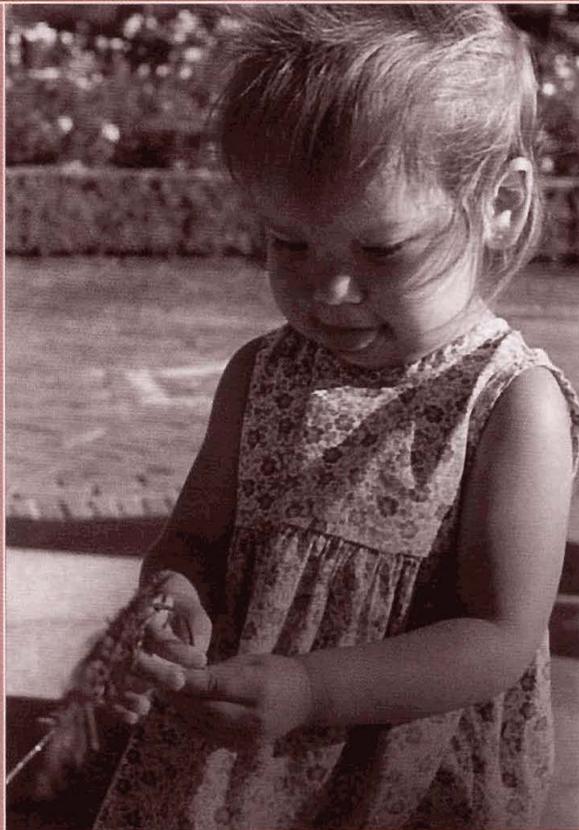


Exploring the Mental Health Needs of American Indian Children and Families: Site Visits to Two Tribal Communities

Chey Clifford-Stoltenberg, MSW & Kathleen Earle, PhD



December 2002



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National Indian Child Welfare Association

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¹ The terms Native, Indian, and American Indian/Alaska Native are used interchangeably throughout the document.

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Executive Summary

Introduction

The American Psychological Association (APA) is the world's largest scientific and professional organization representing psychology and has a membership of more than 155,000 researchers, educators, clinicians, consultants, and students. The organization's commitment to children's mental health is evident in the various divisions devoted to children's issues as well as committees and task forces that address the needs of children, adolescents, and families. APA also demonstrates its commitment to American Indian/Alaska Native issues through committees such as the Society of Indian Psychologists and Psychologists in Indian Country.

In order to increase tribal awareness of and access to APA's important resources and expertise, the National Indian Child Welfare Association (NICWA), in collaboration with the Indian Health Service (IHS), organized and conducted site visits to two tribal communities. The purpose of these visits was both to increase APA's understanding of the extent and severity of Indian children's mental health needs and to establish awareness among Indian Nations of the resources available from APA and its members.

Literature Review

American Indian/Alaska Native children appear to be at greater risk for emotional problems than other children in the United States (Inouye, 1993). Native communities, especially with regard to children, however, have not easily embraced the overall concept of mental illness. Many American Indian/Alaska Native people embrace a relational worldview (as opposed to a linear worldview) in which wellness in the individual's social, mental, physical, and spiritual realms depends on proper balance across these arenas. Services for Indian children and families with mental health needs must take into account the context within which the person lives as well as his/her strengths in the mental, physical, and spiritual realms. In most cases, emotional disturbance is not considered by Native communities to be a problem separate from these realms.

It is estimated that approximately 25%-35% of all Native individuals in the U.S. today grew up apart from their birth families, in foster homes, adoptive homes, or institutions (George, 1997).

Placements in boarding schools were an additional attempt by the federal government to dispose of Native language and culture. Adults who returned to their families from these placements found it extremely difficult to assume their proper cultural and emotional roles within Indian society and, often inadvertently, continued the legacy of

abuse suffered at these boarding schools and out-of-home placements (Yellow Horse Brave Heart, 1999).

During the time that Native children were being placed away from their families and communities and Native culture was being eroded, mainstream mental health care was not being offered. It is assumed that indigenous ways were used to address many of the mental health needs within Native communities from 1500 to the 1970s, when the need for these types of services was recognized (Attneave, 1984).

Currently, the Indian Health Service (IHS), under the U.S. Department of Health and Human Services, provides much of the health and mental health care to enrolled American Indian/Alaska Native children and families. The Indian Self-Determination and Education Assistance Act of 1975 allowed tribes to take over some of the services being offered, and, by 1992, tribes were operating about one third of the programs formerly run by the IHS (Barlow & Walkup, 1998). Other agencies and groups have also sought to fill the need for tribal mental health care, including social services funded through the Bureau of Indian Affairs (BIA), tribal indigenous and mainstream mental health programs, and mainstream agencies adjacent or relatively close to reservations.

Methodology

Upon receiving a contract from the IHS in Fall of 2001, NICWA staff began contacting both urban and rural tribal sites that serve Indian children and families with mental health needs to inquire about setting up a visit. Sites that NICWA staff contacted included the Oglala Sioux Tribe and the Phoenix Indian Medical Center (PIMC). Both sites agreed to host representatives from IHS, APA, and NICWA in order to assist participants in developing an understanding of mental health needs and issues faced by these communities and to improve advocacy efforts and tribal collaboration with these organizations.

Once each tribal site agreed to host a visit, NICWA organized these visits during the week of May 6–10, 2002. Information obtained at each visit was hand-recorded and then assembled into detailed proceedings notes for review by each participant. After receiving feedback on the proceedings notes from participants, NICWA staff developed a draft document and distributed it to all parties involved in the site visits for feedback, which was eventually incorporated into the final document.

Summary of Site Visits

The first site visit was conducted at the Oglala Sioux Tribe in Porcupine, South Dakota.

Participants were first provided with information on cultural competence as well as the history of the tribe. Afterward, representatives from the tribe's Nagi Kicopi Program, a tribal health educator, a special education department coordinator, and a parent of a child with serious emotional disturbance (SED) discussed the services available to children and families with mental health needs. For example, the Nagi Kicopi program provides a holistic healing process through the use of Lakota purification ceremonies, elders and traditional healers, extended family members, and traditional peacemaking. The program serves individuals ages 0–21 and provides a variety of mental health services based on Lakota traditional healing practices.

After visiting the Oglala Sioux Tribe, participants traveled to the Phoenix Indian Medical Center (PIMC)—a direct service arm of the Phoenix Area IHS office. During the visit, participants were given a chance to talk with an individual who works with the Arizona nonprofit sector, IHS direct service providers, representatives from a substance abuse program for women and children, and the director of PIMC. These individuals

discussed services they provide to clients with mental health needs, including outpatient, psychiatric, and substance abuse services. They also discussed the importance of cultural competence training and recruitment of Native individuals into the mental health field.

Recommendations

From information obtained during the site visits, emerging themes were identified that included interagency collaboration, historical trauma, and lack of resources. Out of these emerging themes, eight recommendations were developed with regard to policy, practice, and research. These recommendations are as follows:

POLICY

- Allow for direct tribal access to federal funding for children's mental health services and children's health insurance.
- Allow for reimbursement for the use of traditional practices and services with Native clients.

PRACTICE

- Increase training in cultural competence for program staff and administrators.

- Recruit more Native individuals into the mental health field, and increase the ability for tribal sites to hire more Native individuals.
- Increase technical assistance opportunities for tribal communities with regard to children's mental health services and the development of resources to support these services.
- Strengthen opportunities for collaboration between tribes, between agencies and tribes, between agencies, and between national organizations that provide children's mental health services (including Child Protective Services [CPS] and the juvenile justice arena).

RESEARCH

- Conduct research on outcome measurements for the utilization of traditional healers and spiritual practices in serving Native children and families with mental health needs.
- Increase the amount of research being conducted on juvenile mental health issues.

Introduction

The world's largest scientific and professional organization representing psychology, the American Psychological Association (APA), has a membership of more than 155,000 researchers, educators, clinicians, consultants, and students. Psychology is unique among health and human service professions because it is both a scientifically grounded, academic discipline and a health care service-oriented profession. Many psychologists are on the front line working on behalf of our nation's children, particularly children with behavioral and emotional challenges. APA's commitment to children's mental health is evidenced by the number of divisions of the membership devoted to children's concerns, including divisions of developmental psychology, clinical child psychology, pediatric psychology, school psychology, and family psychology. That commitment is further demonstrated by APA's governance structure, which includes the Committee on Children, Youth and Families, as well as various task forces devoted to family and adolescent issues. In addition, psychologists concerned with issues affecting American Indians/Alaska Natives have been active in APA's Committee on Ethnic Minority Affairs, the Society for Psychological Study of Ethnic Minority Issues, the Society of Indian Psychologists, and the newly formed interest group, Psychologists in Indian Country.

In order to increase tribal awareness of and access to APA's important resources and expertise, the National Indian Child Welfare Association (NICWA), in collaboration with the Indian Health Service (IHS), organized and conducted site visits to two tribal communities. The main purpose of the site visits was to increase APA staff's understanding of the extent and severity of Indian children's mental health needs and to establish awareness among Indian Nations of the resources available from APA and its members.

The information provided in this report is intended for use by a broad audience, including:

- tribal leaders
- intertribal organizations
- tribal and urban Indian human service programs
- APA staff and administrators
- IHS staff and administrators
- policymakers
- other non-Indian agencies

This information will be valuable in presenting a background on the successes and challenges of providing services to Indian children with mental health needs as well as recommendations for future policy, practice, and research.

Literature Review

American Indian/Alaska Native children appear to be at greater risk for emotional problems than other children in the United States (Inouye, 1993). Associated problems such as alcoholism and drug abuse, suicide, homicide, and child abuse and neglect are all reported to be higher for Indian children and their families than for other racial or ethnic groups (Child Welfare League of America, 2000; U.S. Department of Health and Human Services (DHHS), 1996, 2001; U.S. Department of Justice (DOJ), 1999). American Indian/Alaska Native children ages 0–19 also differ from other children in the United States in that they make up 41.7% of the total population of American Indians/Alaska Natives. This compares to 28% of Whites and 35.8% of Blacks who are ages 0–19 (Goodluck & Willetto, 2001).

Recent authors have concluded that a myriad of social problems among American Indian/Alaska Native people stem at least partially and perhaps totally from U.S. government policies of genocide and forced assimilation of Native peoples over the past few hundred years (Duran & Duran, 1995). What has amazed many authors and professionals in the social science field is the resilience of American Indian/Alaska Native children, their families and their communities, who continue to survive and even to thrive in the face of these destructive policies (Nagel & Snipp, 1993). Some authors address the issue of mental

health from the concept of worldview, in which Western definitions of emotional disturbance simply do not fit the American Indian/Alaska Native child, and in which the application of these definitions is marginally helpful. In the diagnosis and treatment of emotional disturbance in American Indian children, both historical and cultural issues are at play.

Conceptions of Mental Health and Mental Illness

Mental health is defined by the absence of mental illness. Mental illness is defined by applying labels to persons that fit a set of predefined characteristics. Virtually all of these labels can be found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which has undergone several revisions since its first publication (American Psychiatric Association, 2000). The DSM is a manual containing multi-axial diagnostic criteria for all mental disorders, including children's disorders and developmental disabilities. Mental health professionals commonly use it across various disciplines for the purpose of diagnosing individuals. These mental health professionals use the diagnosis to suggest specific methods of treatment for different types of disorders. The most recent edition, DSM-IV-TR, published in 1994, includes a section (Appendix I) entitled *Outline for Cultural Formulation and*

Glossary of Culture-Bound Syndromes

(p. 843–849). Within these few pages are listed some

“... culture-bound syndromes ... of aberrant behavior and troubling experience which may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be ‘illnesses,’ or at least afflictions, and most have local names” (p. 844).

The DSM-IV lists 25 syndromes found among “immigrants and ethnic minorities” in the United States. Three are found among American Indians/Alaska Natives. One of these, *iich’aa*, reported among members of the Navajo Nation, is said to be similar to *amok*, observed among people from Malaysia, and to other similar syndromes in Laos, Philippines, Polynesia, Papua New Guinea, and Puerto Rico.

Pibloktoq, observed among Eskimo peoples, is also described, as is ghost sickness, “observed among members of many American Indian tribes” (p. 846). Clinicians who use the DSM-IV are instructed to consider these descriptions of local syndromes as part of their diagnostic approach. Recent authors have reported that the DSM-IV, despite the *Outline* referenced above, remains inadequate for diagnosing American Indian children (Novins, Bechtold, Sack, Thompson, Carter, & Manson, 1997).

O’Neill, in his 1989 review of the literature, identified and described several additional culture-specific disorders among American Indian/Alaska Native people or specific tribes. These included *pibloktoq* (arctic hysteria) and *ch?idnoh* (one form of ghost sickness), as well as *windigo* (melancholia and delusions), *schwas* (spirit intrusion), *iich’aa* (taboo breaking) (Trimble, Manson, Dinges & Medicine, 1984); *tawatl ye sni* (totally discouraged) (Johnson & Johnson 1965); and *wacinko* (to pout) (Lewis, 1975). These loose translations of the terms cited varied from group to group. Among other descriptions of mental illness, Wallace (1959), an anthropologist by training, described mental/physical symptoms among the Iroquois that were believed to have been caused by influences outside the individual and that were cured by various rituals performed by secret Iroquois societies.

When Lewis described *wacinko* in the *American Journal of Psychiatry* in 1975, he stated that the syndrome, well known among the Oglala Sioux, had not been identified by non-indigenous physicians who had been working on or near the reservation for over 100 years. Lewis suggested that mainstream clinicians consult with indigenous practitioners to better understand the disorders of indigenous people.

In describing hallucinatory experiences among Hopi women in mourning, in which they perceive

the presence of the person who has died, Matchett (1972) explained that the reason these symptoms were not identified by non-Indian practitioners may have been that the phenomenon was not widely discussed among the Hopi, whose society discourages open expression of “strong affect” (p.193). Yet the Hopi recognized the symptoms when they occurred.

All of these authors agree that these syndromes do not overlap with diagnostic categories found in the DSM-IV. Indeed, they may confound the diagnoses given to persons of Indian heritage as in the case, for example, of attributing schizophrenic symptoms to a Hopi woman who has a non-psychotic hallucination of her dead relative, but who is fine a week later. Matchett compares the experience of these women to that of Brutus in Shakespeare’s *Tragedy of Julius Caesar*, who was visited by Caesar’s ghost, or to that of Scrooge, who visited with the dead Joseph Marley in Dickens’ *A Christmas Carol*. Neither of these fictional characters was diagnosed as schizophrenic, having appeared in books written prior to Kraepelin and Bleuler, who were among the first to describe the symptoms of schizophrenia (Kolb, 1973), and the DSM.

In short, there are various syndromes in existence among American Indian/Alaska Native people that appear to reflect mental illness but that are not frequently recognized by Western

practitioners, do not fit neatly into Western diagnostic categories, and may be transitory rather than permanent symptoms of distress or disorder. They may even originate outside, rather than within, the person who is distressed.

The overall concept of mental illness is one not easily embraced by many indigenous people, especially for children. Many American Indian/Alaska Native people traditionally embrace a relational worldview, in which wellness in all areas (i.e., social, mental, physical, and spiritual) is dependent on proper balance among these spheres (Cross, 1995) rather than on lack of diagnosable symptoms of disorders. Cross states that there are two predominant worldviews—relational and linear. To treat most disorders, most practitioners in the Western world use the linear worldview. It resembles the medical model of care, in which a symptom leads to a diagnosis, which leads to treatment, and thus leads to a cure. It is a cause-and-effect model, in which interventions are targeted to the cause of the disorder. The greatest drawback of the linear worldview is that the cause and treatment of a construct such as emotional upset may be regarded as similar to the cause and treatment of a physical injury, such as a broken bone. Further, the construct may be seen to reside within the person who has come for treatment rather than within his environment or the person-environment interrelationship.

The relational worldview, in contrast, teaches practitioners to

“... see and accept complex (sometimes illogical) interrelationships that can be influenced by entering the context of the client and manipulating the balance contextually, cognitively, emotionally, physically, and/or spiritually. Interventions need not be logically targeted to a particular symptom or cause but rather focused on bringing the person back into balance. Nothing in the person’s existence can change without all other things being changed as well” (Cross, 1995, p. 147).

Cross (1995) cites the example of a sweat lodge, used in many Native cultures to treat alcoholism. The social context of the sweat lodge includes the leader and the other participants (social realm); an intellectual and emotional framework provided by the teaching that occurs (mental realm); steam that cleanses the body (physical realm); and an overriding spiritual content of the activity itself (spiritual realm). The sweat lodge is used, writes Cross, “to treat alcoholism not because it makes the person not drink but because it begins to help the person restore the balance, the harmony” (p.151).

Barlow and Walkup (1998) describe the effectiveness of a Southwestern tribe’s tribally initiated

suicide prevention team based on a specifically indigenous approach to care:

“... traditional healers were lifetime residents of the reservation, were on call 24 hours a day, and were dispatched by the local tribal police department. When called, they made immediate home visits and consulted with the entire family, including extended family members. All family members were included in the treatment. The consultation was generally in the Native language and could include prayer and spiritual ceremonies that were aimed at bringing the entire family back into balance. The healers would stay as long as was deemed necessary, which could be several hours In contrast, the clinical mental health providers were generally non-Indian and lived off the reservation. They provided counseling during set clinical hours for limited blocks of time. Clinical counseling sessions were individualized and other family members were inadvertently shut out. The clinic itself was ... a difficult place to visit, especially for a child or adolescent” (p. 562).

Mental health care for American Indian/Alaska Native people must take into account the context within which the person lives, as well as his or her strengths in the physical, mental, and spiritual

realms. In most cases, emotional disturbance is not seen as a problem separate from these other elements of the relational worldview.

Historical Trauma

Various authors have presented the view that American Indian/Alaska Native people were healthier and happier before the Europeans arrived (see, for example, Duran & Duran, 1995; Nabokov, 1991; Wilson, 1991). There is no question that they were healthier, as diseases brought to North America from Europe decimated the indigenous residents. Estimates are that, using the most conservative figures, two-thirds of indigenous people were wiped out within the first 400 years of contact with Europeans (Weaver & Yellow Horse Brave Heart, 1999), from an estimated high of 10 million indigenous people to a recorded low of 250,000. Since the time of contact, U.S. policy toward Indian Nations has swung between terminating and assimilating Indian tribes and respecting their status as sovereign nations located within the United States. Meanwhile, the numbers of American Indians/Alaska Natives have continued to rebound, with approximately 2.5 million people enrolled in federally recognized tribes and an additional 1.6 million reporting Indian ancestry today (U.S. Census Bureau, 2000).

Tribes were given sovereign nation status by the

U.S. Constitution, making them, essentially, nations within a nation and not subject to the jurisdiction of the states surrounding them. This status was refined early in the history of the American Republic by the *Cherokee Nations v. Georgia* (1831) and *Worcester v. Georgia* (1832) Supreme Court decisions. These cases defined tribes as neither foreign nations nor U.S. states but as “domestic dependent nations” that relate solely to the federal government and over which states have no jurisdiction (Canby, 1998; Prucha, 1990). In direct violation of these landmark decisions, with the help of newly elected President Andrew Jackson, however, the states were able to remove the Cherokees and the other four of the Five Civilized Tribes (Choctaw, Creek, Chickasaw and Seminole) to Oklahoma in what has been come to be called the “Trail of Tears.”

Members of these tribes made every effort to assimilate, drafting laws and constitutions and becoming model landowners and farmers. Nevertheless, when Whites wanted their land, they were forced, some in chains, to walk to Oklahoma. Many were allowed to take only one blanket on the trip. Scores died en route or within the few years after arrival in the new land. The Cherokees lost a quarter of their people; the Creek, half (Nabokov, 1991).

Indian rights continued to be eroded, ignored, or curtailed. There were a few dissenters. New Jersey Senator Theodore Frelinghuysen had

stated the view that the Cherokee and other Indian Nations should not be removed from their lands in 1830 as follows:

Every administration of this government ... has ... held treaties with the Cherokee ... Yes, sir, whenever we approached them in the language of friendship and kindness, we touched the chord that won their confidence; and now, when they have nothing left with which to satisfy our cravings, we propose to annul every treaty—to gain say our word—and, by violence and perfidy, drive the Indian from his home (Prucha, p. 51).

Since that time various court cases have challenged tribal sovereignty, with limited success (Canby, 1998). Meanwhile, competing laws and sympathies have forced the removal of Indian children from their homes to residential boarding schools, have forced adults and families to move to urban areas, have terminated tribes, and have removed tribes from their land and land from the tribes.

It is estimated that approximately 25%-35% of all American Indians/Alaska Natives in the United States today grew up apart from their birth families, in foster homes, adoptive homes, or institutions (George, 1997). Many were sent to boarding schools, where their languages and cultures were systematically expunged through harsh measures (Colmant, 2000). When tribal parents refused to

enroll their children in school, Indian agents withheld food or used the agency police to round up the children, leaving “the men ... sullen and muttering, the women loud in their lamentations, and the children almost out of their wits with fright” (Adams, 1995, p. 211).

Adults who later returned to their families were unable, culturally or emotionally, to assume their proper roles as parents in Indian society. These adults, many of whom manifested ineffective or destructive parenting, inadvertently continued the legacy of abuse suffered at the boarding schools (Yellow Horse Brave Heart, 1999).

Centuries of oppression, removal, and neglect have led, in many Native communities, to an all-pervasive sense of dread among members of those communities. In 1995, Duran and Duran described these feelings of despair and pain among American Indian/Alaska Native people as a “soul wound”. Soul wound is explained in the literature as arising from long-term historical trauma that is cumulative in nature and that operates over the generations of people affected (Red Horse, Martinez, Day, Day, Poupart & Scharnberg, 2000). Its symptoms resemble Post Traumatic Stress Disorder (PTSD), although there may be no stressors present in the patient’s immediate background.

While tribal people were fighting for their way of

life and sometimes for their lives, mainstream mental health care was not provided. It is assumed that indigenous ways were used to combat the many difficulties facing Indians from 1500 to the 1970s, when the need for mental health services was recognized (Atneave, 1984).

Beginning in the 1800s, limited health care was provided to people on reservations in return for large tracts of land. Treaties stipulated this agreement, and free, federally funded health care for enrolled members of American Indian/Alaska Native tribes has become a right as a result.

The identification by the federal government as to who is and is not "American Indian," designated by enrollment in an Indian tribe or nation, is also problematic. Slaughter (2000) states that an Indian is defined as a member of a tribe or the biological child of a tribal member. The determination of membership, however, is made by each tribe and may be based not only on biology but also on matrilineal descent, as in the case of the Iroquois. In either case, tribal membership is not based on "individual consciousness, subjectivity, or lifestyle. Because of this, it is possible for a person to spend his entire life in a tribe and if he does not meet the blood or ancestry criteria, he cannot be a tribal member" (p. 235). Until the end of the 19th century, determination of tribal membership was unfettered by federal restrictions and was a more open process than in later

years; Slaughter states that the federal government initiated the enrollment of Indian people in order to eliminate people from eligibility and thus to reduce the rolls. Currently, however, each tribe, with some constraints, has the right as a sovereign nation to determine its own membership and thus eligibility for services.

Services Today

The Indian Health Service (IHS), under the U.S. Department of Health and Human Services, was established in 1955 and provides much of the health and mental health care to enrolled American Indian/Alaska Native people and their children today. The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) allowed tribes to take over operation of some of these services, and by 1992 tribes were operating about a third of the programs formerly run by the IHS (Barlow & Walkup, 1998).

The first provision of mental health services through the IHS occurred in 1965 (Nelson, McCoy, Stretter, & Vanderwagen, 1992), although Indian mental health and child welfare remain an under-funded initiative of the federal government (Cross, Earle, & Simmons, 2000). In 1990 there were approximately 263 staff supported by IHS mental health funds to treat a population of approximately 1.5 million American Indian/Alaska Native people (Nelson et al., 1992). Other agencies and groups have sought to fill the need for

tribal mental health care. These have included social services funded through the Bureau of Indian Affairs (BIA), tribal indigenous and mainstream mental health programs, and mainstream agencies adjacent or relatively close to reservations.

Roughly half of American Indian/Alaska Native people live off-reservation, and these people's mental health needs are met, one assumes, by mainstream mental health agencies. In one of the few comprehensive studies of mental health services provided to a specific population, it was found that American Indians within New York state received mental health services at a much lower rate than Whites. American Indians/Alaska Natives were served at a rate of 1/100 population by mental health providers in the state, compared to a rate of 11/100 for White, non-Hispanic people. Services referenced in the study included those provided through all private and public mental health agencies in the state, including the Indian Health Service, but did not include prisons (Earle, 1998). Since an equal number of Native people who received mental health services were receiving them in prison, a follow-up study was completed to determine if prison was an alternative treatment setting for American Indians/Alaska Natives. Findings were that the American Indians/Alaska Natives were less likely than other persons in the prisons to have a diagnosis of a severe mental illness and more likely to

be sent to mental health services due to behavior that was unexplainable or threatening to the guards (Earle, Bradigan, & Morgenbesser, 2001). These two studies raised the question: Where do Indians in New York state go for mental health care?

Barlow and Walkup (1998) argue that, for most emotional problems, traditional American Indian/Alaska Native care is seen by Native people to be more effective than mainstream services. These authors suggest, however, that teams of mental health professionals can assist Indian Nations in identifying and addressing locally defined causes for many preventable mental health problems such as high rates of alcoholism, drug abuse, or suicide. They also call for culturally appropriate screening tools and population-based epidemiological studies of mental health needs among tribal youth as ways to identify areas of need.

Promising practices in the treatment of emotional disorders among American Indian/Alaska Native children were identified and reported by the Child, Adolescent and Family Branch/Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS (Cross, Earle, Echo-Hawk Solie, & Manness, 2000). These authors described five mental health systems of care for American Indian children:

- K'e Project: Navajo Nation
- Kmihqitahasultipon ("We Remember"): Passamquoddy Tribe, Indian Township, Maine
- Sacred Child Project: Spirit Lake Nation, Standing Rock Nation, Three Affiliated Tribes, Turtle Mountain Band of Chippewa, and Trenton Indian Service Area
- With Eagles' Wings: Arapaho Nation, located on the Wind River reservation in Wyoming
- Mno Bmaadzid Endaad ("Be in Good Health in His House"): Sault Ste. Marie Tribe of Chippewa Indians and the Bay Mills Tribe of Chippewa Indians, Michigan

The projects were evaluated and described using the relational worldview as an evaluation tool. Recurring strengths among these projects were as follows:

Context. Use of: extended family; cultural restoration via mentors, groups, and crafts; methods that build connection to community, culture, group, clan, and extended family; elders or intergenerational approaches; helping values from traditional teaching such as 24-hour care and self-care; approaches that strengthen or heal the community; and incorporation of a value of respect for in-group diversity and exercising that value in services.

Mind. Use of: specific cultural approaches; cultural adaptations to mainstream system of care practices such as wrap-around, respite, crisis intervention, and collaboration; methods to promote healing of Indian identity and the development of positive cultural self-esteem; methods that build up a sense of dignity and strength; methods that prepare children to live cross-culturally and cope with racism and prejudice; native language; all of the above, along with conventional services such as counseling, therapy, and health care; and conventional and cultural methods to recognize and treat historic cultural, intergenerational, and personal trauma.

Body. Maintenance of an alcohol-free and drug-free event policy; dealing with substance abuse; and use of specific cultural approaches such as sweat lodges, feasts, etc.

Spirit. Use of: traditional teachings that describe wellness, balance, and harmony or that provide a mental framework for wellness and use these as objectives for the family; methods that invoke the positive effects of spiritual belief or tap into spiritual strengths or support; and specific cultural approaches such as talking circles and ceremonies (Cross et al., 2000, pp. xi-xii).

As illustrated by these findings, the five projects were able to successfully blend traditional Native treatments and approaches with mainstream mental health care. This involved including families, extended kinship, and community networks in care, as well as sensitivity to cultural and historical issues. For therapists interviewed in this study, the crucial variable in treating Native children was cultural appropriateness. A return to what was, to what had been taken or lost over the past few hundred years, was successful in treating emotional disorders among the children and adolescents in these tribes.

As stated by an unnamed Iroquois leader early in the history of the United States:

You who are Wise must know that different Nations have different Conceptions of things (Franklin quoting the Iroquois Confederation, 1784/1794, 28–29)
(Slaughter, 2000, p. 227).

This different conception of things referenced by the Iroquois Confederation indicates that different approaches may be needed to address the emotional dysfunction of American Indian/Alaska Native children.

Methodology

In the fall of 2001, the National Indian Child Welfare Association (NICWA) received a contract from the Indian Health Service (IHS) to organize at least one site visit to a tribal systems of care children's mental health program. After some discussion, two different sites, one rural and one urban, that serve Indian children and families with mental health needs were chosen to fulfill the contract. The purpose of attending two separate site visits was to inform participants about the issues specific to both rural and urban Indian populations and to assist them in developing an understanding of needs and issues faced by these communities.

In order to begin organizing the site visits, mental health representatives from two separate tribal communities were contacted. Both sites agreed to participate in order to improve advocacy efforts and tribal collaboration with the American Psychological Association (APA), IHS, and NICWA. The sites included in the project were the Oglala Sioux Tribe in Porcupine, South Dakota, and the Phoenix Indian Medical Center (PIMC) in Phoenix, Arizona.

The tribal sites were picked based on their involvement in serving Native children and families with mental health needs. The Oglala Sioux Tribe recently completed a three-year planning grant obtained in 1998 through the Circles of Care

(COC) Initiative² under the U.S. Department of Health and Human Services (DHHS); they are now offering mental health services developed through the planning grant, which will be described later in detail. The Phoenix Indian Medical Center (PIMC) also delivers mental health services such as psychiatric, psychological, and outpatient services to the Native population located within the urban setting of Phoenix, Arizona.

Once permission was obtained from the tribal sites, NICWA then organized these visits to occur during the week of May 6–10, 2002. Two representatives from NICWA (Gus Abeita and Chey Clifford-Stoltenberg), one representative from the IHS (Jamie Davis Hueston), and two representatives from APA (Daniel Dodgen and Denis Nissim-Sabat) were all in attendance during the visits. Information obtained through the site visits was hand-recorded and assembled into notes detailing proceedings and was then sent out for review by participants. In order to ensure accuracy of the data collected, once feedback was obtained from site visit participants on the proceedings notes, a draft document was developed and disseminated to all parties involved in the tribal site visits. Feedback was obtained from representatives of each tribal community, as well as IHS, APA, and NICWA representatives, and their suggestions were incorporated into the final document.

² The Circles of Care Initiative provides funding to tribal sites for planning, designing, and assessing the feasibility of implementing a culturally appropriate mental health service model for American Indian/Alaska Native children with serious emotional disturbances and their families.

Summary of Sites

Oglala Sioux Tribe

The Oglala Sioux Tribe, located on the Pine Ridge Reservation in Porcupine, South Dakota, has approximately 40,000 enrolled members throughout the 1.8 million acre reservation (personal communication with Monique Giago, May 6, 2002; Oglala Lakota GFA, 1998). Children living on this reservation are faced with severe societal deficits, including poverty, shortages in housing, substance abuse, family violence, and lack of basic services, which often translate into depression, anxiety, learning disorders, physical and sexual abuse, spiritual confusion, and emotional and behavioral disorders (Oglala Lakota GFA, 1998). Despite the societal deficits described above, the Oglala Sioux Tribe retains many strengths, including the strong spiritual and cultural practices still evident among its people.

In order to address these societal issues, however, the Wakanyeja Wape Tokeca (“Children of a Different Way”) Project was developed as part of the Circles of Care (COC) Initiative. After completing the planning stages, this site applied for a services grant and was awarded funding to assist Native children and their families utilizing a wrap-around approach and the Lakota traditional healing model. The new program, called Nagi Kicopi (“Calling the Spirit Back”) is administered by Wakanyeja Pawiciyapi, Inc. (“Children First, Inc.”) and provides a holistic healing process for families

by utilizing “the inipi ceremony [Lakota purification ceremony], the counsel of wise elders and traditional healers, the support and knowledge of tiospaye (extended family) members, and the practice of traditional peace-making” (Nagi Kicopi brochure, 2001). This program serves individuals ages 0–21 and provides the children and youth with mental health programs based on Lakota traditional healing. Diagnosis is provided currently both by a psychologist, who speaks fluent Lakota and comes to the reservation quarterly, and by two Lakota traditional healers. Additionally, every year, the program staff organizes and leads the children on sacred site visits in order to regain the balance of the hocoka (“sacred center”) and to regain balance both within themselves and within the family system. Based on this successful cultural and spiritual approach developed to meet the mental health needs of children in the Oglala Sioux community, this project was chosen as one of the sites to visit.

The site visit began with an informational session entitled “Healing the Spirit: Redefining Cultural Competence,” to give participants from APA, IHS, and NICWA a better understanding of Oglala culture and spirituality. At the start of the meeting, these participants were asked what feelings and/or thoughts they had with regard to their environment upon first driving onto the reservation. Varied answers were given, including comments on the devastation and survival

capabilities of the tribe. The executive director of Wakanyeja Pawiciyapi, Inc.—Michael Standing Soldier—then discussed the effects of the reservation environment on providing services to their children and families. Mr. Standing Soldier indicated that the devastation and survival skills needed on their reservation are a reality and something that tribal members have to live with on a daily basis. He noted that it was especially important to keep those first impressions in mind when learning more about their culture in order to fully understand the needs and historical trauma that may be present within their service population.

Important information was presented on the meaning of culture and spirituality specific to the context of the Oglala Sioux Tribe, including a historical perspective on how their tribal culture and laws were created, the meaning of cultural sensitivity, specific words used in their culture, and the three major periods affecting the sustainability of their tribe. First, Mr. Standing Soldier talked about the idea of culture being created by a people or a group, and the belief that their laws were given to the Oglala people by a sacredness and a connection to the sacred being. These laws were not created or passed on through humans. He indicated that the natural law of the Oglala world is that one respects creation.

Mr. Standing Soldier also discussed what cultural sensitivity means to the Nagi Kicopi program

staff, which includes being aware of: 1) the dynamics of European-American privilege; 2) cultural expectations; 3) tribal history; and 4) levels of assimilation. Their program care coordinators are called Wacante Ognaka (“Carry Them in Your Heart”), and this term embodies the philosophy and psychology of the Oglala hocoka (“sacred center”). The program staff members serve as role models to children, families, and communities, and attempt to teach children what has been taken away from them through a thought process (e.g., historically, Indian children have been told they were bad for speaking their language and for being Indian, so the staff is trying to help them heal from that experience). The staff is also trying to help families and the community as a whole heal from historically traumatic events such as the Wounded Knee Massacre. The mass killing of the wakanyeja (“children”), elders, and entire families during that time still affects the community today. To assist in this process, the program has developed assessment tools specific to the Oglala, such as a diagnostic guide with diagnoses specific to Oglala people. One example of such a diagnosis is nagi cola oun (“living without a spirit”). This disorder results from severe abuse, either physical or sexual, or some form of severe trauma, and symptoms can include a wandering lifestyle, alcoholism, chronic depression, inability to focus, and/or suicide attempts (Iron Cloud-Two Dogs, 2002).

Finally, Mr. Standing Soldier and other program staff defined the three major periods of time within the United States that affected tribal sustainability—the genocidal period, the assimilation period, and the renewal period. The genocidal period was an attack on the physical dimension of the *hocoka*. This attack was evidenced by the unnatural death (e.g., diseases introduced by Europeans, massacres, and plagues) and unnatural distortion (e.g., verbal lies, the sight of children and elders being murdered, foreign sounds such as gunfire, and toxic substances) introduced into tribal communities.

The second period, or the assimilation period, was an attack on both the emotional and the mental dimension of the *hocoka*, and included the following events/periods:

- Christianization
- individualization
- boarding schools
- land allotment
- reservations
- destruction of traditional government
- teachings of self-racism in boarding schools (e.g., lighter-skinned Indian people were held in higher regard than darker-skinned Indian people, who were seen as “dirty”)

This period allowed for the destruction of ideology, which resulted in the Oglala people no longer believing in one thing or one way. Thus, there was a fracturing of belief systems evident in the current tribal environment.

The final period—renewal—began in 1968 with the Freedom of Religion Act. This Act allowed American Indian people to practice their religions, many of which were outlawed in the 1800s by the Indian Offenses Act. During this time, Indian people began to rebuild what was lost during the genocidal and assimilation periods, and were able to openly engage in their spiritual and cultural practices. Mr. Standing Soldier noted that, although the physical, mental, and emotional aspects of the *hocoka* were attacked and ultimately defeated, the spiritual realm of the *hocoka* was never defeated, which is a very important piece in the renewal of their tribe.

Upon completion of the cultural competence presentation, participants were given the opportunity to meet with a variety of tribal representatives, including a health educator, a special education department coordinator, a parent of a child involved in the Nagi Kicopi program, and Casey Family Programs (CFP) staff at the Pine Ridge Reservation area office. The first individual that participants spoke with was Mary Tobacco, a tribal health educator who discussed the importance of physical fitness within their

community. Ms. Tobacco described the “Zeus-like” appearance of the Oglala people prior to colonization. After colonization, a shift in lifestyle occurred, with tribes moving from a nomadic to a sedentary lifestyle, which resulted in an increase in diabetes, heart disease, and depression. One of the biggest obstacles to fitness for their tribal population is the lack of facilities available to the Oglala people; therefore, in order to address these issues, on the Pine Ridge Reservation, two fitness centers as well as two dialysis units were built. The tribe is currently working on getting another fitness center because of the overwhelming need that is still present. Originally, people utilizing the fitness centers were tracking their own progress; however, the program just received funding for staff to be at the facilities in order to serve as resources. Currently, the focus of the program is on caring for an existing disease instead of prevention; it does not focus on nutrition because program staff feel the biggest change individuals can make right now is to adopt an active lifestyle.

After speaking with Ms. Tobacco, participants were introduced to Annie Montileaux, the special education department coordinator for the tribally contracted Little Wound School. Ms. Montileaux discussed the makeup of the school, which includes six teachers who work with students who have learning disabilities and some students

with multiple handicaps. She explained the evaluation process for children with special needs, starting with referral to the Teacher Assistance Team (TAT), a team of teachers who engage in problem-solving to come up with means to help the child do better in school. If nothing suggested by the TAT works, then the child is referred to special education. The child is then evaluated by the school psychologist using tests such as the Stanford-Binet Intelligence Scale, the Wechsler Intelligence Scale for Children (WISC-III) test, and a behavior assessment. The Individualized Education Program (IEP) team then meets and discusses how to address the child’s needs based on his/her psychological results. If they find they cannot adequately meet the child’s needs, then he/she is referred out for other services.

Some of the children get referred to the Nagi Kicopi program; however, these services are fairly new, and they are slowly becoming integrated into other programs for referral. About half of the children in the Nagi Kicopi program are also involved in special education. Many of these children who are emotionally disturbed do not consider school as a top priority. Referral to the program has to be made by a legal guardian of the child. Ms. Montileaux indicated that, in her opinion, there is resistance in the schools with regard to acknowledging that the wakanyeja (“children”) have needs too, and currently there is a set way

of doing things within the school system that makes school staff reluctant to change.

When asked about particular challenges she deals with, Ms. Montileaux referred to the following:

- 1) Most parents do not really know their rights, and are often too scared to demand services for their children. This creates a barrier in addressing their children's needs, and there needs to be advocates available for parents so they can learn about their rights.
- 2) There are a number of children who are always in trouble but are not referred out for testing, especially the more quiet children who may have a learning disability. Oftentimes, these children are just moved through the system or eventually drop out of school.
- 3) There is a need for an in-house school psychologist to test the wakanyeja, as well as more learning disability (LD) teachers. Right now, they only have two LD teachers to serve 61 LD children.

After speaking with Ms. Montileaux, participants were then introduced to a parent of a child diagnosed with a serious emotional disturbance (SED) involved in the Nagi Kicopi program. This parent discussed the importance of utilizing a systems of care approach in Indian communities

for addressing children's mental health needs.

The parent indicated that he believes in culturally appropriate systems of care and has assurance that it works for American Indian/Alaska Native children and families. He also stated, "If culture becomes a part of [children's] diets, spiritually, mentally, and politically, then things will get better. Overall, it's a big relief to have some spiritual connection. Everybody needs that."

As a parent, he participates in the Parent and Family Support group offered by the Nagi Kicopi program. At the group, families come together to talk about issues affecting them. He indicated he would like for the group to begin dealing more with legislative committees in tribal governments and to come up with policies for administration and staff in schools on how to deal with these children. Additionally, workshops and trainings on the topic of parenting children with SED would be beneficial.

Finally, the parent indicated that he is very pleased with the Nagi Kicopi program and that he would recommend these culturally relevant kinds of services to other families as opposed to IHS services and/or medication. He feels that it is a relief to both parents and children to be involved in this type of program and that it makes the children feel good by giving them a "spiritual high."

After meeting with the parent, participants were taken to the Casey Family Programs (CFP) reservation-based area office in Pine Ridge, South Dakota. During the visit to the CFP office, program staff discussed the needs of their service population, which included the following:

- 1) *Fragmentation of services*: Clients are having problems navigating through different service systems and are also having trouble obtaining needed referrals. In order to address this, there is a need for strengths-based wrap-around services that are consistent for all clients. Additionally, there needs to be more networking and collaboration between service providers. Many agencies seem to be overwhelming themselves by trying to provide too many services. Through increased collaboration, they could eliminate the duplication of services.
- 2) *Dealing with historical trauma*: There is a great need to address the effects of boarding schools on American Indian/Alaska Native families and communities. This will take a large amount of collaboration between agencies; however, CFP staff is confident that the answer to addressing this need lies within Native culture and what they have as Native people that can help them to heal and to grow.
- 3) *Transportation*: For older children that may be starting out on their own, transportation becomes a problem. In order to take care of themselves, they must have access to some form of transportation (e.g., access to public transportation, personal vehicle) so that they can fulfill everyday life tasks, such as meeting appointments or grocery shopping.
- 4) *Lack of access to services*: One CFP staff member indicated that when the state takes a referral for investigation of child abuse/neglect, if the case is unsubstantiated, then the families involved receive no case management or other services. If these families decide they would like services, then they are expected to go out and find them on their own. Additionally, Native children in need of a foster home placement often are placed in non-Native homes due to the lack of Native homes available. Without access to these homes, Native children are not receiving services that are tailored to fit their cultural needs.
- 5) *Lack of resources*: CFP program staff indicated that there is a lack of funding for programs and services on the reservation. This results in inadequate housing, education, and employment opportunities, as well as a lack of qualified workers to provide services to the reservation population.

The site visit concluded with participants being provided the opportunity to be involved in an inipi ceremony (Lakota purification ceremony; some tribes refer to this as a sweat lodge ceremony). The ceremony was led by Lakota traditional healer Richard Moves Camp and allowed participants to discover the strength behind and importance of these ceremonies for healing community members and families.

Phoenix Indian Medical Center

The Phoenix Indian Medical Center (PIMC) Behavioral Health Division is a direct clinical service arm of the Phoenix Area IHS office and serves approximately 14,000 patients per year (this number includes outpatient, field-based, and consult-based services). In psychiatry, service providers see about 130 patients per month, while in psychology, service providers see about 90 patients per month, with approximately 20% of patients being referred out for other services. Additionally, PIMC provides 24-hour-a-day on-call crisis services, and they receive about four to five requests for face-to-face emergency room evaluations per week and approximately one to two after-hours calls for phone assistance per day for this service (personal communication with Dr. Jon Perez, May 8, 2002).

During the site visit to PIMC, participants were given a chance to visit with Dr. Sandi Perez, a child psychologist who is the Senior Program Officer for the Arizona Community Foundation and works with the Arizona nonprofit sector in acquiring funding. Dr. Perez discussed the needs present within the nonprofit arena, including the need for an increase in the overall number of nonprofit organizations that serve the urban Indian community. Currently, there are only six programs total that serve this population. In addition, Dr. Perez indicated that there is also a lack of capacity to sustain programs that serve the Native population, and therefore, an increase in funding is greatly needed.

After speaking with Dr. Sandi Perez, participants engaged in discussion with Dr. Anthony Dekker, Dr. Jon Perez, and Dr. John Spaulding on cultural competence within the IHS system. These IHS representatives stated that, in 1999, a survey conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) revealed that the IHS was not orienting their new employees sufficiently to the culture of the population they were serving. The survey was disseminated to all IHS staff serving patients in traditional practice, and over 400 surveys were returned. The results of the study revealed that about 90% of the staff had participated in a traditional ceremony; however, about 70% of these

Emerging Themes from the Tribal Site Visits

During the visits to the two tribal sites, several themes emerged with regard to services being provided. These themes were evidenced in the discussions and presentations within each tribal site and oftentimes were indicative of the system of care principles and values identified in an article written by Stroul and Friedman (1996). Stroul and Friedman state that the three core values of a system of care are that the system be: 1) child-centered and family-focused; 2) community-based; and 3) culturally-competent. From the summary of the site visits, it is easy to glean that these sites were focused on all three of these core values that were brought out through the unique services offered to community members.

First, the concepts of child-centered and family-focused systems of care as well as community-based services were evidenced in both of the tribal sites. For example, within the Oglala Sioux Tribe's Nagi Kicopi program, staff provides support services to both children and their families. Parents can attend group sessions to talk about their needs and issues with other parents having the same experiences, while children are given the opportunity to engage in cultural ceremonies and events in order to promote healing. All of these services are offered within the family's own community, allowing these families to address their needs without having to leave the reservation. The Phoenix Indian Medical Center (PIMC) also presents culturally appropriate services to

families by offering them referrals to traditional healers within their own communities if needed.

Finally, the concept of culturally competent services was evidenced at both sites through discussions on the meaning of culture and spirituality in providing services to Native individuals. At the Oglala Sioux Tribe site visit, staff discussed how they would define cultural sensitivity and the understanding and awareness staff members must have when working with Native clients. Cultural competence is also being addressed at this site through both the hiring of Native program staff and psychologists, as well as the traditional healing ceremonies (e.g., inipi ceremony, smudging) each client is offered through the Nagi Kicopi program. The program also has Lakota traditional healers on staff to provide specific services to children and families with mental health needs. Additionally, all of the presentations and materials provided to site visit participants incorporated tribal language, which can increase the success of outreach efforts to tribal community members.

At PIMC, staff members indicated that they have a traditional practice committee to refer clients to traditional service providers for services, and they are now utilizing a new biopsychosocial assessment tool to address cultural needs. They are also beginning to address the training needs of new employees and the recruitment of more

Native individuals in mental health careers.

Aside from the above-mentioned systems of care concepts, several other themes emerged during the site visits. The following additional themes were evidenced at the tribal sites:

1) *Interagency collaboration*: Both sites indicated that this is an important step in providing appropriate services for tribal communities. For example, the Oglala Sioux Tribe provided information to site visit participants on a variety of topics, including physical health, mental health, foster care, and special education. Representatives from each of these programs indicated a need for interagency collaboration and talked about the need for referrals to culturally competent programs. Staff members from Casey Family Programs' Pine Ridge office indicated that there is a fragmentation of services occurring on the reservation, and they must focus more on strengths-based wraparound services. Agencies who try to provide too many services find themselves overwhelmed. This issue could be addressed through networking and appropriate referrals.

With regard to interagency collaboration, the Guiding Star Program that participants visited discussed the importance of collaboration in providing more comprehensive services for their service population. The networking this

agency has become involved in has helped their clients gain skills that will assist them and their children in sustaining a healthy lifestyle (e.g., obtaining a job, attending school).

- 2) *Historical trauma*: The Oglala Sioux Tribe presented participants with information on the historical devastation of boarding school placements that impacted their tribe's current state of being. They indicated that families, children, communities, and program staff must begin to address this trauma in order to heal properly. Although it is important to address this type of trauma, staff members indicated that it will take a long time to heal from this devastation. It is important, however, for all community members to begin addressing this issue in order to move forward and repair the damage that has been done to the four realms of the *hokoka* (physical, mental, emotional, and spiritual). In addition to the Oglala Sioux Tribe, representatives from the Casey Family Programs' Pine Ridge office indicated that it is going to take a lot of collaboration to deal with this trauma and that the answer to healing lies within tribal culture.
- 3) *Lack of resources*: The issue of lack of resources covered a variety of needs, including lack of transportation, lack of funding sources, lack of facilities, and lack of overall

services and access to these services. For example, CFP staff in Pine Ridge indicated that community members have trouble finding transportation in order to fulfill everyday life tasks or access services. Oftentimes, community members in need of these services are forced to seek them out on their own and thus are not always able to access services that fit their needs culturally or spiritually. An Oglala Sioux parent also discussed the need for sustainability of the current programs through increased funding. The tribe does not receive enough federal funding to develop and maintain services that will serve their community, which often forces Native individuals to seek services off the reservation.

At PIMC, staff discussed the need for more services in the nonprofit arena. In order to provide services to community members, an increase in funding is greatly needed to raise the number of nonprofit agencies addressing the needs of Native populations. The Director of PIMC also stated that there is a need for a comprehensive service site that can provide psychosocial, medical, and developmental services all in one place. This would allow Native individuals who have trouble obtaining transportation to the service site to take care of more than one need, if necessary, all in one day.

Recommendations

Policy

Recommendation One: Allow for direct tribal access to federal funding for children’s mental health services and children’s health insurance.

Currently, as with other social services programs, American Indian/Alaska Native tribal communities have limited access to federal funding sources for children’s mental health services. One way to address this issue is to provide for direct access to these funding sources for tribes. Federal funding sources that will assist tribes in providing much-needed services to their communities include the Mental Health Block Grant, Title XX Social Services Block Grant, and Title IV-E Foster Care and Adoption Assistance.

Tribal governments are currently unable to directly access funding under the Mental Health Block Grant, Title XX, and Title IV-E. Direct tribal access to federal funding is consistent with tribes’ status as sovereign nations with a variety of governmental authorities that are distinct from state governments. Tribes and tribal organizations are in the best position to provide services to their members, as they have the unique knowledge, qualifications, and skills necessary to provide appropriate and effective services to their communities. Under the Mental Health Block Grant, tribes could begin to address both immediate mental health needs as well as long-term

capacity-building for tribal communities.

In addition, this funding would allow tribes to join in the national mental health movement toward developing comprehensive, community-based, and culturally competent systems of care.

Aside from direct access to the Mental Health Block Grant, tribes could benefit from direct access to Title XX and Title IV-E federal funds. The Title XX Social Services Block Grant is a national program that was intended to provide social services for children and families throughout the United States. However, funding from Title XX in the past has only been allocated to state and territorial governments, leaving American Indian/Alaska Native children and families out of the benefits from this important funding source.

Finally, if tribes are given direct access to Title IV-E Foster Care and Adoption Assistance funding, they can begin placing Title IV-E eligible children in subsidized homes. Currently, in order to receive reimbursement for maintenance, training, and administrative costs associated with foster care and adoption, tribes have had to enter into agreements with their respective states. These agreements are often limited in scope and may only contain provisions to provide funding for foster care maintenance funds; states, however, receive funding for foster care maintenance, training, and administrative costs as well as funding for information system development.

With regard to children's health insurance programs, tribal services could be improved by providing direct access to Medicaid, Medicare, and Children's Health Insurance Program (CHIP) funding. Currently, access to health care is limited to health clinics that are run by the IHS or to those clinics that have negotiated with the IHS to be provided reimbursement through the IHS or state systems. This has compromised tribal efforts to arrive at sustainability and provide quality health care (including mental health care) for their children.

Recommendation Two: Allow for reimbursement for the use of traditional practices and services with Native clients.

Spirituality plays a major role in the mental health of American Indian/Alaska Native communities. For this reason, it is important for individuals utilizing traditional Native practices to be included in the definition of mental health providers and to be offered reimbursement for their services. Currently, traditional healers are not included in the mainstream definition of mental health providers and therefore do not receive reimbursement for providing their culturally appropriate services, although their practices are often a vital part of treatment that helps American Indians/Alaska Natives restore balance within the realm of mental health. Native individuals who may be in need of mental health services often

run up against stigmatization by visiting a mental health clinic; visiting a traditional healer, however, may not invoke the same feelings.

Practice

Recommendation Three: Increase training in cultural competence for program staff and administrators.

This training should be systematically introduced at the local level to include information on historical trauma with an emphasis on the different significant historical events in specific tribal communities, Native concepts of mental health and mental illness, working with Native individuals and families, and the appropriate use of assessment instruments for Native clients (based on tribal background, level of assimilation, and cultural identity). This training would provide a context for the programs in which these individuals work. By understanding these concepts, service providers and program administrators can provide more appropriate services to Native children and families.

Service providers must also understand the definition of Native mental health in order to address the needs of this population. For example, the use of traditional healers and spirituality is a natural process for Native individuals, and therefore, providers must have the knowledge and skills necessary for referring their clients to these types

of services and know how to become engaged in the process, which is often vastly different from the standard Western mental health process. Regular, ongoing training of this sort, and exposure to local traditional healers and participation in community cultural events is essential for service providers and administrators to continually develop their level of cultural competence both as individuals and as an agency.

Recommendation Four: Recruit more Native individuals into the mental health field and increase the ability for tribal sites to hire more Native individuals.

As mentioned by an IHS representative, the number of Native individuals working in the mental health field is surprisingly low. Therefore, there must be more active recruitment of Native students into this field in order to provide more culturally competent services to the American Indian/Alaska Native population. This educational recruitment component is critical in that it results in a larger pool of Native employees from which to choose. The ability to hire more Native service providers will in turn contribute to the development of appropriate, sustainable services for American Indian/Alaska Native communities.

One example of a successful program that addresses this issue is the Indians Into Psychology Program (INPSYCH), which began in 1995 and supports the training of American

Indian/Alaska Native psychologists. The program provides support for undergraduates, summer internship programs, and graduate training at four universities. This program has been successful in recruiting American Indians/Alaska Natives into the field of psychology and should be extended to increase the number of universities in the program. In addition, the program should be expanded to expose high school students to the various mental health disciplines that provide direct clinical services to American Indian/Alaska Native populations.

Recommendation Five: Increase technical assistance opportunities for tribal communities with regard to children's mental health services and the development of resources to support these services.

Providing tribal communities with more technical assistance opportunities for developing culturally appropriate mental health services and resources should be a priority. It is important for tribes to develop not only programs but also sustainable resources to meet the needs of their communities. By engaging in technical assistance opportunities, tribal communities can increase their knowledge base in serving their own tribal populations, thus decreasing the need for off-reservation program resources. Community-based, Native-specific programs are critical for meeting the mental health needs of this population.

Recommendation Six: Strengthen opportunities for collaboration between tribes, between agencies and tribes, between agencies, and between national organizations that provide children’s mental health services (including Child Protective Services [CPS] and the juvenile justice arena).

In order to provide more competent services for American Indian/Alaska Native children and families, tribes, agencies, and national organizations (e.g., IHS, NICWA, APA, Substance Abuse and Mental Health Services Association [SAMHSA], and the National Congress of American Indians [NCAI]) must collaborate extensively. This collaboration could allow for more sharing of information between tribal communities about current promising practices, including increased parent involvement and advocacy as well as the utilization of community members and traditional healers in serving Native children and families with mental health needs. Additionally, collaboration could decrease the fragmentation of services that currently occurs within tribal communities. If agencies began networking and developed an understanding of available tribal services, then they could begin making appropriate referrals for Native individuals. It is also important to begin looking at expanding collaboration efforts outside of conventional mental health service systems to include other systems that may come in contact

with American Indian/Alaska Native children with mental health needs, such as CPS and the juvenile justice system. By looking outside these conventional service systems, total systems of care for these Native children could be established.

Research

Recommendation Seven: Conduct research on outcome measurements for the utilization of both traditional healers and spiritual practices in serving Native children and families with mental health needs.

Currently, there is little research on outcomes resulting from the utilization of traditional healers in Native communities. Therefore, it is recommended that researchers focus on understanding the effects of incorporating traditional practices and spirituality into treatment of children and families with mental health needs. Having some useful and well-planned outcome data would contribute to the knowledge base about the importance of traditional practices and could further justify increased funding for tribal communities and these types of services.

Recommendation Eight: Increase the amount of research being conducted on juvenile mental health issues.

This research could include topics such as suicide in Native communities and juvenile justice

issues. There is currently a lack of information available in these subject areas, and data obtained through research of this type could improve tribal services by exploring what treatments are working and not working for American Indian/Alaska Native individuals. Additionally, information obtained from this research could be used in requesting an increase in resources from funders and policymakers.

Conclusion

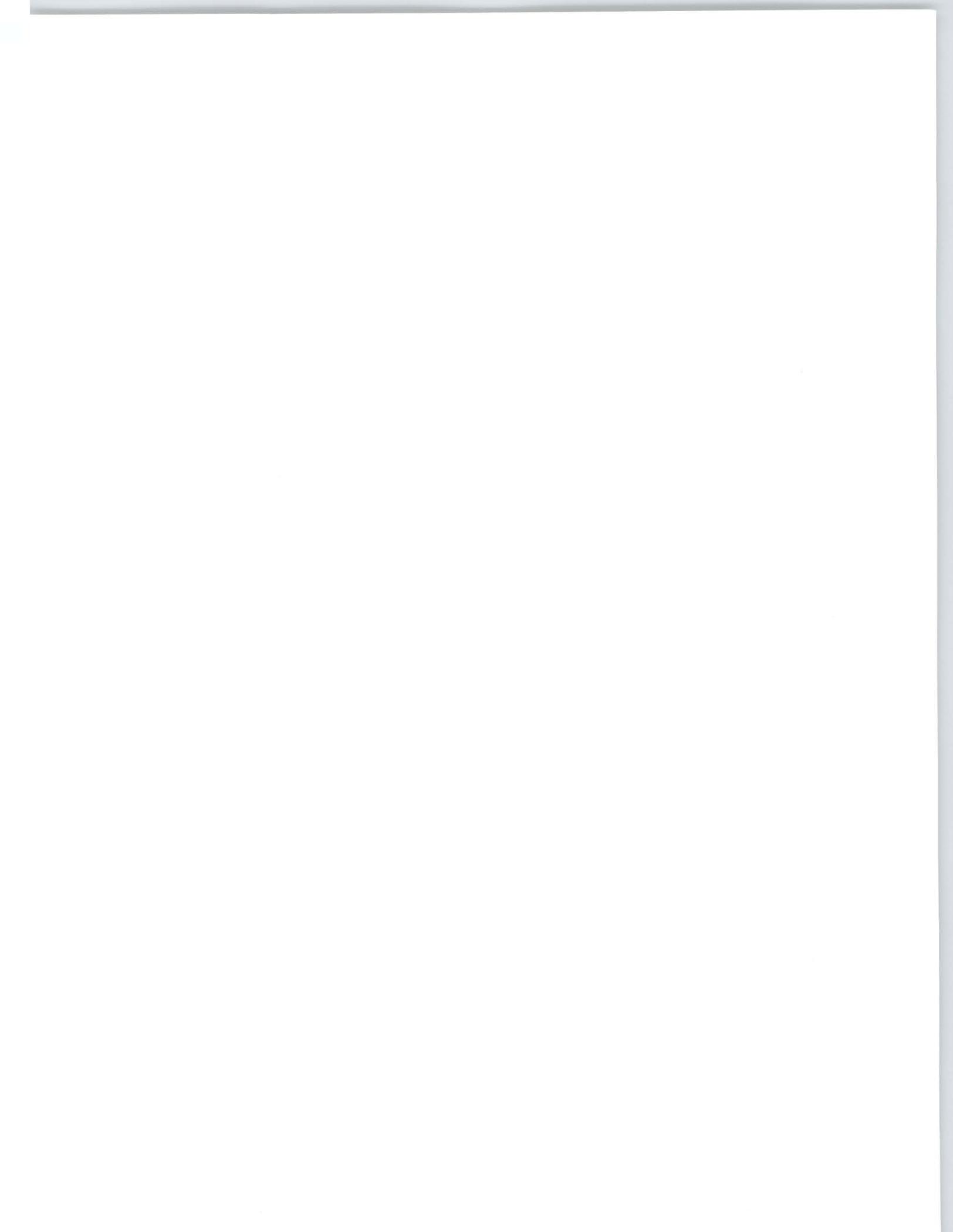
Overall, the information provided by representatives from each tribal community will serve to improve mental health services for American Indian/Alaska Native children, families, and communities by providing examples of promising practices within Native communities. The collaborative efforts put forth by all participants clearly revealed the importance of sharing information in improving access to services for Native individuals. Although the recommendations provided above are not all-inclusive, they serve as a starting point for further discussions on the needs present within additional Native communities. Further research, however, as indicated in the recommendation section, should be conducted both on these specific needs and on promising practices within tribal communities that address those needs. It is important to explore these topics further in order to raise awareness of the existing mental health issues currently faced by Native children and families.

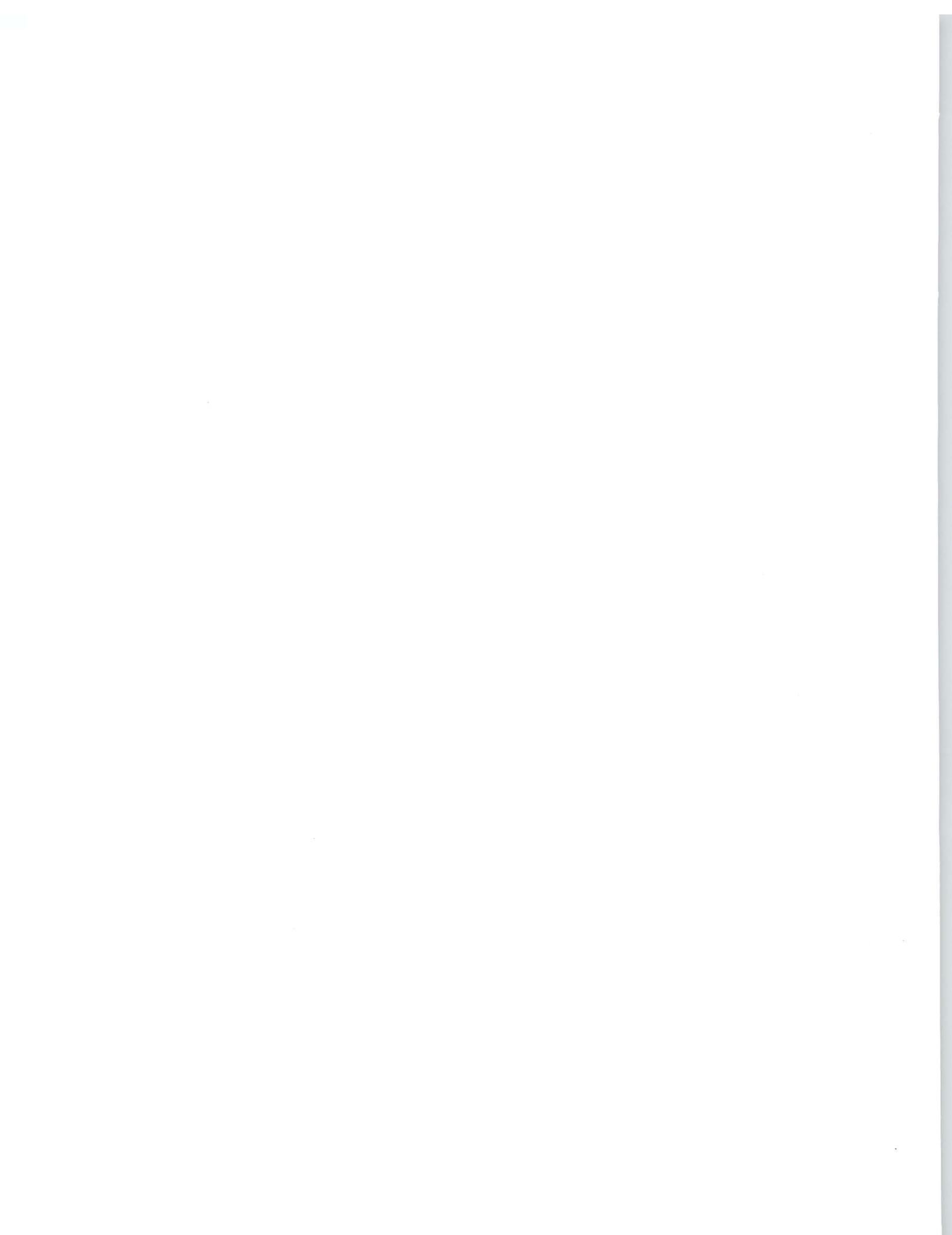
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About the Indian Health Service

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.

Our Mission... to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Our Goal... to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Our Foundation... to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

About the National Indian Child Welfare Association

The National Indian Child Welfare Association (NICWA) is a private, non-profit organization dedicated to improving the lives of Indian children and their families. NICWA accomplishes this goal by offering training and technical assistance related to Indian child welfare services; making available information regarding the needs and problems of Indian children; helping to improve community-based services; and working to promote improved public policies for Indian children.

The National Indian Child Welfare Association's Purpose

- ☼ To preserve and protect the most valuable resource of Indian people—Indian children.
- ☼ To promote safe, healthy, and culturally strong environments for Indian children.
- ☼ To promote a positive sense of heritage among Indian children.
- ☼ To advocate for and facilitate proper implementation of the Indian Child Welfare Act.
- ☼ To provide a clear voice for the needs of Indian children and Indian child welfare programs.
- ☼ To provide coordination and information sharing among Indian child welfare programs.
- ☼ To promote the provision of effective services to Indian children by child welfare workers.
- ☼ To promote education and leadership opportunities for Indian child welfare workers.
- ☼ To develop resources for programs relating to Indian children, youth and families.
- ☼ To obtain and disburse funds for specific projects related to Indian child welfare.
- ☼ To provide technical assistance on Indian child welfare matters.

For additional information about this report or other NICWA projects, please contact:
National Indian Child Welfare Association
5100 SW Macadam, Suite 300
Portland, OR 97239
(503) 222-4044
(503) 222-4007 FAX
www.nicwa.org



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