dependence and abuse, and suicide. IHS mental health programming had begun just shordy before, in 1965-66, with a small outpatient clinic on the Pine Ridge Reservation and the formation of the Office of Mental Health Programs.

Interest in mental health services soon spread to other IHS areas. Yet these efforts almost exclusively emphasized adult services, as demonstrated by Attneave and Beiser's system-wide evaluation in 1974 (16). In their evaluation, the authors concluded that ''services to children tend to be sporadically dispersed throughout IHS mental health programs. In part the focus on this age group depends on the activities of other programs such as Maternal and Child Health within IHS and Headstart and Day Care outside of IHS. "

Public attention to the mental health needs of and services for Indian youth reached its zenith between 1976 and 1978. It came about through the convergence of three separate but related lines of advocacy. One effort focused on child welfare services. In 1976, the Children's Bureau within the Ofilce of Human Development published a major study by the Denver Research Institute entitled *Indian Child Welfare: A State-of-the-Field* Study (329). It, together with a similar volume issued by the Indian Family Defense Fund (53), documented the alarming rates at which Indian youth were removed from their homes and placed for either foster care or adoption with non-Indian families. Major mental health problems were believed to follow from this practice, attributed in large part to the subsequent disruption of the child's still-evolving social and cultural identity. The well-known and still controversial Indian Child Welfare Act (Public Law 95-608) resulted from these and related endeavors, giving rise to local Indian Children's Welfare programs that have played an important role in identifying and caring for troubled youth and their families.

Another effort continued earlier criticisms of the general state of Indian health care. The *Final Report* of the American Indian Policy Review Committee, delivered to Congress in 1977, opened with a broad condemnation of Federal and State policies regarding human services in Indian communities (321). Stating that the quality of Indian life ranked lowest by virtually any statistic, the

I In 1955, responsibilit, for Indian health was transferred from the U.S. Department of the Interior, Bureau of Indian Affairs (BIA), to the then U.S. Department of Health, Education, and Welfare (now DHHS), and the Indian Health Service (IHS) was formed,

Committee concluded that it was not surprising that so many Indian tiunilies had been devastated by social disintegration caused by mental illness and alcoholism.

The third effort sprang from the 1978 President's Commission on Mental Health. The Report of the Special Populations Subpanel on the Mental Health of American Indians and Alaska Natives (253) reaffirmed the findings of these previous reports and strongly endorsed their recommendations. 1n addition, it briefly highlighted the special mental health needs of handicapped youth, of juveniles in the criminal justice system, and of youth experiencing rapid sociocultural change. The subpanel called for the development of a wide array of child mental health services, including family-oriented resource centers to provide diagnostic assessments, counseling, and followup, foster care and adoption services, and youth group homes. Their report frequently repeated the need to coordinate across State, tribal, and agencies.

1n response to these reports, the IHS outlined plans for a series of regional 1ndian Children's Programs that would render and/or coordinate a continuum of mental health care, ranging from basic screening efforts to intensive residential treatment. The first program began in 1979 at Albuquerque, New Mexico, and was founded on a then unique interagency agreement between the IHS and BIA. Unfortunately, effective advocacy for Indian child mental health services gradually dissipated in the face of a major economic recession and severe budget cuts of federally supported health and human services. The Albuquerque-based Indian Children's Program proved to be the only one of its kind ever funded. Eventually even it was dismantled, having been unable to shift to the national scope required for successful justification of continued support. However, before closing, the program conducted a review that determined that Indian ''children with social and mental health problems are not well served' (342). This report, *Phoenix IHS Area Review: Perceptions of Service for Special Needs Children (342),* indicated that younger children in need of care are not identified appropriately and are the most difficult to link with appropriate services, that the urban Indian population is essentially unaware of available services for children, and that the youth of rural Indian families are least likely to receive specialty care. As the highest priority for future programs, the Indian Children's Program report stressed coordination among tribes, State, and Federal Government. The proposed mechanism involved teams involving multiple disciplines and agencies, with case management, a registry system, and an interagency resource directory.