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AMERICAN INDIAN CHILDREN'S MENTAL HEALTH SERVICES

An Assessment of Tribal Access to Children's Mental Health Funding and a Review of Tribal Mental Health Programs

National Indian Child Welfare Association

National Technical Assistance Center
for Children's Mental Health
Center for Child Health and Mental Health Policy
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AMERICAN INDIAN CHILDREN'S MENTAL HEALTH SERVICES
An Assessment of Tribal Access to Children's Mental Health Funding

INTRODUCTION

Native American children in the United States who experience serious emotional disturbances do not currently have equitable access to treatment services. The Native American Children's Mental Health Access Project was developed by the National Indian Child Welfare Association (NICWA) to help increase access to federal, state and private mental health resources for these children. The project is designed to help tribal governments develop greater knowledge of available mental health funding and services and to identify and promote successful strategies for access to currently available resources. In addition, the project seeks to identify and examine currently unavailable or unattainable resources and the barriers that must be overcome if Indian children are to have equitable access to mental health services.

The project is a joint venture between NICWA and Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health, and is supported by the Center for Mental Health Services. This multiyear project focuses on the following tasks:

- conducting a review of public and private funding sources that can be used by tribes to increase their capacity to provide basic mental health services to their children;
- identifying, analyzing and disseminating information on the extent of the problem and on the barriers tribes experience in attempting to provide children's mental health services;
- conducting strategy-building technical assistance meetings with tribal governmental officials and mental health providers.

This report provides an overview of Indian children's mental health issues and how tribes are currently coping. The information provides a brief synopsis of where we now stand in the process of increasing access to services for Indian children who are emotionally disturbed and what additionally could be done. Summarizing the results of a tribal leaders' forum conducted by NICWA on this topic, this document reviews the findings of a survey of tribes conducted as part of this project and cites several studies and task group recommendations developed over the last ten years. This report is intended as a catalyst for discussion and problem solving.

The information is intended for use by several key stakeholders on the periphery of the mental health system, including

- tribal social service staff seeking access to funds to provide children's mental health services;
- tribal leaders who are seeking access to mental health services for their children;

- state and local mental health departments who may be in positions to enter into partnerships with tribes;
- federal officials and staff who need to know the problems and some potential solutions;
- private foundations who could fund demonstrations of effective strategies;
- legislative staff and officials who could change laws and help remove the barriers to access.

As tribal leaders, service providers and child advocates come together to examine these issues, clear concepts of a system of care are essential for developing effective solutions. Services that are community-based, address the whole child and involve the family are the core concerns of this report. How systems of care can be developed in the current configuration of services and funding is not clear. Only through examination and experimentation will answers be developed. Although the information contained in this document is not new, it is hoped that its synthesis will inspire new solutions to old problems.

BACKGROUND

Severe life stresses place Indian people at high risk for mental health problems. On a national level, Indian communities are affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, child neglect and suicide. Most authorities agree that there is a substantial level of unmet need for mental health services in tribal communities (Swinomish Tribal Mental Health Project, 1991).

Indian youths are particularly in need of appropriate mental health services. According to *Indian Adolescent Mental Health,* a 1990 report from the Office of Technology Assessment, information is scarce on the extent of mental health problems among Indian adolescents and on the availability, accessibility and effectiveness of mental health services specifically for Indian adolescents.

NICWA's exhaustive review of the literature on the mental health needs of Indian children revealed no readily available articles, reports or studies that address the number of Indian children considered emotionally handicapped. Generally, minority children with mental health problems are often not identified and go without appropriate treatment. Non-white children are less likely to receive all forms of treatment and are particularly likely to be served in correctional facilities (Knitzer, 1982). Gould, Wunsch-Hitzig and Dohrenwend estimate that the nationwide incidence of emotional disturbance is 11.8 percent of the population under 18 (Gould et al, 1980).

The 1990 Census revealed that almost two million American Indian people are living in the United States. Of this number, 39 percent are under the age of twenty. If we apply known statistics to the census count of Indian children nationwide, we would expect to find approximately 93,000 emotionally handicapped Indian children in the United States. However, cultural, economic, social and historical factors, coupled with the failure to identify minority children in need of services, render such an extrapolation of the national estimates virtually meaningless (Swinomish Tribal Mental Health Project, 1991).

Nonetheless, the information that does exist makes clear that mental health services for Indian adolescents are inadequate and that Indian adolescents have more serious mental health problems than all races' populations in the U.S. with respect to

- development disabilities, such as mental retardation and learning disabilities;
- depression;
- suicide;
- anxiety;
- alcohol and substance abuse;
- running away;
- school drop-out.

Many Indian youths have been identified as "at-risk" through boarding school surveys and screenings. According to an unpublished paper by the Bureau of Indian Affairs, *Therapeutic Residential Schools—Promise of the Future*, off-reservation residential school students are either "at-risk" or "very high risk" students. Most of these students have suffered sexual, physical and emotional abuse; abandonment and/or rejection; and have been involved in self-destructive behaviors. Supporting documentation shows that some students are on probation from the juvenile court system. In addition, the scope of alcohol and drug abuse among entering students is overwhelming: 80 percent to 100 percent. Over 80 percent are from a home environment where one or both parents have been identified as having a drinking problem. The paper further reports increasing dysfunction in all areas investigated in mental health screenings. The majority of students screened (approximately 95 percent) reported critical medical, social, mental and educational needs that have not been and are not being met.

These findings are not new. In 1969, a Senate Special Subcommittee on Indian Education reached extraordinary 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" (U.S. Congress, Senate Committee on Labor and Public Welfare, 1969).

The effects on Indian society in general of the forced removal of children to boarding schools are only now being fully recognized. Children began to change in ways that their parents and grandparents could not understand. Often they returned home for vacations expressing serious identity confusion. Some children became ashamed of being Indian and bitterly disowned the values and lifestyle of their families. Others became rebellious, distrustful, withdrawn or depressed. Many Indian children who spent their formative years in boarding schools grew up unable to fit comfortably into either Indian or non-Indian societies (Swinomish Tribal Mental Health Project, 1991). When and if these children returned to their tribes, they often had difficulty fitting into a family and tribal life that they did not completely understand. Having been

denied normal Indian childhood experiences and role models, they were delayed in their social and emotional development as Indian people (Attneave, 1977). A large number of these children developed severe problems in adulthood, such as alcoholism, depression or violent behavior.

Another consequence of the boarding school experience has been an upsurge in child neglect and a cycle of removal of successive generations of Indian children from their parents. Young Indian parents who had been virtually reared in boarding schools did not learn from their own families about how to raise children. In particular, they received the non-verbal message that Indian people could not be good parents. It is an inescapable fact of Indian life that entire generations of parents (now, for the most part, people in their middle years) were denied the experience of a normal Indian family life (Hollow, 1982). Today, there are still over 11,000 Indian youth and children in government-run or funded boarding schools. Of these, approximately 4,000 are elementary-age children. The consequences of not growing up within a family continue (Geboe, 1995).

Despite the existence of serious mental health problems, Indian people historically have received only very limited mental health services. Services theoretically available to all have, in practice, been largely inaccessible to Indians. The geographical isolation of many reservation communities, the lack of transportation and the inability of many Indian families to pay even the small fees charged by agencies with sliding scales limit the accessibility of "mainstream" services.

According to the *Indian Adolescent Mental Health* report (U.S. Congress Office of Technology Assessment, 1990), the resources to cope with these serious problems are clearly inadequate. At the time of the report, at least 397,000 children and adolescents were in Indian Health Service (IHS) service areas, yet IHS funded only 17 mental health providers trained to treat children and adolescents, a ratio of less than one mental health provider to every 23,250 children and adolescents. The report stated that in total, approximately 1 to 2 percent of IHS's budget was allocated to mental health services for Indians of all ages. Only 3 percent of tribal and urban staffs were mental health providers.

While the need for services to address these problems continues to grow, access to critical funding has been inconsistent and often nonexistent. Nationwide, tribal governments have experienced great difficulty in accessing mental health funding to provide the services that could improve the overall well-being of their children and families. Consequently, tribal governments have had concomitant difficulty in trying to plan for the long-term solutions necessary for promoting self-sufficiency in tribal communities. This lack of funding means that Indian children are not only the most at-risk for serious emotional problems of any group of children in the United States, they are also the most underserved (Cross, 1986).

ISSUES AFFECTING ACCESS TO TRIBAL MENTAL HEALTH SERVICES

Jurisdictional Issues

Enrolled members of federally recognized Indian tribes have a unique political status in the United States. They are citizens of two nations. Each tribe retains inherent sovereign powers to govern itself as a nation, including the right to determine who its citizens are. Tribal governments can be considered nations within a nation. This status is based on the facts that tribal governments predate the United States government and are recognized as governments by treaties and the United States Constitution. Not until 1924 were American Indians made citizens of the United States by an act of Congress. As citizens of both the United States and of Indian nations, enrolled members of tribes are, in theory and under current law, eligible for all services for which any other citizen is eligible. Why then, in practice, particularly in the arena of children's mental health, is this not currently true?

There is significant confusion at the state, local and tribal levels about this issue, largely because legal jurisdiction (the power to regulate) is different from the obligation to provide services to citizens. Though Indian people are citizens of two nations, they are, in most states, subject only to the laws and regulations of the government where they are physically located. In other states, they are subject to both tribal and state law. In mental health and child welfare, the power to regulate and the obligation to serve are intertwined. Custody and commitment, for example, are issues of regulation, but therapeutic interventions are matters of service. This confusion, along with a history of tribal peoples' being served by the federal government, has contributed to a situation in which there is no functioning system to serve Indian children with serious emotional disturbances. Thus, they fall between a large crack in the safety net.

As a result of the issue of cloudy jurisdictions, just how responsibility for mental health and social services for Indian people should be distributed among federal, state and tribal agencies has never been clear. Ambiguity and false assumptions that some other agency is responsible have contributed to Indian peoples' remaining underserved (Swinomish Tribal Mental Health Project, 1991).

According to *Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children* (Cross, 1986), federal, tribal, state and local governments all bear some degree of responsibility for the mental health of Indian children. The perception, however, is that the "other" agency is responsible. The reality is that a large number of systems overlap. The issues of jurisdiction, both in a legal and in a programmatic sense, are complicated by the reality of a complex system. They are also complicated by the perceptions of Indian and non-Indian service providers.

The boundaries among tribal, state, federal and local responsibility differ from tribe to tribe and from state to state. In most cases, the boundaries are so legally complex that they are unclear at the practice level, thus leaving the system vulnerable to confusion over differences in interpretation. For example, Public Law 83-280 allows civil and criminal jurisdiction on Indian reservations (in 11 states) to rest with state and local governments, further complicating the responsibility issue. The responsibility for services and the relationship between the tribe and state can only be sorted out on a case-by-case basis. Even on the reservations that clearly have jurisdiction, resources that translate into services for emotionally handicapped children are extremely limited.

The Indian Child Welfare Act of 1978 (Public Law 95-608) may also influence whether a tribe has jurisdiction over an emotionally handicapped child. If services involve a change in custody or if the child is already in the child welfare system, the child's tribe may have jurisdiction. When a tribe cannot or does not assume jurisdiction, the child in need of child welfare services comes under the jurisdiction of the state. Although the Indian Child Welfare Act was designed to enable tribes to maintain control over child welfare matters involving tribal members, responsibility for service to emotionally handicapped Indian children is undefined at both the program and the practice levels. Children in need of treatment are often caught in limbo waiting for the responsibility issue to be settled, or they may be placed in the only available alternative rather than one specifically designed to meet their needs.

Tribes usually cannot support services beyond crisis intervention for emotionally handicapped Indian children. The limited funds available are usually allocated primarily for basic services such as child protection and physical health care. Even when tribes contract with the Indian Health Service to provide mental health services, the funds for services to children are limited. Conflicts that arise over who pays and perceptions of who should pay create tension between service providers at the program level and thereby function as barriers to service delivery (Cross, 1986).

Isolation

Many tribal communities are in geographically isolated areas with the results that access to services is more difficult and at a higher cost. Sixty-seven percent of Indian people live in the west and midwest, mainly in rural areas. In Alaska, for example, over 200 tribal communities are located more than 200 miles from state services, and travel must often be by airplane.

Nearly all informants who responded to the NICWA survey on tribal mental health funding access stated that isolation was a significant barrier to service access. Many felt that services from state agencies are difficult to obtain because of the remoteness of their Indian communities. Some felt that the isolation of their community contributed to the difficulty of recruiting and retaining qualified mental health staff. Transportation was another barrier to service access that was identified by key informants in rural communities. They stated that transportation of a child to a mental health services facility that is many miles away can be nearly impossible to attain.

Children whose emotional problems are such that treatment is deemed necessary are frequently removed from their community and family. Often, non-Indian homes or institutions far from the reservation are the only resources that put a child within reach of necessary services. Distance from home and community make family involvement and re-entry into the community difficult. Children are also removed from the support systems of extended families and placed in a culturally unfamiliar environment, which may put them at risk of having their emotional problems exacerbated.

What is being done to serve these children varies according to tribe, their residency on or off reservation, and the severity of their problem. Looking at the different systems that share responsibility for these children gives the observer an idea of the complexity of the service delivery system.

Cultural Barriers

Historically, individuals with emotional problems have been viewed in most Indian communities as being out of harmony; that is, "out of synch" with the natural order of existence. In other instances, behavior that would be seen as "crazy" in Western society was interpreted as "special" in the Indian community. Individuals were accepted and often treated in ceremonies involving the whole community. Problems were viewed as caused by factors outside the person, usually spiritual in nature. Little stigma was attached to such problems. The dominant society, however, has fostered the concept of mental illness and its concomitant stigma.

The predominant perceptions about mental health services identified in the Indian community include a historic distrust of the dominant society approach to dealing with mental health (Lockhart, 1981). This distrust is based not only on different cultural approaches but also on the belief that formal mental health services are an extension of the dominant society's attempts to assimilate the Indian. Past negative experiences reinforce this lack of trust. A perception exists that non-Indian service providers do not understand Indian culture, retain stereotypic images and use approaches and techniques designed for and by the dominant society (Lewis and Man, 1975). A belief that formal mental health services tend to be judgmental, demanding and inconsistent (Dana, 1984) also contributes to the lack of service usage by Indian peoples (Cross, 1986).

Although state and locally funded mental health and social services programs are theoretically available to all residents, "mainstream" mental health agencies have generally not been successful in serving Indian people. Services offered by state and county agencies are often not appropriate for Indian clients, who may feel uncomfortable in dealing with nontribal agencies. When mental health providers are unfamiliar with tribal lifestyles, family values or communication style, there is a high probability of misunderstanding. Many non-Indian providers are not even aware that important value differences exist. This lack of awareness increases the danger of Indian clients being misunderstood, labeled or rejected (Swinomish Tribal Mental Health Project, 1991).

The need for enhanced cultural awareness and training among health care providers of all kinds has long been recognized. The IHS has not fared well in past efforts to admit traditional Indian psychotherapeutic interventions into its daily operations. Such interventions are more characteristic of tribal programs contracted through the Public Law 93-638 mechanism (described in background section) (U.S. Congress Office of Technology Assessment, 1986). Nevertheless, the draft of the IHS Mental Health Programs Branch National Plan includes cultural considerations in its recommendations:

> 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 accept or 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 (U.S. Department of Health and Human Services, 1989).

Traditional Healing Practices Relevant to Mental Health Care

According to *A Gathering of Wisdoms* (Swinomish Tribal Mental Health Project, 1991), most tribal communities have traditional Indian healing specialists or spiritual leaders who form an important component of physical and mental health care for Indian people. These healing practices are embedded in thousands of years of Indian culture and healing/spiritual knowledge. Many Indian people have deep faith in these methods of help and receive unquestioned benefit from the services of traditional specialists. Despite these facts, traditional healers have rarely received either professional respect or financial support from the mental health system. The lack of inclusion of the traditional methods usually stems from a lack of understanding and conflicting world views.

Conflicting World Views

World view is a term used to describe the collective thought process of a people or culture. Thoughts and ideas are organized into concepts. Concepts are organized into constructs and paradigms. Paradigms linked together build a world view. The conventional methods of mental health and the traditional Native American view of mental health are shaped by two conflicting, predominant world views, linear and relational. This section summarizes both world views and then explains how mental health can be understood from the relational view.

Linear World View

The linear world view finds its roots in Western European and American thought. It is logical, time-oriented and systematic, with cause and effect relationships at its core. To understand the world is to understand the linear cause and effect relationships between events.

In mental health we are usually taught that if we can understand the causes of a problem, by taking a social history, then we will better know how to help. Interventions are targeted to the cause or symptom, and the relationship between the intervention and the symptom is measured. Yet, the linear view is narrow. It inhibits us from seeing the whole person. It is not good or bad. It simply is, and in the U.S. it is dominant. Historically, however, Indian people have not used linear cause-and-effect thinking. Rather, the approach could be called a relational or cyclic view.

Relational World View

The relational world view, sometimes call the cyclical world view, finds its roots in tribal cultures. It is intuitive, nontime-oriented and fluid. The balance and harmony in relationships among multiple variables, including spiritual forces, make up the core of the thought system. Every event is in relation to all other events, regardless of time, space or physical existence. Health is said to exist only when things are in balance or harmony.

In the relational world view, helpers and healers are taught to understand problems through the balances and imbalances in the person's relational world. We are taught to see and accept complex (sometimes illogical) interrelationships that can be influenced by entering the world 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 are focused on bringing the person back into balance. Nothing in a person's existence can change without all other things being changed as well. Thus an effective helper is one who gains understanding of the complex interdependent nature of life and learns how to use physical, psychological, contextual and spiritual forces to promote harmony.

A Relational Model

The relational world model for assessing human functioning can be illustrated via a four-quadrant circle. The four quadrants represent four major forces or sets of factors that must come into balance with each other. They are the *context*, the *mind*, the *body* and the *spirit*. The mind includes our cognitive processes such as thoughts and memories, and knowledge and emotional processes such as feelings, defenses and self-esteem. The body includes all physical aspects such as genetic inheritance, gender and condition, as well as sleep, nutrition and substance use. The

context includes culture, community, family, peers, work, school and social history. The spirit includes both positive and negative learned teachings and practices as well as positive and negative metaphysical or innate forces.

These four quadrants are in constant flux and change. People are not the same at 4 p.m. that they were at 7 a.m. Our level of sleep is different, our nutrition is different and our context is probably different. Thus, behavior will be different, feelings will be different, and what we think about will be different. Our systems are constantly balancing and rebalancing themselves as we change thoughts, feelings, our physical state or our spiritual state. If we are able to stay in balance, we are said to be healthy, but sometimes the balance is temporarily lost. We have the human capacity to keep our own balance for the most part, yet our different cultures provide many mechanisms to assist in this process. Spiritual teachings, social skills and norms, dietary rules and family roles are among the many ways we culturally maintain our balance.

Death, for example, is an event that threatens harmony. When we lose a loved one, emotionally we feel grief; physically we may cry, lose appetite or not sleep well. Spiritually, however, we have a learned, positive response, a ritual called a funeral. Usually, such events are community events, so the context is changed. We bring in relatives, friends and supporters. In that context we intellectualize about the dead person. We may recall and tell stories about him or her. We may intellectualize about death itself, or be reminded of our cultural view of that experience. Physically, we touch others and give and receive hugs and handshakes; we eat, and we shed tears.

These experiences are interdependent, playing off each other in multirelational interactions that, if successful, allow us to resolve the grief by maintaining the balance. If we cannot maintain the balance, then we are said, in a Western sense, to have unresolved grief, or in some tribal cultures, to have a ghost sickness or to be bothered by a spirit. Different world views often use different conceptual language to describe the same phenomenon.

The Context

The context within which Indian families function is filled with strength-producing or harmonizing resources. Oppression, despite its damage to us, creates an environment where survival skills are developed and sharpened. We learn to have a sixth sense about where we are welcome and where we are not. We teach our children to recognize the subtle clues that may spell danger. We sit with our children at the movies or in front of the TV and we interpret, cushioning the assaults of the mainstream media. We learn how to cope with the dynamics of difference, and we pass our strategies on to our children.

The richness of our histories and heritage provide anchors that hold us to who we are. Our relations, relatives or kin often form systems of care that are interdependent and system-reliant. Healthy interdependence is the core of the extended family. It does not foster dependence and does not stifle independence. Rather, it is a system in which everyone contributes in some way

without expectation of reciprocity: I give my cousin a ride to the store, and while at the store my cousin buys some items for our grandmother. Our grandmother is home watching my brother's children, who are planning to wash my car when I return home. No one person is paying back another, and yet the support and help keep cycling throughout the family.

The community provides additional influences. From church, to social organizations, to politics, we all are affected by the events in the world around us. Family resilience is supported by role models, community norms, church structures and the roles of elders and natural helpers or healers.

However, we struggle with negative forces in our environments: poverty, oppression, substance abuse, unemployment, crime, trauma or any of hundreds of negative influences. Together, these enter into the balance of who we are and how we cope.

The Mind

In the mental area the Indian family is supported intellectually by self-talk and by stories we hear about how others have managed. Sitting around the kitchen table or on the front steps, we learn strategies for interacting with the world or how to use resources. In passing on the stories of our lives, we pass on skills to our children, and we parent for resiliency. We instill the values of relationships, of getting by, of not needing, and hard work for little return. Storytelling is perhaps our greatest teaching resource for communication of identity, values and life skills. The stories also let us know who our people are and what they stand for, providing role models and subtle expectations.

Emotionally, we learn a variety of ego defenses that allow us to deal with overwhelming odds. Denial, splitting, disassociation and projection are each useful in their own way as mechanisms for surviving oppression. Function can only be understood in context. For example, many of our families know real pain and endure grief almost beyond the comprehension of middle-America, and yet they still give back to their community. Because of oppression, substance abuse or poverty, many have learned not to need, not to feel and not to talk about it, and yet they still help out at the church and at school or by giving sister a break from the kids. These are kindnesses that bring the life-sustaining energy that flows from an auntie's approving looks, from a child's laugh or from a pat on the back.

Other emotions rob people of their resources. Rage, depression, anxiety, grief and jealousy, among others, are likely to contribute to a lack of harmony. Our people have experienced generations of loss from which we are only now beginning to recover. This sense of loss, and the intergenerational grief that it is part of, are strong elements affecting the balance of our families.

THE BODY

Although the term *body* usually means the individual body proper, it also signifies family structure and roles. Kinship has been discussed. How we relate to our kin, how we act as a system and how we sustain each other will greatly influence the balance in our lives.

Family norms about eating and drinking can and do act against harmony at times, such as when the alcoholic enlists the family in a co-dependence relationship. The harmony of the family is kept by denial and by helping the alcoholic drink. But it is a false harmony that will only last until the alcoholic dies or until the family system can no longer support the drinking.

How well the family copes with problems will be affected by diet, sufficiency or lack of sleep, fitness and general health. Disabilities, chronic illnesses, genetic disorders and allergies may drain energy or add resilience. Also in the physical realm of the body is the use and abuse of substances, which has far-reaching impact on the harmony of the family.

THE SPIRIT

Spiritual influences in the family include both positive and negative learned practices. The positive practices are those we learn from various spiritual disciplines or teachers: faith, prayer, meditation, healing ceremonies or even positive thinking. They are actions that we learn to bring about a positive spiritual outcome or to bring positive spiritual intervention. Negative learned practices are actions that invoke negative spiritual outcomes or negative spiritual interventions, like curses or bad medicine. Sin, promotion of chaos and perpetuation of confusion could also be considered learned negative spiritual behaviors.

Here, in the spiritual quadrant, our teachings and the spiritual institutions play a great role by providing learned positive practices to counter the negative practices in ourselves or others. In Indian communities, the churches and/or traditional spiritual ways play a significant role in shaping the spiritual practices of the family.

In the relational world view, human behavior is also influenced by spiritual forces beyond one's own making. Luck, grace, helping spirits, and angelic intervention are just a few of the terms used to describe the phenomenon of getting the right help at the right time. One does not have to believe in or practice any spiritual discipline to have experienced the phenomenon. Bad luck, bad spirits, ghosts, the devil, and misfortune are a few of the names for the course of events that bother people, whatever their spiritual practices. These forces are often turned back or controlled through prayer, rituals or ceremonies.

Wholeness

In the relational view of the world, all the casual factors are considered together. The interdependence of the relationships among all the factors gives understanding of the behavior. The constant change and interplay among the various forces accounts for resilience. We can count on the whole system's natural tendency to seek harmony. We can promote resilience by contributing to the balance. Services need not be targeted to a specific set of symptoms but, rather, toward the restoration of balance. Family support services are an example of seeking to rebalance.

It is not, then, our extended family or church or particular survival skills, or any other single factor that provides family harmony, but the complex interplay among all of these factors. Finding harmony and staying in harmony are the tasks.

Two Ways of Helping

In the Western European linear world view, we are taught to examine a problem by splitting the factors into independent, linear cause-and-effect relationships. This procedure does have value in developing knowledge of each factor and does give us specific interventions to try, but this splitting leaves us with incomplete knowledge. Services based on this approach fail to acknowledge the spirit.

In the linear view, the person owns or is the problem. In the relational view, the problem is circumstantial and resides in the relationship among many factors. The person is not said to have a problem but to be out of harmony. Once harmony is restored, the problem is gone. In the linear model we are taught to treat the person, and in the relational model we are taught to treat the balance.

Today, the linear model dominates delivery of family services, but almost half or more of all Indian clients hold a relational world view. In Indian child welfare, we have an opportunity to work within the relational world view, to work with traditional methods of helping and healing that focus on the restoration of balance and harmony.

The medicine person, the elder, or the spiritual teacher, usually works in these ways. They may work in the realm of the mind with advice, counsel or with storytelling and dream work. They may work in the physical realm with herbs, fasting, sweat lodge or diet. They might work on the spiritual level with ceremonies, and healing rituals or by teaching. Always, they become part of the context of the person being helped and they add to the balance with only their presence and willingness to help.

The challenge in mental health is to honor both the linear and the relational world views in any services that intervene, assess and attempt to help the Indian family. Each view has strengths and weaknesses, and knowledge of both will help professionals serve families more effectively. Until recently, however, a belief in the relational model was considered not just irrelevant but pathological. Belief in spirits, healing ceremonies and other rituals was considered part of the problem rather than part of maintaining and restoring mental health.

We have summarized the differences in the two systems of thought to demystify the role of the healing natural helper, yet the blending of these two systems of thought and helping remains problematical. In general, funding for Indian children's mental health has been a significant barrier; financing such services in the current managed care environment is even more difficult.

CURRENT CHILDREN'S MENTAL HEALTH FUNDING SOURCES FOR TRIBES

There is currently no funding specifically available to Indian tribes targeting mental health services for children. In fact, tribes are not eligible for federal mental health block grants, one of the primary resources states receive to support their mental health services. Many tribes have used funds from various related sources to piece together services for children. Tribes have had to be creative in response to pure necessity. Mental health services for American Indian children are both inadequate and severely fractured. This is due to the reality that there is no single system for delivering mental health treatment to Indian and Native youths. Rather, a series of agencies and institutions with different responsibilities creates a patchwork of resources that varies from community to community.

Tribal mental health workers may be funded partially by Indian Child Welfare Act grants, by contracting with IHS for mental health funds, by funds from tribal enterprises, by funds earmarked for educational purposes, or through cooperative agreements with local mental health centers. However, 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 (U.S. Congress Office of Technology Assessment, 1990).

The following is a review of common funding sources for tribal child welfare services and mental health programs.

Federal Funding Sources

INDIAN HEALTH SERVICE

Indian Health Service (IHS) is the branch of the Department of Health and Human Services that has broad responsibility for the prevention and treatment of health problems facing Indian people nationwide. For many years, the Bureau of Indian Affairs had almost total responsibility for managing the resources, education and general "welfare" of Indian people. The Indian Health Service took over primary responsibility for health care of Indian people in the 1950s and added limited mental health care more recently. However, funding and staffing restrictions have meant that IHS services have generally been insufficient to meet the needs, either in quantity or in cultural orientation.

Recently, as the interrelationship among mental, substance abuse and physical problems has become increasingly clear, the Indian Health Service has increased the priority placed upon mental health services for Indian people. The mission of the Indian Health Service Mental Health

Programs Branch is to provide access for all Indian persons to high-quality and culturally relevant mental health services that are appropriate to the nature and severity of their mental illness (U.S. Department of Health and Human Services, 1989*). However, IHS mental health services are primarily for adults.* Limited mental health services are available for children.

IHS provides health and health-related services to eligible Indians in a variety of ways. The approximately one million Indians who live on or near reservations are theoretically eligible to receive a comprehensive range of services at no cost to the individual Indian, regardless of other health insurance coverage or ability to pay. This program of services is provided in facilities owned and operated by IHS and is known as the *direct care program* (U.S. Congress Office of Technology Assessment, 1990).

The IHS operates health clinics at reservations and urban settings across the country. These clinics may be directly accessed or contracted with by the tribes or urban organizations. Most Indian Health Service mental health care is provided on an outpatient basis either in IHS facilities or in tribal offices. The primary model of service is individual or family weekly appointments. Inpatient services are provided either through contracts with local hospitals; through referral to state psychiatric hospitals; or in one of two Indian Health Service inpatient psychiatric facilities nationwide, both of which have long waiting lines. Larger tribes often have IHS mental health workers assigned to tribal locations. Members of smaller tribes may receive services from "field" mental health staff who come to the tribe one or more days per week. In other cases, clients must travel to the nearest Indian Health Service clinic, which may not be nearby.

Although, in principle, IHS services are comprehensive and readily available at no user cost, in fact, they are limited by IHS budget constraints and by the uneven distribution of services among IHS areas that have developed over the years (U.S. Congress Office of Technology Assessment, 1986). When no IHS facility is accessible or when specific services are not available from IHS facilities, Indian patients may require referral to private providers under the IHS *contract care program*. Contract care is a separate item in the overall IHS budget, and contract care budgets sometimes have been so limited that needed referrals cannot be made. Thus, while they may not be directly affected by ability to pay, Indians may face serious obstacles to obtaining health care services through IHS (U.S. Congress Office of Technology Assessment, 1990).

Another factor in the IHS delivery system, since the Indian Self-determination and Education Assistance Act of 1975 (Public Law 93-638), has been the operation of health facilities and service programs by Indian tribes. Direct care facilities, contract care programs, facilities construction, and special programs such as community health representatives and mental health and drug abuse and health education initiatives may be administered by tribes under *self-determination* or 638-contracts. Most of these services, like IHS's own services, are reservation-based, and they are provided to IHS-eligible Indians at no cost to the individual (U.S. Congress Office of Technology Assessment, 1990).

The Indian Self-determination Act allows tribes to contract directly with IHS to operate their own health and mental health programs. Funding allocations are based upon the tribe's population. This may result in funding sufficient for several positions or funding only sufficient for a fraction of a position, depending on the size of the tribe. The limited resources and the difficulties inherent in the federal bureaucratic structure make it impossible for the Indian Health Service to meet the level of need existing in tribal communities today. An increasing number of tribes are electing to contract directly with IHS in order to operate their own service unit or to otherwise negotiate increased tribal control of services and monetary resources (Swinomish Tribal Mental Health Project, 1991).

Although IHS programs provide health, dental, mental health, alcoholism and preventive health services, most of IHS's resources are used to provide hospital-based and ambulatory services for acute and chronic physical conditions. For example, $723 million of IHS's total fiscal year 1988 budget of $935 million was used for hospitals and clinics, exclusive of dental, mental health and alcoholism services. Only 1.3 percent was used for direct and tribal mental health services, whereas 3.1 percent went to direct and tribal alcoholism services (for services to all age groups) (U.S. Congress Office of Technology Assessment, 1990).

The distribution of IHS 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. 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, Montana, and Portland, Oregon, areas. *Only 17 (9 percent) of the 198 direct care professionals were trained to work with children or adolescents although children aged 19 and younger account for approximately 43 percent of the Indian population* (U.S. Department of Health and Human Services, 1989). This amounts to an average of 0.43 providers per 10,000 children and adolescents. In four of the 12 IHS areas, there are no mental health professionals trained to work with children and/or adolescents. Virtually no partial hospitalization, transitional living or child residential mental health treatment facilities are available in IHS direct or tribal operations (U.S. Congress Office of Technology Assessment, 1990). IHS's own draft National Plan for Native American Mental Health 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.

Bureau of Indian Affairs

The Bureau of Indian Affairs (BIA) was established in 1824 as part of the War Department and became a part of the U.S. Department of Interior in 1849. 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. The Bureau of Indian Affairs provides social services to tribes, either directly or through contracts.

BIA social services are characterized as last resort; that is, they are available only when services cannot be obtained from other sources. No specific mental health services for children are provided. However, in the course of their work with families, BIA social workers (or contract workers) may be in contact with such children. Their primary role is referral. Further, many adolescents who might otherwise be considered emotionally handicapped and in need of mental health services, are often referred for placement in BIA-operated boarding schools. Some mental health services are available as a part of the boarding school. The schools, however, are considered an educational facility and not a treatment facility.

In the 1987-1988 school year, the BIA funded a total of 182 education facilities. 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, and monitor students who experience social and mental health problems. *In 1988, the BIA reported that 19.8 percent of all Indian children were in BIA-funded schools* (Ashby, et al, 1988).

Child Welfare-Related Programs Administered by the Bureau of Indian Affairs

The BIA provides the largest amount of federal funding for tribal child welfare services. It funds child welfare services for federally recognized tribes through the Snyder Act, the Indian Self-determination Act and the Indian Child Welfare Act. The BIA does not fund states to provide child welfare services for tribal children.

Indian Child Welfare Act (ICWA) grant program. The ICWA (Public Law 95-608) authorizes grants to federally recognized tribes and organizations to support the establishment and operation of Indian child and family service programs on or near reservations, and to support the preparation and implementation of child welfare codes. The ICWA grants were originally awarded competitively. Beginning in fiscal year 1994, ICWA monies were made available to all federally recognized tribes as formula grants. The law specifies that ICWA funds may be used by tribes to meet the matching share requirements of other federal programs for child and family services funding.

Unfortunately, the funding level for these programs continues to be inadequate to meet the need. ICWA funding is based on tribal population. Most tribes fall into a category to receive less than $30,000 annually. In spite of the lack of resources, many tribes have developed successful programs that have done much toward strengthening Indian families and developing tribally based alternatives for Indian children in need of care. Services that can be provided with ICWA funds include

- child abuse and neglect prevention/intervention;
- parent education;
- foster care for children;
- case management for children;
- parent support;
- staff training relevant to promoting stable families;
- various other child and family related services that carry out the intent of the ICWA.

Although the ultimate disposition of ICWA cases is not well documented, Indian child welfare workers are known to play a role in identifying abused children in need of mental health services and in attempting to see that these needs are met. 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 (U.S. Congress, Office of Technology Assessment, 1990). In reality, ICWA Title-II funded programs can do little more than identify mental health needs in individual children or families. Workers are neither trained to address nor focused on addressing the mental health needs other than to try to find such services elsewhere for their families.

The Indian Self-Determination Act contract and grant programs. The Indian Self-determination and Education Assistance Act of 1975 and the Indian Self-determination Amendments of 1987 (Public Law 100-472) direct the BIA to establish service contracts with tribes that want to provide for themselves the services that BIA would otherwise have provided for them. When contracts are established, the BIA transfers to the tribes the funds that the federal agency would have expended in the delivery of the services and additional funds for indirect costs.

Any services that the BIA was providing for the tribe can be taken over by any federally recognized tribe through contract. All programs under this category are limited to clients who are *not eligible for other public assistance programs*, including IV-E Foster Care and Adoption Assistance. Actual contract amounts and priority of services for contract is negotiated between the tribe and BIA. Services that can be contracted for include

- any social service that the BIA is providing for the tribe;
- limited child welfare assistance—some foster care;
- general assistance—finance assistance payments;
- burial assistance.

The services that can be contracted for are provided from the annual BIA budget. The Snyder Act is the authorizing legislation for BIA expenditures for the benefit, care and assistance of the American Indian population. The funds are used for general support, education, relief and conservation of health, among other purposes, and are provided *only when tribal members cannot obtain such assistance from other sources and within the constraints of the annual budget*. The BIA provides (itself or through tribal contracts) limited monies to members of federally recognized tribes for child welfare assistance, including foster care, residential care and special needs.

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

The Administration for Children and Families (ACF), within the Department of Health and Human Services, directs, funds and oversees programs for vulnerable children and families in the United States. Within ACF, the Children's Bureau supports state and tribal programs to provide family preservation and support services, child welfare, foster care and adoption. In addition to funding child welfare services, ACF oversees the provision of child welfare protections mandated by the Adoption Assistance and Child Welfare Act of 1980. This law ties child welfare services funding under Titles IV-E and IV-B Subpart 1 to compliance with requirements for child welfare programs.

The law requires that each state receiving Title IV-E funds provides child welfare services to all eligible children, including Native American children, in the state. Tribes may assume responsibility for providing these services to tribal children, but tribes are not eligible to receive IV-E funding directly. In all instances, ACF expects states to coordinate with tribes for the provision of services and protections to tribal children who are in public custody. If tribes want to run their own services, they must enter into contracts or very complicated and cumbersome agreements with the state and subject their records to state review for audit purposes.

CHILD WELFARE-RELATED PROGRAMS ADMINISTERED BY ACF

The Administration for Children and Families (ACF) funds state and some tribal child welfare programs under three titles of the Social Security Act. Title IV-E supports state foster care and adoption assistance programs. Title IV-B supports states' and some tribes' child welfare programs as well as family preservation and support services. Title XX supports state social services, including child welfare services. The Indian population is counted in the formula that is used to calculate each state's block grant, but tribes are not eligible to receive Title XX directly. While states may share these monies with tribal child welfare agencies, only four states currently do.

Title IV-E of the Social Security Act: The Foster Care and Adoption Assistance Program. In 1980, Public Law 96-272 transferred the Title IV-A foster care program to Title IV-E of the Social Security Act, specified protections for children in foster care, and established a new

adoption assistance program under Title IV-E. Foster care funding is available only for children whose families are eligible for Aid for Families with Dependent Children (AFDC). Title IV-E funds are provided as federal matching funds. Tribes are not currently eligible to receive Title IV-E funds directly from the federal government, but states may contract or form agreements with tribes to provide Title IV-E services. Only a handful of tribes have such agreements in place. Services that can be provided with IV-E funds include

- foster care and adoption assistance;
- case management services related to foster care and adoption assistance;
- services for children who need placement in an institution after removal from their home;
- services to assist adoptive children that have special needs such as physical, mental or emotional handicaps.

Title IV-B Subpart 1 of the Social Security Act: The Child Welfare Services Program. Title IV-B Subpart 1 is a capped entitlement program that provides 75 percent matching-share grants to states and tribes for a broad range of child welfare services. Grant amounts are calculated with a formula using the state's or tribe's under-21 population and per-capita income. These funds can be used to pay for services for all children. Services that can be developed with this funding are

- child abuse and neglect prevention/intervention;
- parent support groups;
- child day care;
- respite care;
- parent training;
- foster care or adoption, and various other services that attempt to prevent children from being removed from their homes and that reunify them with their families after they have been removed.

Title IV-B Subpart 2 of the Social Security Act: The Family Preservation and Support Services Program. Title IV-B Subpart 2 of the Social Security Act is a capped entitlement program that was created in 1993 by the Family Preservation and Support Act (Public Law 103-66). Subpart 2 grants are allocated on the basis of population and provide a 75 percent federal match to support state and tribal provision of family preservation services and community-based family support services. One percent of the annual appropriation is to be set aside for tribes that qualify for at least $10,000 in funding. This stricture prevents the vast majority of tribes from accessing this funding or participating in Title-B Subpart 2 Family Preservation and Support Services. Services that can be developed with this funding are

- family preservation services that assist families in crisis, where a child is at imminent risk of being placed in out-of-home care because of abuse and/or neglect;

- family support services that are preventive activities with the aim of increasing the ability of families to nurture their children successfully, such as parenting classes, respite care and assistance in obtaining benefits.

The law does not allow all tribes to participate. In fiscal year 1996, 53 tribes participated.

Title XX of the Social Security Act: The Social Services Block Grant Program. Title XX of the Social Security Act was created in 1974 by Public Law 92-672, which authorized entitlement funding for states to support social services with certain goals, requirements and limitations. In 1981, Public Law 97-35 amended Title XX to establish a block grant for social services. These block grants are allocated to states on the basis of population (including tribal members) and are available without a state matching-share requirement. States are under no obligation to pass these funds on to tribes, although four states do.

Title XX funding supports state programs to address, prevent or remedy neglect, abuse or exploitation of children and adults unable to protect their own interests, and to preserve, rehabilitate or reunite families. States are allowed considerable discretion in determining the services they will provide and the groups that are eligible for these services. States may share funds with private agencies and tribes to provide Title XX services. Services that can be developed with Title XX funds include

- prevention of child abuse and neglect;
- child care;
- home-based services;
- protective services for children and adults;
- special services for children or adults who have disabilities;
- services to promote economic self-sufficiency;
- a variety of other social services.

Child Care and Development Block Grant. The Child Care and Development Block Grant Act of 1990 established a program to provide grants to states, territories and Indian tribes for child care services for low-income families. With the advent of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (also known as the "Welfare Reform" Law, Public Law 104-193), the Child Care and Development Block Grant (CCDBG) is superseded by the Child Care and Development Fund that is dispersed in one lump sum from two funding streams. The former CCDBG, one of those funding streams, is now called Discretionary. The other funding stream is called Mandatory.

With the new "Welfare Reform" Law, the Child Care Bureau of the Administration on Children, Youth and Families of ACF now operates under a single set of rules. The Bureau's vision promotes child care services that promote health, child care development and family self-sufficiency. Beyond that, its vision includes encouragement of the following:

- quality services (safe and healthy learning environment, parent involvement, training and support for providers, continuity of care for children);
- comprehensive services (health and family support that links the child and family to other community agencies);
- information/referral (consumer outreach, public awareness of the necessity for child care as the basis for the well-being of the family and outreach into the private/community sectors to leverage more services for child care).

The purpose of the program is to increase the availability, affordability and quality of child care for low-income families and to increase the availability of early childhood development and before-school and after-school care services. To be eligible, a family must need child care either because a parent is working, attending a training or educational program, or because the family receives or needs to receive protective services. Children under age 13 are eligible for child care services. If the grantee chooses, however, teenagers who are physically or mentally incapable of self-care or who are under court supervision may receive child care services.

Under the new law, tribal grantees, with permission of the Secretary of HHS, may use the fund for construction or renovation of child care facilities (Binker and Gorman, 1996).

Family Violence Prevention and Services Program. Funding is available to states, federally recognized Indian tribes and tribal organizations through the Administration for Children and Families. Tribes must demonstrate the capacity to carry out a family violence prevention program by showing (1) current operation of a shelter, safehouse or family violence prevention program; (2) establishment of collaborative or service agreements with a local nonprofit agency for the operation of family violence prevention activities or services; or (3) establishment of social services by receipt of 638-contracts with the Bureau of Indian Affairs. Funding allocations are based on population figures from the most recent census. Services that can be developed with domestic violence funding include

- establishment, maintenance and expansion of programs and projects to prevent family violence;
- providing immediate shelter and related assistance for victims of family violence and their dependents.

Under the "Welfare Reform" Law, states [or tribes who are operating their own Temporary Assistance for Needy Families (TANF) program] can exempt up to 20 percent of their caseload from the 60-month lifetime limit for receipt of TANF benefits. The state (or tribe) can waive certain TANF requirements that, due to current or previous domestic violence, the victim is unable to fulfill. An abuse survivor may simply not be able meet the requirement to go to school, receive training, obtain counseling or go to work because clothes or books were destroyed, sleep was not possible, child care was reneged upon, transportation was withheld, or abuse was perpetrated. Survivors of domestic violence may be harassed, beaten, stalked and so on.

Waivers allow the survivor to escape and relocate without having to meet a new area's residency requirements, and to apply for benefits and without having to reveal their whereabouts by confronting or asking for information from the perpetrator. However, the survivor must reveal (through one of a broad range of methods such as medical/police reports, restraining order, a friend's corroboration, etc.) their victimization to the agency when application for TANF benefits is made. Confidentiality is critical, since the victim is statistically in more danger if the perpetrator knows that the abuse is revealed, thoughts of leaving are being entertained, or escape has occurred.

Public Law 104-193 is certain to put a strain on domestic violence resources, such as counseling, shelters, basic amenities including, but not exclusive to, housing, food, and clothing (Cyson, 1996).

Administration for Native Americans (ANA). The Administration for Native Americans (ANA) promotes social and economic self-sufficiency through the enhancement of the institutions of self-governance for Indian tribes and organizations and other Native American communities. Under the Native American Programs Act of 1974, ANA is the only organization with a mandate to serve all tribes and Native American organizations. Tribes and tribal organizations throughout the United States are eligible for ANA funding. The funds are provided through a competitive grants process. Services that can be provided with ANA funding include

- creation of new jobs;
- improved services delivery to help at-risk Indian families in the areas of alcoholism/substance abuse and AIDS prevention;
- development or expansion of social service initiatives.

Head Start. Authorized under Title I of the Human Services Reauthorization Act, the Head Start program provides comprehensive developmental services to low-income preschool children and their families. Head Start involves the child's entire family and community. Grants are awarded to local public or private, non-profit agencies. Grantees must match the total cost of the program at a rate of 20 percent. Services available through Head Start include

- early childhood education for parents and children;
- health services including mental health, dental, medical and nutritional;
- social services including community outreach, referrals, crisis intervention, family needs assessments and staff training.

The new tendency in Head Start is to combine Head Start and child care programs, materials, and buildings in an effort to provide seamless services as children transition from preschool to grade school. Head Start now has an early Head Start program for infants and toddlers (Harris, 1996).

Social Security Administration

Supplemental Security Income (SSI). Supplemental Security Income (SSI) is a monthly payment from the Social Security Administration to people with limited income and resources who are aged, blind or disabled. A child may be considered disabled if the physical or mental impairment severely limits the child's ability to function independently, appropriately and effectively in an age-appropriate manner; if the resulting limitations are comparable to those that would disable an adult; and if the condition is expected to last at least 12 months or to result in the child's death. Disabilities may include Fetal Alcohol Syndrome or Fetal Alcohol Effect. Standards for eligibility are based upon need, family resources and income. Recipients are encouraged to also apply for Medicaid and general assistance from the appropriate state offices.

Under the new "Welfare Reform" Law, however, 250,000 children nationally may be removed from the Childhood Disability coverage under the categories of "maladaptive behavior" and "individual functional assessment." After the child is terminated from disability, the parents or guardians need to gather their medical information and present the child for reevaluation.

Another 265,000 individuals nationally will be removed from SSI payments based on the federal government's determination that they are no longer eligible to receive disability payments because they are no longer addicted to drugs or alcohol. After recipients receive notice that their benefits are terminated, they may present themselves for reevaluation. Appeal may be made because addiction is material to their disability; they have reached or are reaching age 65 and are considered aged; or they are disabled without the addiction being material to their disability (Furtado and McSwain, 1996).

Indian people who fall into these categories may have difficulty getting the facts about appeal, learning about their rights and reaching an appropriate agency to get a reassessment. Numerous difficulties—from geographical distance, transportation problems, and complicated language to historical distrust—may interfere with their ability to be reevaluated and have their benefits reinstated.

Other Department of Health and Human Services Programs

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) was established by Congress in 1992 to lead the nation's efforts to improve the quality and availability of prevention, treatment and rehabilitation services in order to reduce illness, death, disability, and cost to society from substance abuse and mental illness. Programs within SAMHSA include

- the Center for Mental Health Services;
- the Center for Substance Abuse Prevention;
- the Center for Substance Abuse Treatment.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Medicaid. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is a joint federal-state program that pays medical bills for certain low-income people who cannot afford medical care. It is a reimbursement system, making payments directly to the provider for services rendered to eligible individuals.

The federal government, through the Health Care Financing Administration in the Department of Health and Human Services, allocates Medicaid funds to states on an open-ended, formula basis. Although states administering this program have broad discretion in determining the specific eligibility criteria for their state programs, however, the following Medicaid eligibility groups are mandatory:

- recipients of AFDC;
- Supplemental Security Income (SSI) recipients;
- children under age six who meet the state's AFDC requirements or whose family income is at or below 133 percent of the federal poverty level;
- recipients of IV-E Foster Care and Adoption Assistance care;
- all children born after September 30, 1983, in families with incomes at or below the federal poverty level;
- certain Medicare beneficiaries;
- special protected groups;
- pregnant women whose family income is below 133 percent of the federal poverty level.

Medicaid is an important source of funding for Indian health programs. Title IV of the Indian Health Care Improvement Act authorizes the Indian Health Service to collect payment from state Medicaid programs for services rendered to Indian clients. Although it was a small fraction of the $138 billion Medicaid in FY 1994 spending, the $103 million dollars collected by Indian health programs in FY 1994 for direct service was estimated to have provided funds for 20 percent of staffing at the service level (Northwest Portland Area Indian Health Board, 1995).

According to Colette Croze, National Association of State Mental Health Program Directors, much of the public mental health system has become highly dependent on Medicaid financing over the past five to ten years that in some parts of the country as much as 40 percent of the community support system for adults and for children is funded through Medicaid.

States in the Northwest and California are national leaders in utilizing managed care for their Medicaid beneficiaries, yet these programs continue to evolve. The states of California, Idaho, Oregon and Washington have developed special procedures for American Indians/Alaska Natives in their managed care programs. Experience has shown that special arrangements will be a continuing necessity with Medicaid reform (Northwest Portland Area Indian Health Board, 1995).

According to *Making Medicaid Work* (1994), an important potential source of reimbursement for many mental health services is Medicaid. In the past few years, states (and some tribes) have learned that, for low-income children who qualify, a well-designed Medicaid program can provide reimbursement for most of the mental health services in a community-based system of care. The Medicaid service categories of greatest relevance to mental health care are the following:

- physician services;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
- general hospital services;
- clinic services;
- other diagnostic, screening, preventive and rehabilitation services;
- targeted case management;
- prescription drugs;
- inpatient services in psychiatric hospitals.

As a result of legislation enacted in 1989, there is a much broader mandate under Medicaid for children's services than for adults, entitling *eligible children to any of the federally defined services they might need.* This mandate is the EPSDT program. Federal law requires states to provide EPSDT to all Medicaid-eligible recipients under age 22 in order to identify physical and mental problems through periodic examinations. Treatment must be furnished to "correct and ameliorate defects and physical and mental illness and conditions discovered by the screening services." As a result of the legislation enacted in 1989, such treatment must include any federally authorized Medicaid service, "whether or not such services are covered under the state plan."

The new "Welfare Reform" Law (Public Law 104-193) severs the link between welfare assistance and Medicaid eligibility, changing the historic relationship between AFDC-SSI and Medicaid. The law preserved the federal-state partnership in administering Medicaid in a way that gives states more authority and leeway for setting parameters that will determine who is eligible. Each state has the perogative to change their applicable income resource methodologies as follows:

- a state may lower its income standards but not below those that applied May 1, 1988;
- states may increase resource standards up to the percentage increase in the consumer price index;
- a state may use less restrictive income and resource methodologies than those in effect on July 16, 1996 (Koziol and Tracy, 1996).

People will no longer automatically become eligible for Medicaid because they become eligible for cash assistance under the new Temporary Assistance For Needy Families (TANF), and the two offices used to make application in many states will be separated from each other. This means that applicants may be required to make a second stop at the office that determines Medicaid eligibility. Already the majority of Native Americans and Alaskan Natives who are eligible for Medicaid are frequently becoming not eligible for TANF. This new "de-coupling" of AFDC (now TANF) benefits from Medicaid makes it very likely even more eligible Indian adults and children will lose or go without the benefits for which they otherwise qualify (Koziol and Tracy, 1996). If tribes take on the running of their own TANF programs, Medicaid-eligible people may also drop through the cracks, at least temporarily, unless the tribe's and the state's eligibility criteria, eligibility program policy rules and data systems are coordinated and compatible with one another.

Not only is welfare reform intended to end the era of a big federal government by passing responsibility and authority to states (or to eligible tribes who are either able to or who chose to run their own TANF program), it is also intended to remove the state's pocketbook from Indian health. To this end, HCFA is reaching final stages of agreement with Indian Health Service to reduce significantly the amount of Medicaid money states have for health care in Indian Country. A memorandum of agreement is designed to expand the 100 percent federal payments in Medicaid to 638-contractors who are tribally operated and owned (Furtado and McSwain, 1996).

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("Welfare Reform"): Public Law 104-193

While no one is certain of the impact that Public Law 104-193 will have generally, the ramifications stand to be far greater in Indian Country than in the general population. The emphasis is on work, but there is no concomitant emphasis that work equates to making a living wage. Further, the recipient of benefits must engage in work within 24 months of receiving benefits or whenever the states determines they are ready to work, whichever is earlier, and there is a lifetime limit on the receipt of benefits of 60 months.

The following several important points were made by presenters on October 29-31, 1996, at the Administration for Children and Families Partnerships for the Future Workshop on Public Law 104-193:

- This legislation directs tribes into the jurisdiction of the state. Tribes who are individual nations (as the United States is a nation) will be placed in a position of being under the directives of state laws via this Act. This is contrary to conducting business nation to nation.
- States and tribes have a history of difficult relationships.
- Work, as defined, does not serve to break the cycle of poverty by encouraging recipients to educate themselves into well-paying jobs. Training is directly related to securing a job and has nothing to do with gaining an education.

- Reservation communities have some of the highest unemployment rates in the United States because job opportunities are scarce.
- Recipients could be forced to leave their family, nation and community to meet TANF work requirements. For Indian people, who have experienced much historical trauma, this can be seen as having all the earmarks of more of the same. It is already being compared to relocation programs by some tribal leaders.
- Resource-poor tribes and tribal programs will need to bolster or institute more job-related training without receiving commensurate monies from the federal or state governments to cover the costs. Most tribes have difficulty meeting their members' service needs already. This is likely to produce further budgetary strain on programs.
- Tribes who opt to run their own TANF plans will need sophisticated systems capable of producing reports and interfacing with the states' already sophisticated systems. The money earmarked by the federal government for systems has been available for almost a year to the states but not the tribes. States have been upgrading and fine-tuning their systems in this arena for decades.
- Children are Indian communities' most precious resource, but under this Act, recipient parents will be expected to place their children in others' hands to meet the mandatory work requirements.

Other Federal Programs

Federal programs beyond the scope of this report but related include the following:

Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau

Department of Education
Office of Special Education

Department of Justice
Office of Justice programs

Department of Health and Human Services, Administration for Children Youth and Families
Projects for runaway and homeless youth, including drug education and youth shelters and centers
Programs focused on reducing child abuse and neglect
Youth gang projects

State/Local Funding

As indicated above, funding for tribal mental health programs comes from a variety of sources, including state and local government, Medicaid reimbursement, private fees and insurance, special grants from state agencies or private foundations, and donations.

State funds are available to serve Indian tribal communities. Direct state funding through contracts or grants is one way to fund services and develop local systems of care. In fact, some state laws require that community mental health centers provide services to all population groups in their local area, including Indian tribes. Since most Indian communities are "underserved," this often represents an untapped resource (Swinomish Tribal Mental Health Project, 1991).

Because of complexities stemming from the different jurisdictions, some states have worked out partnerships and agreements with tribes to improve mental health services for tribal members. For example, a joint powers agreement between the New Mexico Department of Health (DOH) and the Albuquerque Area Indian Health Service (IHS) in 1995 was developed to provide state funds to assist the IHS in planning, implementing and assuring compliance with New Mexico standards and provider requirements for psychiatric rehabilitation services for Indian people who need those services, live in New Mexico, and are served through the Albuquerque and Navajo IHS Offices.

The New Mexico Department of Health is the state agency mandated by state law to implement services to persons with mental illness, substance abuse and developmental disabilities. The Albuquerque IHS is the federal agency mandated by federal law to provide health care to most of the Indian people in the state of New Mexico. The IHS is the Medicaid authority designated by the Social Security Act for Medicaid services to Indian people.

The agreement was intended to develop an infrastructure for the provision of an array of services through public and private sectors that is consistent with managed care. The terms of the agreement included that the New Mexico Department of Health provide state funds to the Albuquerque Area IHS for the development of the Psychiatric Rehabilitation Program of services, which has been established under New Mexico's Medical Assistance Program, and provide technical assistance to IHS regarding the New Mexico standards and requirements for providers of psychiatric rehabilitation services.

The IHS agreed to collaborate with the New Mexico Department of Health, provide technical assistance to relevant IHS staff and tribal leaders about the Psychiatric Rehabilitation Program of services, and meet certification standards. Additionally, in collaboration with tribal programs and each service unit in New Mexico, the IHS was to develop a plan for each service unit that assesses the extent to which psychiatric rehabilitation services are currently being provided according to New Mexico standards, estimate potential revenue that could be generated from

Medicaid billings for current and expanded services, describe how services will be provided, and indicate how Medicaid billings will be utilized to develop and enhance the provision of these services. When services are billed by or through the IHS, no state match is required by Medicaid.

Prior to the development of this agreement, the New Mexico Indian Mental Health Council was organized in 1994 to advise the division on Indian mental health needs and issues. The council comprised representatives of all major tribal groups in New Mexico. Also participating were the Navajo and Albuquerque Area Indian Health Service Mental Health Offices; the Children, Youth, and Families Department; the Division of Vocational Rehabilitation and the Office of Indian Affairs.

One term of the Department of Health/IHS agreement identified the establishment of a mechanism for ongoing communication and coordination via a steering committee and regular monthly meetings with Department of Health and IHS to discuss the status of project activities. Tribes were represented on this steering committee.

This provides an example of the efforts being made to improve mental health services through tribal-state cooperation. Although twenty-seven of the thirty-nine tribes surveyed by NICWA stated that they received some type of state funding to augment their mental health services program, however, none identified state funds as the main source of funding for their programs.

Private Funding (Corporate and Foundation)

Though government sources of funding are generally more constant, funding from private sources can be an important method of increasing or enhancing needed community services. Generally, this funding is short-term, of one to two years. Furthermore, foundations rarely give continued support or funding that can be counted on each year for an extended period.

Although some private foundations, such as the Kellogg Foundation and the Annie E. Casey Foundation, have developed Indian-specific funding initiatives, private foundations generally do not serve Indian communities well. Foundations annually fund $2 billion in grants in the U.S., but less than two-tenths of one percent are given to support human services in Indian Country (Funk, August, 1995b). The Combined Federal Campaign distributes well over $100 million annually, but less than one-tenth of one percent is given to Indian programs. No respondents to the NICWA survey reported that foundation or other private funding represented a significant portion of their budgets.

NICWA TRIBAL MENTAL HEALTH ACCESS PROJECT SURVEY

During the first year of the NICWA Tribal Mental Health Access Project, 55 tribes were identified in our survey; 39 participated. The survey was conducted by telephone and was designed to determine what, if any, funding resources were available to tribes to provide children's mental health services. Sample selection was based on the aim of a broad representation of the following characteristics:

- regional representation;
- population;
- level of isolation from urban centers.

There are 555 federally recognized tribes and Alaska Native villages. Tribal program respondents included professional and paraprofessional staff from programs in tribal mental health, Indian child welfare and social services. The survey instrument consisted of ten primary questions that yielded both qualitative and quantitative data. The survey instrument was administered to the respondents during telephone interviews from March through July 1995. The average interview took approximately twenty minutes to complete. The survey questions included the following:

1. What mental health services are currently available in your community for children?
2. Who funds children's mental health services for your tribal community? Indian Health Service? Indian Health Service contract care? Autonomous tribal programs? State/county agency? Other?
3. What is the largest source of funding for children's mental health services for your tribal community?
4. Approximately how many children are currently being served by the tribal Indian child welfare program?
5. Where do children in out-of-home substitute care receive mental health services? Are mental health services readily available?
6. Does the Indian child welfare or related social service program use the services of traditional healers for children and families?
7. Please describe the barriers you observe in accessing mental health services for children in your community.
8. Please describe your community in terms of the following: population, nearest major city, nearest hospital/clinic, nearest mental health services/therapists.
9. Do the majority of your tribal community members have reliable transportation?
10. Please describe how you think these barriers can be overcome.

The tribes surveyed were the Ysleta del Sur Pueblo, TX; Bad River, WI; Northern Cheyenne, MT; Shoshone, WY; Grand Portage, MN; White Earth, MN; Narragansett, RI; Kickapoo, TX; Elko, NV; Laguna Pueblo, NM; Duckwater Shoshone, NV; Ft. Duchesne, UT; St. Regis

Mohawk, NY; Saginaw Chippewa, MI; Wampanoag, MA; Miccosukee, FL; Penobscot, ME; Oneida, WI; Kiowa, OK; Ft. Belknap, MT; Yakama, WA; Warm Springs, OR; Viejas, CA; Barona, CA; La Posta, CA; Kalispel, WA; Hoh, WA; La Jolla, CA; Rincon, CA; San Pasqual, CA; Los Coyotes, CA; Mesa Grande, CA; Spokane, WA; Squaxin Island, WA; Burns Paiute, OR; Campo, CA; Jamul, CA; Cuyapaipe, CA; and Manzanita, CA.

Findings

Results from this survey were not surprising. Tribal social services staff and ICWA program staff were among the key respondents to the survey, since the majority of children's mental health clients were in the caseloads of the ICWA and tribal child protective services programs, even if they were being treated by tribal or IHS clinic services. The number of children identified in tribal ICWA caseloads ranged from eight to nearly 200.

Thirty-five of the 39 tribes responding reported that they relied primarily or entirely on Indian Health Services to provide the majority of mental health services in their communities. More than half stated that their mental health programs received state mental health funds as well as tribal funds to run their mental health programs. Exactly how state funds were passed on to tribal programs was not specified. Respondents were often unclear of the mechanism by which they received state funding, whether it was through grants, contracts or agreements. One tribal mental health program specified that they received funding from the tribe's casino profits to pay for children's mental health services. Although some tribes identified funding sources such as federal domestic violence funds, or state and county block grant funding, none identified any private foundations as significant funding sources for their mental health programs.

One tribe was identified as a tribally run, licensed, Medicaid vendor but stated that they derived only a small portion of their mental health budget from Medicaid billing due to compliance factors associated with Medicaid. Whereas, their client population tends to be crisis-oriented, Medicaid reimbursement requires longer term care and specific long-range treatment plans. However, as a Medicaid vendor, the tribal mental health program is able to refer children directly to state treatment facilities without outside intervention.

Funding, isolation, transportation, cultural differences and inability to provide long-term services were mentioned as barriers to the effectiveness of tribal mental health services by the respondents. Nearly 80 percent of respondents reported that transportation was a problem for their tribal members, particularly if they needed to obtain services away from their immediate community. Distance to off-reservation services ranged from 10 to nearly 300 miles away.

About one-third of the 39 tribes who participated in the survey stated that they used or had access to traditional healers in their mental health programs, while approximately 20 percent of the respondents felt that a barrier to service delivery was the lack of Native American therapists. How these services were paid for was not clear.

PROFILE OF FOUR TRIBAL MENTAL HEALTH MODELS

During the second year of this project, NICWA took a closer look at successful tribal strategies for funding children's mental health. Specifically, examined five tribes' approaches in-depth. Four of those tribes are profiled here to show how those approaches are working and how others may be able to replicate those programs.

Today, most mental health services are provided in outpatient counseling clinics rather than in state hospitals, even when the client is acutely and chronically mentally ill. When hospital care is needed, this care is closely coordinated with community mental health care. Most hospital stays last less than one month, and clients are referred back to the community mental health center nearest their home for outpatient follow-up care.

These services, so much reduced since "deinstitutionalization" of the mentally ill in the 1980's are today even less available to Indian people for reasons already discussed.

Most mainstream community mental health centers have not developed specific programs or models for serving Indian clients. Though they may have had contact with tribes to explain their services, they have generally expected Indian people to use services in the same way as non-Indians. It is not surprising that the state-funded mental health system, a major resource for mental health care, has been generally underutilized by Indian people.

Culturally oriented services are the core of effective mental health programs, and any mental health services must make sense in Indian terms. For example, services must

- meet the immediate needs of Indian people for practical help in emergencies;
- recognize the extended family as the actual and appropriate "unit of treatment";
- be flexible about the time and place of meetings;
- fit into everyday tribal community life.

Some tribes have made creative use of a variety of funds to develop tribally based, culturally relevant mental health programs. Tribal mental health workers may be funded partially by various combinations of sources from the Indian Health Service; Bureau of Indian Affairs ICWA grants; funds from tribal enterprises, including gaming; federal discretionary funds; funds earmarked for educational purposes, or through cooperative agreements with state or local mental health centers. Many tribes recognize the need for programs that are not only physically located in the tribal community but that are also designed to meet specific local needs and to conform to the values prevalent in each tribal community.

The following tribal mental health projects have implemented community mental health programs incorporating service, flexibility and cultural competence. Though funding, staffing and isolation continue to pose ongoing problems, these programs are effective in meeting a portion of the mental health needs in their communities.

Feather River Indian Health—Behavioral Health Services

Berry Creek/Mooretown Tribal Health Organization, 2167 Montgomery Street, Oroville, California 95965; Contact: Kathryn Manness, Director, (916) 534-3793

The mission of the Feather River Indian Health—Behavioral Health Services (Feather River Indian Health BHS) program within the Berry Creek/ Mooretown Tribal Health Organization is to enhance the functioning of individuals, families and distinct Native American communities living within its catchment area.

The services that are offered are substance abuse counseling, mental health and social services. Cultural integrity and respect for the enormous variability in the clients' degree of traditional commitment, acculturation and assimilation require sensitivity and flexibility. The fulcrum of service delivery is an intense, integrated, case management philosophy.

Tribal and Community Description

Feather River Indian Health Services is one office of the Berry Creek/Mooretown Tribal Health Organization. Feather River Indian Health BHS opened its doors on October 1, 1993. Prior to that, Northern Valley Indian Health Services operated the health clinic. Feather River Indian Health provides services to Native Americans in Butte County (with the exception of Chico); Yuba City Indian Health provides services to Native Americans in Sutter and Yuba counties. These are poor, rural counties in northern California. Agriculture, fishing and timber are the primary industries. Timber supports the economy and employment market less each year.

This area of California is dotted with tiny towns, such as Cherokee with approximately 120 people and other areas such as Feather River Falls, a mountainside community of approximately 800 people that has no organized township. There are about seven recognized municipalities; only two exceed 12,000 in population: Oroville with population 12,000 and Chico with population 85,000. Chico houses a branch of the California university system. Oroville is the county seat in Butte County and is the other primary source for employment in the area. The largest store is Walmart; small businesses continually open and fold. Mooretown Rancheria opened a small, 100-machine casino in a prefabricated building in June, 1996.

Feather River Indian Health BHS is run by the Berry Creek and Mooretown Rancherias, although Enterprise Rancheria also falls within the catchment area. Many Native American families live in the mountains or other remote, rural areas of the foothills. Some of these individuals live in

teepees or lodges without utilities. The children attend elementary school in two-room school houses where as few as 70 children comprise grades K—8, and highschool students are bussed to the schools in nearest cities.

Native Americans indigenous to this area are Maidu, Wintu, Pomo and Miwok. Many are unaffiliated with a particular rancheria and hold no voting power in the rancherias that control the health clinic. There is also a large population of Native Americans not indigenous to this area of northern California, some of whom are California Indians and others of whom are from tribes outside of the state.

Native Americans in Butte and neighboring counties are the poorest ethnic group with the highest highschool dropout rate. Although they account for only 2 percent of the Butte County population, approximately 30 percent of children in voluntary and involuntary foster placement are Native American. Substance abuse, post traumatic stress disorder and domestic violence create enormous mental health problems for Native American youths, who, until recently, have been virtually untreated by non-Indian resources and minimally treated by the Indian health clinic.

Early Development of the Program

The Feather River Indian Health BHS program began in 1993 with one licensed clinical social worker funded through IHS and one women's substance abuse prevention community worker funded through the Butte County Department of Mental Health, Alcohol and Drug Services division. In 1994, the women's substance abuse prevention program lost its funding because of severe funding cuts to Butte County Department of Mental Health. These funds were replaced by one-time, unexpended year-end monies for two years in a row from IHS. One additional youth substance abuse counselor was funded for one year by a one-time grant from the State of California to support the opening of the Yuba City Indian Health Facility.

Description and Funding of the Program Today

Currently, the only program funding is $40,000 annually through IHS. The staff consists of

- Feather River Indian Health BHS director, Licensed Clinical Social Worker (LCSW);
- two substance abuse counselors, certified;
- one substance abuse counselor, trainee;
- one volunteer Masters in Social Work (MSW), 3 days per week (volunteering in exchange for supervision toward her LCSW);
- one volunteer Marriage and Family Counseling Certificate (MFCC) intern 4 hours per week (working toward her MFCC hours for licensing).

Short-term staff commitments are

- one MSW student intern 36 hours per week for 12 weeks;
- one MSW student intern for nine months, 1 ½ days per week (beginning 8/96);
- one Substance Abuse Counselor student intern, 2 ½ days per week (beginning 8/96).

The position of substance abuse counselor trainee was created in response to the need for counselors from the areas served. When the position of a licensed substance abuse counselor was first advertised, only one Native American applied but could not meet the education or experience requirements and therefore could not be hired. However, the Board of Directors recognized the need and agreed to create a position for a substance abuse counselor trainee. Co-sponsored by the California Indian Manpower Consortium, a job-training program, the trainee was required to attend school. After he obtains his certificate, he will become a permanent, full-time employee with a salary commensurate to his training. This has proved to be an invaluable arrangement, since this individual knows the community very well

DESCRIPTION OF SERVICES

The Feather River Indian Health BHS operates under the philosophy that one type of service alone usually cannot address the needs of a person (or family) whose life situation is gravely dysfunctional. Children's needs generally require collaboration with schools and other services for accurate assessment and appropriate treatment plans.

All services are based on a case management approach. The staff operates as a team with one designated staff member responsible for the coordination of services to a client, whether the client is an individual or several individuals within a family. There is a designated counselor as well as case manager, although frequently those two responsibilities may fall within the caseload of only one individual staff member. Frequently, two counselors are involved in the same case because of family services or because the individual goes to a therapist for individual therapy and then participates in a group. Services provided include the following:

1. case management needs assessment;
2. clinical evaluation and diagnosis;
3. treatment planning;
4. individual, group, family substance abuse counseling;
5. individual (child, adolescent and adult), group, family psychotherapy;
6. case management;
7. prevention groups for children;
8. a Small Trail Mentor Program is being developed for male adolescents involving the substance abuse intern and a volunteer Maidu artist;
9. a variety of prevention activities, including
    a) an annual campout for clinic clients, a week-long event for the entire family,

b) an annual mental health forum,
c) an honor gathering for children finishing school,
d) an elder's honor dinner,
e) the Chico State University powwow.

County Services

The mental health department of Butte County services only the severely, chronically, mentally ill and only for short-term therapy and long-term medication management. There is only a 16-bed unit for hospitalization. No private facility has been approved for medical reimbursement; therefore, there are no alternatives. There are no overnight detoxification facilities and only one outpatient facility, a methadone treatment facility in Butte County.

Feather River Indian Health BHS Services

Clients usually are referred by the medical department or through a friend who has been satisfied with the services. A needs assessment is conducted, not a mental health evaluation. If the person/family requires more than social services, substance abuse and mental health evaluations are performed. The worker clarifies with the client/family what they want from the organization, and a treatment plan is developed.

That plan is discussed at a staff meeting, and a case manager is assigned. The case manager has the primary responsibility for making all referrals, attending collaborative meetings, helping the client obtain various other services and making sure that the chart is in compliance with uniform departmental charting regulations. Ongoing maintenance services take place as appropriate. The case manager may or may not be the primary counselor/therapist as well. Almost all clients require counseling or therapy as their primary need. The clinic's philosophy is to tailor services to the needs of the clients rather than trying to bend the clients' needs to fit what is offered by the Feather River Indian Health BHS program.

Additional Information on California Behavioral Health Services

Within the 36 Behavioral Health Services (BHS) programs in the state of California, staffing personnel includes the following:

- 1 psychiatrist;
- 11 psychologists (Ph.D.);
- 11 licensed clinical social workers;
- 3 MSWs;
- 11 MFCCs;
- 3 interns (students);

- 41 traditional counselors, paraprofessional counselors, MFCC interns;
- 56 substance abuse counselors;
- 14 outreach, community, activities counselors; and caseworkers.

One major health clinic has no BHS program. ICWA programs are usually independent of the health clinics and employ no mental health clinicians. Two ICWA programs were identified as part of IHS-funded health clinic programs, but those personnel were not identified as mental health or substance abuse counselors and were excluded from the above count.

There are a total of 37 programs with 142 mental health/substance abuse clinical personnel. The distribution of BHS personnel (which includes, by definition, mental health, social services, substance abuse counselors) within the clinics is shown below:

BHS personnel in clinic	Number of clinics
0	1
1	5
2	6
3	11
4	3
5	2
6	3
7	1
8	1
9	1
10	1
11	1
15	1

The average number of BHS personnel per clinic is 3.84. One clinic has no BHS personnel; one has 15. Twenty-three of the thirty-seven programs have three or fewer personnel who would qualify as Behavioral Health Service providers. Of the 37 programs, only three are without a certified substance abuse counselor, whereas 17 programs are without any licensed mental health professional.

Among 37 programs in the state, the certified staff are distributed as follows:

M.D.	1 clinic
Ph.D.	10 clinics
LCSW	9 clinics
MFCC	9 clinics

Restoration of K`e' Project

Navajo Nation, P.O. Box 164, Tohatchi, NM 87325; Contact: Jenny Rodgers, Executive Director, (505) 733-2482.

Introduction

K`e' is a complex concept deriving from traditional Navajo (Dine') principles and values that approach wellness and healing in terms of spiritual, physical and mental balance and harmony. The main goal of the K`e' Project is to strengthen and empower Navajo children and families through the traditional principles and values expressed in k`e.' For centuries, k`e' has sustained the well-being of the Navajo people through their relationships with their spiritual and natural environments. These relationships are guided by respect and caring. The K`e' Project uses conventional (Western) mental health assessment and intervention strategies and Navajo-specific interventions to (1) restore family wellness by reinstituting and/or strengthening k`e'; (2) develop or expand a comprehensive system of care through interagency collaboration; (3) coordinate the participation of spiritual healers according to client preferences; (4) empower parents and elicit their partnership in healing programs; (5) identify various factors related to attaining wellness and determine the contribution of each factor.

The impact of Western cultural ideals, education, religion and forms of government has led to the dismantling of traditional social practices, including a breakdown of the k`e' system. The resulting choices as to whether to keep with tradition, assimilate or adopt the good and the bad from both sides is difficult. It is believed that this has caused an increase in the number of Navajo children with severe emotional disturbances. Current interventions through isolated Western institutional services have been ineffective because they do not work with the k`e' system.

The K`e' Project seeks to help children and families accept responsibility for their lives through a deeper understanding of community resources, and it includes families as partners in the healing process. This effort is critical to the long-term survival and success of the Navajo people.

Tribal and Community Description

The Navajos comprise the largest Indian tribe in the United States. Today there are approximately 170,000 Navajo Indians; 88 percent of them reside in the southwestern United States. The reservation has eight major and five secondary communities, inhabited by an estimated population of 30,000, approximately half of which are Navajo.

Governed by a tribal council of 88 members representing 110 chapters, the Navajo Reservation lies in the heart of the Four Corners region and extends into three states: Arizona, New Mexico and Utah. It encompasses approximately 25,000 square miles (16 million acres), or one-fifth of all Indian lands in the United States.

The reservation is a land of high plateaus, deep canyons and low-lying plains traversed by a range of mountains that rise along the Arizona-New Mexico state line. Although annual rainfall may be as high as 27 inches at high altitudes, climate is generally arid or semiarid. Resources of the Navajo Reservation include petroleum, coal, uranium, land, timber and a wide variety of tourist attractions. According to the 1990 census, the median family income was $11,885; 57 percent of Navajo families fell below the poverty level.

Local/County/State Services

No other tribal mental health services are available to tribal members, although the tribe's Department of Behavioral Health Services is attempting to implement access to services in Arizona. There is limited access to services through New Mexico Children, Youth and Families Department. They fund local programs and provide some funding for adults through the Department of Mental Health in New Mexico.

Formal intergovernmental agreements exist for child protection services, including an agreement between the Navajo Nation and the state of New Mexico for Mental Health Services for Children.

Project Description

Services. The K`e' Project targets children and youths below the age of 22 who have severe emotional disturbances and who reside within one of the seven K`e' Project service areas on the Navajo Reservation. Self-referrals are accepted, and other referral sources include various agencies that serve children and families (e.g., schools, courts and social services). There is a particular focus on children and their families who have been victims or perpetrators of sexual abuse, but services are extended to victims and perpetrators of other forms of child abuse as well. Interventions are targeted toward the identified client in the context of his or her network of family and significant others, which may include 30 or more individuals.

The central project office is located in Tohatchi, New Mexico, and coordinates the work of the seven site offices located elsewhere on the large Navajo Reservation. The K`e' Project covers a great deal of territory and provides home-based services to clients who live in rural and remote communities.

Case managers serve on each treatment team. They are responsible for preparing and monitoring the client's individual service plan. They gather historical data and other information from multiple sources for intake evaluation. They make an initial assessment of the client's strengths and needs, and they diagnose along Diagnostic Statistical Manual of Mental Disorders (DSM)-IV axes IV and V.

When a referral has been made and accepted, team members assess the client and family according to their individual perspectives as therapist, native healer, case manager, child advocate, etc. Individual service plans are developed in weekly meetings with the clinical director. The case manager and/or child advocate works with the child's school, and a representative of the Department of Education often participates in team meetings.

The Project uses a community outreach model, providing services in the home. Family is broadly defined so that a team might work with a child and his or her parents and also with 30 or 40 other individuals who are related to them by blood or clan affiliation. Each site employs the parent of a child with serious emotional disturbance to serve as a family support specialist, a salaried member of the staff who is responsible for advocating for the rights of the family and assisting in the development and implementation of a treatment plan that reflects the family's goals and builds on its strengths.

Staffing. The central K`e' Project office is staffed by the project director and an administrative assistant. Additional staff, who report to the project director, include a curriculum coordinator, two clinical directors, a research specialist and seven site directors. Each site employs a site coordinator, two conventionally trained and licensed therapists, a traditional counselor/native healer, a case manager, a family support specialist and an administrative assistant. The family support specialist is hired based on personal experience with a child who has serious emotional disturbance (SED). Three sites have a child advocate. Staff members are expected to understand and promote the principles and values of k`e'.

Most project staff are Navajo with varying levels of experience. Traditional language and practices as well as differences in spiritual practices are represented by the staff.

Funding. Majority funding for this comprehensive community project has come from a five-year grant through the Center for Mental Health Services (CMHS) Mental Health Services Initiative for Children and Families, which began in 1994. The Indian Health Service and other federal agencies provide direct and indirect technical assistance and training. For example, training opportunities are offered by federal grantees and contractors such as the National Resource Center on Child Sexual Abuse and the National Resource Network for Child and Family Mental Health Services.

The salaries of some support staff are partially covered by Job Training Partnership Act (JTPA) funds. The security of these positions depends on continuation of JTPA subsidies. Forms have been developed to document information that can be used by the project in billing Medicaid or other parties for qualified services.

Use of Traditional Healers. Traditional counselors/healers are used at each site of the K`e' Project. There have been concerns, however, regarding liability and difficulty in obtaining liability insurance for traditional healers, as well as disagreement about which traditional interventions should be offered and by whom. These concerns have limited the project's traditional healing component significantly. Traditional healers continue to assess, refer and counsel but are barred from conducting or receiving funding for many of the traditional ceremonies.

Barriers to Services/Funding Access. The K`e' Project covers a great deal of territory and provides home-based services to clients who live in rural and remote communities. Services such as office-based social welfare or mental health care may be extremely difficult for families to reach. Some families live in such remote areas that teams can only reach one home per day. Since few telephones are available to these families, appointments are difficult to confirm or reschedule. In addition, there is a shortage of vehicles available to staff who provide in-home services.

Other challenges are faced in implementing the project. First, there is a shortage of culturally competent therapists who have conventional training and credentials that are acceptable to funding sources such as Medicaid. Second, the Navajo Nation is diverse, so that cultural competence may be defined differently by different persons, creating a need for the project to accommodate multiple points of view. Turnover of staff has been fairly high among non-Navajos.

Third, professional liability insurance that will cover native healers, whose credentialing process has not been formally defined for accreditation purposes. Further, the project has been unable to provide traditional healers "in-house," and collaboration with outside native healers is limited because most client families cannot afford these unreimbursible fees. *Traditional healing methods are currently not billable under Medicaid.* This may change in response to the development of a credentialing process for native healers or a change in federal regulations.

Although Medicaid certification will be complicated by the need to meet requirements of the governments of four states as well as the Navajo Nation, this is the most important step the project can take toward developing an independent source of funding that can be used as the project deems necessary.

Washoe Family Trauma Healing Center

Washoe Tribe, 919 Highway 395 South, Gardnerville, Nevada 89410; Contact: Art Martinez, Ph.D., Director, (702) 265-5001.

Introduction

The Washoe Family Trauma Healing Center provides evaluation and treatment for those who have been victims of abuse. The request for services may be initiated by the individual, court, family, child guardian, or tribal, municipal or state social workers. Services include: (1) case consultation, (2) evaluation and assessment of childhood trauma issues, (3) treatment services and (4) ongoing case management and consultation. Each individual referred to the Healing Center undergoes a comprehensive evaluation that focuses upon issues related to the alleged abuse. Upon completion of this process, an evaluative report is provided outlining a course of specialized treatment. If therapeutic treatment is indicated, these specialized services may be obtained at the Healing Center.

The mission of the Washoe Family Trauma Healing Center is one of great vision. That vision is to provide culturally specific services to family and individual survivors of victimization and trauma, to join families in the reversal of generations of traumatic family stress and to provide such efforts to all Native families of northern Nevada and eastern California.

Tribal and Community Description

The Washoe Tribe of Nevada and California is a federally recognized tribe organized under the Indian Reorganization Act of 1934 to exercise certain rights of home rule and be responsible for the general welfare of its membership. Tribal history, however, extends back an estimated 9,000 years in the Lake Tahoe Basin and adjacent eastern and western slopes of the Sierra Nevada range. Tribally controlled lands within the aboriginal homelands now fall within Douglas County and Carson City, Nevada, and Alpine County, California.

The tribe conducted its own census in 1993 and determined that there was an on-colony service population of 1,380 people. This number includes all individuals in the households irrespective of enrollment status. Washoe tribal enrollment now totals 1,523. Most tribal members living off-reservation live in communities surrounding tribal lands.

Local/County/State Services

Since the Washoe Tribe crosses into the jurisdiction of California, which is a Public Law 280 state, the tribe has had to establish memoranda of agreement with different jurisdictions in the

management of child welfare and social services. In the past year, the tribe has reassumed jurisdiction over children in foster care in Alpine County (where a majority of the cases are Indian children). As a result, foster care funding is provided directly to the tribe for these children. The Washoe Tribe already has jurisdiction over children in Nevada.

The Washoe Tribe is currently in negotiations with the Indian Health Service to open an adolescent regional treatment center for youths at high risk of alcohol and other drug abuse and dependence. The center will serve Native American youths within the Shurz Service Unit (which includes the Washoe Tribe's service area). Adolescents involved in the services would receive day treatment, aftercare, family counseling, assessment and collateral psychological services. The Washoe Tribe intends to establish a model program for outpatient care for minors within the Indian Health Service. The tribe is collaborating with Carson-Tahoe Community Hospital in Carson City, Nevada. The collaboration and accommodation of privileges will allow the project to utilize the referral resources of psychiatric outpatient, psychiatric inpatient, drug and alcohol detoxification and inpatient detoxification. These services will exist as an adjunct to the outpatient aftercare/day treatment facility to be provided by the Washoe Tribe. Co-located near the day treatment program will be a therapeutic foster care group home to allow clients from distant locations to be served via short-term stabilization stays.

Project Description (Washoe Family Trauma Healing Center)

Services. Upon report or identification of a child abuse issue, the family will be screened for appropriateness of treatment services at the Washoe Family Trauma Healing Center. The agency responsible for investigation of chemical dependency, child abuse or child placement, will preliminarily screen the child for referral to the Washoe Family Trauma Healing Center for a more comprehensive evaluation. This evaluation will focus on the issues specific to the alleged abuse, trauma assessment of the child, and the perpetrator or family system. These evaluative processes will be compared for therapeutic consistency. The evaluation will offer a clinical opinion to the court and delineate a course of treatment addressing issues of the court's concern.

The referral for evaluation is expected to be issued by the tribal or state Department of Social Services. This document will authorize the evaluation of any minors involved by name and will state the issues of concern to be addressed through the evaluative report.

The evaluation is designed to assist in understanding the child's experiences and to develop treatment plans to remediate problematic family dynamics. In these ways, and through other treatment services, the Healing Center seeks to identify and remediate issues of family trauma.

Once the Tribal Department of Social Services has completed its initial phase of investigation, the case may then be referred for an initiation of the treatment plan. The party responsible for the child or adult client must sign appropriate limits of confidentiality, permission to treat, therapeutic contracts, and a release of the necessary information.

Specialized counseling services focus on the treatment of the family and child trauma. The Healing Center seeks to provide specialized child, individual, family and group counseling services in an effort to break the cycle of abuse. Treatment emphasizes cultural strengths in protecting the children and reducing the risk of future abuse within the family.

Staffing. A highly skilled staff of experienced providers in the field of family trauma therapy provide comprehensive services at the Washoe Family Trauma Healing Center. A Native American psychologist and two therapists bring over 30 years of combined experience in working with Native families and child abuse survivors.

Funding. Efforts to fund the early development of the Washoe Family Trauma Healing Center began in August 1992. The Washoe Social Services and Health Clinic prepared an initial budget of $150,000 and presented a project narrative to IHS and Congress on child sexual abuse problems. In September 1992 the Congressional Record showed the intent to include $450,000 in the IHS mental health budget for the Washoe sexual abuse programs.

Difficulties in obtaining the release of appropriated funds and technical difficulties related to an analysis of the program's site feasibility caused nearly one year's delay in implementing the project. The contract application was eventually scrapped and a budget modification was made to the clinic's existing 638-contract. The contract modification went into effect in September 1993, adding $450,000 to the clinic's budget to implement the sexual abuse treatment program.

Majority of funding for the Healing Center is through IHS and third-party billing, including Medicaid and private insurance. The Healing Center does not receive any funding through private foundations. It may apply for these funds in the future.

Use of Traditional Healers. The Washoe Family Trauma Healing Center currently does not use traditional counselors or healers.

Sirius Research Group, Inc.

P.O. Box 195, Akron, NY 14001; Contact: Frank Capatch, Director, (716) 542-5230

The Sirius Research Group, Inc., is an independent group of social work professionals who are subcontracted through St. Jerome's Hospital (Batavia, New York) and the State of New York to provide social-work services to enrolled members of the Tonawanda Band of the Seneca Nation. The state-run clinic serves more that 500 residents in rural, northwestern New York State and is located just off the reservation.

The Tonawanda Band of Senecas lives on the 7,550 acres of the Tonawanda Reservation located in northwestern New York on Route 267 near Batavia. Approximately 675 people are in residence on the reservation.

THE PROGRAM

The Sirius Research Group's program has less than three full-time staff. They include one full-time MSW supervisor; one part-time social work assistant/student intern; one full-time indigenous consultant.

However, the Genesee County Department of Mental Health provides one part-time licensed psychologist/family therapist (on-site); and the Genesee Council on Alcoholism and Substance Abuse provides one full-time MSW/chemical addictions counselor (CAC).

Referrals come through the medical clinic (via the nurse practitioner) or a consulting physician who work in a triage capacity with Sirius Group staff and the Community Health Care Workers Program to provide a holistic approach to treatment services. Although the program is housed within a medical facility, it is not based on a medical model. Services are provided by out-stationed workers in various settings, including the Tonawanda-Seneca Family Care Center/Clinic, the Akron Central School/Native American Student Liaison's office, and the Tonawanda-Seneca Nation Tribal Office/Community Health Care Workers Program.

THE SERVICES

The Sirius Group's services include

- child and family counseling for "V-code" clients (i.e., problem-specific versus psychiatric diagnosis issues);
- assessment and referral services;
- pre-screenings for adjustment disorders and family crisis interventions.

When possible, community resources such as elders, clan mothers and extended family are included in intervention processes. Indigenous staff members, consultants, and community volunteers augment the cultural aspect of services and further empower the community.

The Sirius Group also provides other activities such as community teen and youth groups; parenting workshops; self-help groups (based on the Alcoholics Anonymous model); community outreach; and social work education.

General Concerns

Similar to many other Indian programs, professional services are contracted out. Usually, they are contracted to individual clinicians, including psychiatrists, psychologists, licensed clinical social workers, and MFCCs, as opposed to an organization. Rarely are the professional services provided by Native people.

Although this program provides an array of services, it is piecemeal. Indian clients usually come by referral. They may remain in the program long enough to be assessed or screened, but are then referred out again thus making it less likely that needed services will be received. Such a system breeds the potential for despair, hopelessness and helplessness. The more a client is in need of the services, the more frustrating the confusion of referrals can be. Unless there is a strong initial rapport between the client and the worker or the worker has gained client and/or community trust, likelihood is strong that the client will get lost in, or merely wander away from, a system that can be perceived to be giving little other than another office to which to go.

The program is like many other Indian programs in its lack of cohesiveness. Social services comprise the thrust of this program, as in many other reservation-affiliated programs, many of which exist through BIA funding for the support of Indian child welfare programs. Although some monies are provided for mental health services generally, those services are usually contracted out to one or more professionals in the community, rarely Native, or are made available by hiring a part-time, or occasionally full-time, mental health professional. The services are often Indian Child Welfare Act-specific or related. The mental health component is secondary to ICWA, and case management and the understanding of profound mental health issues are poor.

BARRIERS TO TRIBAL ACCESS FOR MENTAL HEALTH FUNDING

For programs to serve tribal communities effectively, the funding source should operate on the following basic principles:

- It should provide direct access to funds by tribes. This can be accomplished through legislatively prescribed tribal set-asides as is the case with the Child Care and Developmental Block grant. (See description on in section on issues affecting access).
- Funding formulas for the distribution of tribal funds must emphasize not only need and equity but also provide for a minimum operating cost. Again, the Child Care and Developmental Block grant is a good example, as it provides a 3 percent set-aside for tribes that can be utilized to operate at least a minimal program.
- Regulations must allow tribes to design and operate programs that meet the unique circumstances and values of their communities. Too often, federal programs overregulate tribal programs and require activities or services that do not fit the tribal communities' needs, values or administrative capacity. Where regulations have been broad enough to give the community control and flexibility over the types of services that can be offered, tribal responses to child abuse and neglect have proven to have effective outcomes while still meeting the federal program's goals.

Specific issues of concern are as follows:

Inadequate State Pass-through of Federal Funds to Tribes

Most state governments provide little assistance to tribes by way of child welfare or mental health funding. States are not mandated by federal law to fund tribes with federal or state dollars, thus leaving tribes vulnerable. Even when states do make funds available to tribes, the amount of funds is commonly small relative to the costs required to administer them. Additionally, significant compromises in tribal sovereignty often result from agreements that states require for receipt of funds.

Most tribes receive little or no Title IV-E or Title XX funding. Several federal requirements limit the tribes' access to Title IV-E and Title XX funds. Congress provided no authority for Administration for Children and Families (ACF) to award Title IV-E and Title XX funds directly to tribes. Legislation neither requires nor encourages states to share funds with tribes. Efforts to develop the necessary tribal-state Title IV-E funding agreements and Title XX funding arrangements are constrained by requirements that put states at financial risk for tribes' use of Title IV-E funds and mandate a matching share for tribes' IV-E funds.

Although it is not strictly targeted for child welfare services, the Social Services Block Grant is the largest source of social service funding available from the federal government. Many of the 50 states that receive these funds annually dedicate the majority of them to child and family services. The FY 1994 appropriation level for Title XX was $2.8 billion dollars, to be distributed only to states and territorial governments. When the block grant was authorized in 1981, little thought was given to the impact of not providing any mechanism for the direct funding of tribes. Thirteen years later, only six states report any sharing of Title XX funding or tribal involvement in planning for services supported by Title XX funding, even though state allocations of Title XX funding are based on the total state population, including Indian people. Of those states that do share some of their state allocation of Title XX funds with tribes, most share a disproportionately low amount, given tribal population size and needs.

States governments, on the other hand, have had the advantage of receiving these recurring federal funds for many years. As a result, states have more social service infrastructures in place than do many tribes.

A 1994 report by the Office of Inspector General documents that in 15 of the 24 states with the largest Indian populations, eligible tribes received neither Title XX nor Title IV-E funds from 1989 to 1993. In the remaining nine states, which have large Indian populations and did provide some funding from these programs to tribes, only a combined level of $3 million per year over a five-year period was provided.

Reductions in Traditional Funding Sources for Tribes

Traditional sources of funding for tribal services are at risk as never before. Dramatic cuts are proposed by the Senate Appropriations bill passed in August, 1995. The bill proposed a 27 percent reduction in the Bureau of Indian Affairs tribal priority allocations, the account that supports essential tribal services such as law enforcement, child welfare, social services, fire protection and senior citizens services. These cuts will be a devastating blow to tribal governments that operate their own programs and hence to tribal self-determination and self-governance. (U.S. Department of Interior, 1995).

Although Indian Health Services has not fared as badly, the House and Senate cut the FY 1996 request for IHS programs by about $95 million, or four percent. These cuts will impede the ability of IHS to maintain basic health service programs for Native Americans and Alaska Natives at current levels.

Welfare Reform/Block Grants Will Affect Funding Streams

A very important factor in considering barriers to tribal access to mental health funding, is the outcome of welfare reform legislation in Congress. Federal legislative efforts to make vast changes in the current welfare system in America is just now being understood and has changed

dramatically during the course of development of this report. Most of the discussion in Congress has centered around state concerns and priorities, while excluding tribes as recipients of service funding. The welfare reform bill that passed the Congress and was signed by the President does not affect a number of child welfare programs, as was proposed under earlier versions. As passed, tribes will be included in the block grants for Temporary Assistance to Needy Families, child care programs, child support enforcement and employment programs. For the first time, tribes will be able to run their own cash assistance programs for families, but it is too early to tell whether it is economically feasible for tribes to assume this optional responsibility.

Difficulty in Accessing Medicaid as Vendor

Only one tribe in the NICWA survey was identified as eligible for direct Medicaid reimbursement because the tribal health agency is licensed as a Medicaid provider. Discussions about this arrangement focused on the difficulties involved in meeting the stringent Medicaid licensing requirements, including clinical recordkeeping, treatment plans and billing procedures. In spite of access to Medicaid to enhance financing of health care and mental health services, the tribe reported that Medicaid reimbursement represented only a small fraction of their budget due to the strict requirements about the types of mental health services that can be billed.

The advantages of Medicaid have to be weighed against the complications of adhering to federal rules and negotiating approval from regional offices of the federal Health Care Financing Administration (Koyanagi and Brodie, 1994). As funds for human services become scarce, utilizing Medicaid is almost essential to building a system of care for children. Medicaid can be a major source of revenue for mental health authorities with small budgets and very low levels of expenditure for children and adolescents, but using Medicaid to finance systems of care requires planning and detailed programmatic rules.

RECOMMENDATIONS TO INCREASE ACCESS TO FUNDING

Funding is one of the most important factors in assuring that appropriate and effective prevention and treatment services for mental illness and substance abuse are available to those who need them. But funding services in the mental health sector are complex, and many different funding streams must be tapped to provide even an approximation of full range of services required by children with serious emotional disturbance. The lack of adequate funds to develop or deliver services was mentioned by nearly every one of the 39 tribes surveyed as a major block to meeting the mental health needs of Indian children.

The need for increased funding and improved tribal access to mental health services, particularly for Indian children, is an issue that continues to be addressed at regional and national tribal conferences. These are not new issues that have only surfaced in recent years. The following recommendations concerning mental health needs of Native American people have been made on regional and national levels for the past decade, thus they are consistent themes that have been identified throughout Indian Country:

1986 Study, Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children

(Prepared jointly by the Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families, Portland State University and the Northwest Indian Child Welfare Institute, a Project of Parry Center for Children).

- Funds devoted to the needs of emotionally handicapped children, in general, are both inadequate and inequitably distributed; a more equitable distribution should be made and a revision of the current funding mechanism undertaken.
- Efforts must be made to encourage service providers at the state, federal and tribal levels to reorganize data collection to reflect the number of emotionally handicapped Indian children served; operational definitions of emotional handicaps should be developed for this purpose. A quantitative investigation should be undertaken to examine the extent of the problem.
- The nature of the socio-cultural factors (e.g., cultural identity and stress of assimilation) that impact Indian mental health should be further investigated.
- A means to encourage dialogue between governmental and bureaucratic entities involved in mental health services to tribes should be created, as well as a mechanism by which issues of responsibility can be arbitrated without the loss of tribal sovereignty or self-determination. Tribes must be empowered to provide necessary services to their own children.
- Services must be made more accessible to Indian families; placement of children away from families and other support systems should be avoided.

- Efforts must be made to combine the traditional knowledge of balance and harmony with modern concepts of mental health to provide training curricula that encourage culturally appropriate practice.
- Publication and dissemination of the existing and potential knowledge base in this area should be encouraged and supported on an ongoing basis (Cross, 1986).

1989 Recommendations: Senate Select Committee on Indian Affairs: "Community Based Mental Health Initiative for Indian People"

- Fund programs that involve entire family systems in treatment.
- Fund programs that encourage cooperation with traditional Indian healers or medicine people.
- Develop Indian mental health programs under local Indian control.
- Develop legislation aimed at improving coordination of services among tribal programs, Indian Health Services, National Institute of Mental Health, and state and county mental health agencies; and among tribally run mental health, alcoholism, health, education and social services programs.
- Develop holistic models of mental health, capable of addressing complex and interacting problems.

1990 Recommendations: Indian Adolescent Mental Health Study

The Office of Technology Assessment's (OTA) evaluation of American Indian and Alaska Native adolescents' mental health needs and the services available to them suggested a number of options for Congress to consider as it designs legislation to improve the mental and emotional health of American Indian and Alaska Native adolescents. The following are recommendations agreed upon by an OTA panel of experts and are consistent with principles derived by similar groups:

- Increase categorical funding for IHS mental health services.
- Provide categorical funding for mental health services specifically for Indian children and adolescents.
- Provide for a specific level of full-time equivalent mental health professionals, a portion of whom are to be for children and adolescents.
- Ensure that the Indian Health Care Improvement Fund is allocated, at least in part, to mental health services.
- Provide set-asides for Indian adolescents in general legislation, such as the Alcohol and Drug Abuse and Mental Health Block Grant, Juvenile Justice and Delinquency Prevention Act, Vocational Rehabilitation Act, Sec. 130, and Maternal and Child Health Services Block Grant.
- Clarify the intent of Public Law 98-509, which permits the US Department of Health and Human Services to provide alcohol, drug abuse and mental health block grant funds directly to Indian tribes.
- Mandate services to Indian adolescents under federal programs such as Medicaid (Title XIX of the Social Security Act).

- Provide for demonstration projects for alternative models for access to mental health services such as mobile practitioners, use of the village support worker model, consultation and technical assistance to indigenous mental health workers, and transportation to available services (U.S. Congress Office of Technology Assessment, 1990).

1993 Recommendations: Journey of Native American People With Serious Mental Illness

At the 1993 First National Conference, The Journey of Native American People with Serious Mental Illness, funding issues were emphasized as being of primary importance. In a keynote address, Dr. Scott Nelson, Chief of Mental Health Programs, IHS, remarked that the national budget for mental health services in the IHS was only $28.9 million to cover the entire country, including mental health programs in about 135 local service units and the 12 area offices. The $28.9 million funded about 350 IHS clinical staff around the country, an average of about two or three per service location, depending on the size of the community. Tribal programs and contractors also provide mental health services, and some state, local, county and private nonprofit facilities are utilized in a number of locations across the country. Seventy-five percent of IHS's mental health programs are run by IHS; 25 percent are run by tribes with the goal to encourage tribes, whenever possible, to run their own health services, including mental health, substance abuse and social services. Recommendations from the conference participants are as follows:

- Provide more federal and state government resources specifically for mental health services to Native Americans.
- Develop resource documentation on the current status of funding, state by state.
- Develop a resource document on state-tribal relationships, including the status of mental health services currently provided.
- Develop a collaborative strategy (tribes, states, DHHS, BIA) to assist tribes in capacity-building and development of program services, including the capacity to become licensed to provide Medicare and Medicaid services.
- Develop a database on tribal mental health needs and services (Sanchez and McGuirk, 1993).

1995 Recommendations: National American Indian and Alaska Native Family Summit

In 1995 the National Indian Child Welfare Association co-sponsored the National American Indian/Alaska Native Family Summit in Tulsa, Oklahoma. The conference was co-sponsored by the Cherokee Nation in conjunction with several national Indian and non-Indian organizations, including the National Congress of American Indians, the Association on American Indian Affairs, National Indian Health Board, Bureau of Indian Affairs, Christian Children's Fund, the Annie E. Casey Foundation, and the Kellogg Foundation. The goal of this national conference was to generate dialogue about, analysis of and advocacy on behalf of the state of the American Indian family by tribal, Native village and urban Indian community leaders. The resulting "call to action" focuses on protection, survival and enhancement of Indian family systems.

Among the key presenters and speakers were Ada Deer, Assistant Secretary for Indian Affairs, Department of Interior; Wilma Mankiller, Cherokee Nation Chief; Terry Cross, NICWA Executive Director; Dr. Scott Nelson, IHS Mental Health Service Programs Chief; Dr. Johanna Clevenger, IHS Alcoholism Substance Abuse Programs Branch Chief; Cecilia Firethunder, Lakota Sioux Community Activist; Yvette Joseph-Fox, National Indian Health Board Executive Director.

More than 300 tribal leaders and community members from around the country participated in this conference and developed recommendations from 12 work groups related to issues affecting families: education, health, economic development, children and youth, spirituality, etc. Draft recommendations were presented on the final day. These recommendations will be summarized and presented at various regional and national conferences as well as to key policymakers.

During this summit, NICWA conducted a strategy-building, technical assistance meeting for tribal leaders on children's mental health issues. Facilitated by NICWA staff, the meeting consisted of approximately 30 tribal representatives, including leaders from Yakama, Washington; Ft. Belknap, Montana; Couer D'Alene, Idaho; Colville, Washington; Chippewa, North Dakota; Chumash, California; Cheyenne River Sioux, South Dakota; Skokomish, Washington.

Participants in this meeting shared their concerns as well as their vision for a future in which Indian families will be mentally and emotionally healthy; where tribes will have direct access to the same federal funds as do states and will be able to administer those funds in a system of seamless delivery; where Indian children will have access to community-based, culturally appropriate mental health services; and where tribes will be the main delivery point for Indian child mental health services and will develop multidisciplinary systems of care consistent with cultural norms, values, family patterns and concepts of health and healing. Close access to a continuum of treatment resources, from family support and therapeutic foster care to residential services and the capability to treat even the most severe forms of emotional disturbance, was considered a priority. Tribal leaders and community members presented the following recommendations for improving mental health services for Indian children:

Federal Recommendations

- Tribal set-asides should be provided from Mental Health Block Grants for direct funding to tribes.
- Tribes should have direct access to funding that will be tribally administered.
- Direct access should include, but not be limited to, Title XX, Title IV-E and Title IV-B.
- Formulas to Title IVB, Part 2 should be revised to expand access to all tribes.
- Access to Title IV-B, Part 1 should be increased.
- Collaboration among private sector, nonprofit, state and federal entities must improve.
- IHS should give priority to children's mental health in funding.
- Children's mental health should be a tribal service, regardless of the funding source.
- Reporting requirements should be simplified to facilitate social service delivery.

- Mental health services and funding for youths and families should be increased.
- Mental health services must be culturally appropriate.

State/Local Recommendations

- Mandate state reporting of mental health services to Indians.
- Develop a continuum of care for children's mental health by tapping into state funding for technical assistance to tribes to become managed care providers, and develop partnerships with private care providers.
- Provide training and support to families with children who have severe emotional disabilities and/or who are coping with sexual abuse.
- Initiate a data collection/collation project to examine the extent of mental health problems among Indian children.

Tribal Recommendations

- Develop tribal foster home standards for therapeutic care and foster parent training for special needs children.
- Secure treatment for foster children, and develop therapeutic foster homes.
- Take tribal responsibility to eliminate violence as a result of alcohol and drugs and stop denying problems.
- Increase family-oriented rehabilitation services for juveniles.
- Promote spirituality (A National Conference on the "State of the American Indian Family," 1995).

1996 Listening Session Recommendations: National American Indian Conference on Child Abuse and Neglect

In 1996, the National Indian Child Welfare Association sponsored the National American Indian Conference on Child Abuse and Neglect, during which a "Listening Session" was held. The session was designed as an opportunity for Indian leaders, child advocates and service providers to come together with the staff from the Center for Mental Health Services to discuss the mental health needs, problems and service status of American Indian children. Several recommendations that have been described above were discussed. The major points of the discussion were

- Tribes should receive direct mental health block grants from the federal government as do the states.
- The current means available for funding child mental health programs are expensive, ineffective, and difficult to administer to the point of being prohibitive for tribes.
- A national initiative on funding is needed, providing both research and demonstration projects as well as activities which bring focus to the issues.

- Urban Indians present a unique issue that must be addressed since more than half of all Indian people live off of reservations.
- Ultimately, a long-term solution to the problem needs to be reached by applying Child Adolescent Service Systems Program (CASSP) principles and planning processes within tribal communities and by empowering tribal governments to address the mental health needs of their children (14th Annual "Protecting Our Children" National American Indian Conference on Child Abuse and Neglect, 1996).

SUMMARY OF FINDINGS

Mental health services for Indian children are currently provided in a hodge-podge fashion, often only in crisis situations and by several different systems, many of which remain inaccessible for most Indian nations' members. Most Indian programs have only a modest capacity for evaluation and treatment, but few non-Indian programs have strategies for serving Indian children appropriately.

The major conclusions of this report are as follows:

- There is a serious and persistent lack of funding for Indian children's mental health.
- No single system has assumed primary responsibility for this population.
- Currently, there is no equitable access by tribes for children's mental health funding.
- Native American children suffer a greater degree of environmental and social stresses than mainstream-culture children.
- Native American children appear to suffer from emotional disturbances as often as, if not more often than, mainstream-culture children.
- When Indian children do suffer serious emotional disturbances, they do not have access to the same level of services as mainstream-culture children.
- Traditional healing practices are a vital and useful part of the mental health service delivery system that cannot currently be embraced as a part of the system of care due to mainstream cultural prohibitions and funding barriers.
- Despite very difficult conditions, many tribes are addressing the mental health needs of their children by putting together programs creatively from diverse funding sources.
- A consistent set of recommendations has been made for more than 15 years for improving the situation with almost no response despite worsening mental health conditions among Indian children.
- Tribal governments, given the opportunity and resources, provide the best possible chance for a culturally competent, community-based, child- and family-focused approach based on the CASSP model.

Because so many underfunded systems are involved in mental health care and not one of them has assumed primary responsibility, only those children whose behavior absolutely demands intervention actually receive needed services. Even then, the service provided is more likely to be only what is available rather than what is needed, that is, care is likely to be culturally inappropriate, short-term, inaccessible and/or delivered outside the mental health arena in places such as boarding school, the justice system, etc.

Through this report we have helped frame the issues for discussion and eventual action. Child activists and mental health advocates have been largely unaware of these broad issues. States and counties have been unclear about what their role is and how to provide services to Indian

populations. Federal systems have been underfunded and have not focused on the issues. Together, under the guidance of the Center for Mental Health Services, we can all play a role in restoring balance and harmony to our Indian children and families.

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APPENDIX

Native American Children's Mental Health Access Project

TRIBE/Population	1) Available Children's Mental Health Services	2) Mental Health Funding Sources	3) Primary Mental Health Funding Source	4) Current ICWA Cases	5) How Children's Mental Health Services are Provided	6) Trad. Healers Avail-abla	7) Barriers for Children's Mental Health Services	8) Distance to Off-Reser-vation Services	9) Reliable Trans-portation Available for Tribal Mambers
Ysleta del Sur Pueblo, TX 1,450	Recreation program, Family preservation	IHS, Contract w/ state	State	40	Contract psychologist; other contract mental health services	Yes	3 mo. wait list	Very close to services; tribe is located in El Paso	No.
Bad River, WI 2,400	Family Counseling; No Children's Services	IHS, Contract w/ state	IHS	86	Contract Counseling; No specific service for children	Available, but not often used	Long wait list for services, must provide transportation, scattered communities	75 miles	No.
N. Cheyenne, Lame Deer, MT 1,800	Family/individual counseling, play therapy,	IHS, Tribe	IHS	15 cases per month	ICWA counselors	Yes	One month weit list, not enough counselors, no long term care avail.	100 miles	No
Shoshone, Ft. Washake, WY 3,000	Crisis/individual counseling, psych eval	IHS, Tribe, State	IHS	ICWA clients not identified	Psychologist, contract counseling	No	Cultural barriers using non-Indien services	5 miles(on reservation services); 170 miles nearest city	
Grand Portage, MN 800	Individual/family counseling, play therapy, parenting, crisis intervention	IHS, Tribe, State	IHS	15	Contract psychologist and psychiatrists	Yes	Distance to services, steff training	40 miles	No
White Earth, MN 6,000	Brief therepy, individual/family counseling	IHS, Tribe, State	IHS, State	200	In-home counseling	Yes	Lack transportation, phones, funding, isolation, lack of Indian therapists	Local services, closest large city 90 miles	No

TRIBE/Population	1) Aveileble Children's Mentel Heelth Services	2) Mental Health Funding Sources	3) Primary Mentel Heelth Funding Source	4) Current ICWA Cases	5) How Children's Mental Heelth Services ere Provided	6) Tred. Heelers Aveil-able	7) Barriers for Children's Mentel Health Services	8) Distence to Off-Reser-vetion Services	9) Relieble Trans-portation Available for Tribal Members
Narragansett, RI 2,300	Individual/group counseling	IHS, State	IHS, Stete	10	Psychologist, social workers, juvenile justice services	Yes	Many unidentifies children due to interraciel marriege	5 miles; 42 miles to largest city	Yes
Warm Springs, OR 2,800	Short, long-term counseling; family counseling; case management	IHS, State, Tribe, Medicaid	Tribe (for children's mental health)	ICWA clients not identified	Tribel Health center	Yes	None Identified	Local services	
Kalispel, WA 91	General counseling	IHS, Stete	IHS	ICWA clients not identified	IHS service unit, substance abuse and mental health counselors	Yes	Distance, funding, few qualified providers who accept Medicaid	80 miles	No
Hoh, WA 74	One counselor	IHS	IHS	ICWA clients not identified	IHS clinic	Yes	Distance, not enough counselors	27 miles	No
Spokane, WA 1,200	Counseling	IHS	IHS	ICWA clients not identified	Tribel clinic	Yes	Distence	Local services; specialized services 100 mi	No
Squaxin Island, WA 127	Part-time counselor	IHS	IHS	20	Tribal heelth center w/ counselor 4days e week	Yes	None identified	8 mi	Yes

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TRIBE/Population	1) Available Children's Mental Health Services	2) Mental Health Funding Sources	3) Primary Mental Health Funding Source	4) Current ICWA Cases	5) How Children's Mental Health Services are Provided	6) Trad. Healers Avail-able	7) Barriers for Children's Mental Health Services	8) Distance to Off-Reser-vation Services	9) Reliable Trans-portation Available for Tribal Members
Burns Paiute, OR	Minimal counseling through contract	IHS	IHS; $3000 mental health fund	ICWA clients not identified	Through contract, no tribal mental helath services	No	Funding	Local services	Yes (locally)
Ft. Belknap, MT 2,300	Counseling	IHS, Contract	IHS	ICWA clients not identified	Tribal health center	Yes	Distance, funding, no Indian therapists	Specialized services 150-200 miles	No
Wampanoag, MA 786	Counseling	IHS, Tribe	IHS, Tribe	20-30	ICWA staff provides home visits	No	None identified	Local services available, 120 miles to large city	Yes
Misccosukee, FL 500	Counseling	IHS	IHS, BIA	30	On reservation clinic	Yes	Geographic isolation	50	Yes
Penobscot, ME 500	Counseling	IHS, Tribe, Contract care, State	IHS	2	IHS clinic	Yes	Resistance by parents	Local services	Yes
Oneida, WI 4,400	Play therapy, Group/individual counseling	IHS, Contract, Tribe, State	Tribal gaming funds	180	Tribal health center, ICWA staff	Yes, sweats, long house, spiritual advisor	Distance, communication with counties	Local services	Yes

TRIBE/Population	1) Aveilable Children's Mental Heelth Services	2) Mental Heelth Funding Sources	3) Primary Mentel Heelth Funding Source	4) Current ICWA Ceses	5) How Children's Mentel Heelth Services ere Provided	6) Trad. Healers Aveil-able	7) Berriers for Children's Mental Heelth Services	8) Distance to Off-Reser-vetion Services	9) Relieble Trens-portetion Aveilable for Tribel Members
Kiowa 13,000	Individual/group/ family/crisis counseling	IHS	IHS	25	IHS social worker	Yes	Trevel, lack of services due to funding	Local, closest city 35 miles	No
Yakama, WA 6,100	Counseling, psych testing, therapy, sex abuse treatment	IHS, county, state, federal grants	IHS	15	Tribal health center, contract care	Yes	More Indian therapist needed	locel services	No
Rincon, CA 457	Individual/family/ crisis counseling, substance abuse, in-patient, psych, contrect care, child psychiatrist	IHS, county, federal grants	IHS	57	Health clinic, ICWA social workers	No	Distance to off-reservation providers, need more Indian therepists	30-60 miles to off-reservation services	No
LaJolla, CA 239	Individual/femily/ crisis counseling, substance ebuse, in-patient, psych, contract care, child psychiatrist	IHS, county, federel grants	IHS	32	Health clinic, ICWA social workers	No	Distance to off-reservation providers, need more Indien therapists	30-60 miles to off-reservation services	No
Los Coyotes, CA 212	Individual/family/ crisis counseling, substance abuse, in-patient, psych, contract care, child psychiatrist	IHS, county, federal grants	IHS	4	Health clinic, ICWA social workers	No	Distence to off-reservation providers, need more Indian therepists	30-60 miles to off-reservation services	No
San Pasqual, CA 435	Individual/femily/ crisis counseling, substance ebuse, in-patient, psych, contract care, child psychietrist	IHS, county, federal grants	IHS	20	Health clinic, ICWA social workers	No	Distance to off-reservation providers, need more Indian therapists	30-60 miles to off-reservation services	No

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Kickapoo, TX 700	Counsaling	IHS, State, BIA	BIA (ICWA)	120	Counsaling	Yas	Lack of funding, lack of collaboration among rasarvations	local, 200 miles to larger city	No
Elko, NV 1,200	Counsaling	IHS, State	IHS, Contract cara	New program; none identified	Contract providers in Salt Laka City, Boise	No	Funding, lack of sexual abusa counseling, travel, weather problems	300	No
Laguna Pueblo, NM 5,000	Psychotharapy, saxual abusa counseling, group/crisis counseling	IHS, State	IHS	8	Provided by group home	Yas	Transporation	15; 55 to larger city	No
Duckwater Shoshone, NV 140	Limited sarvices	IHS	IHS	45-55	IHS social workers traval to raservation avary two waaks	No	Cost, distance, isolation	75; 300 to large city	No
Ft. Duchasne, Ute, UT 3,500	General counseling	IHS	IHS	20	Counseling at IHS clinic	Yes	Nead more counselors, not enough long term cara	15-20 at tha clinic; 210 at Salt Lake City	No
St. Ragis Mohawk 6,000	Ganeral Counsaling	IHS, Stata	IHS	50-100	Community clinic	Yes	Not enough Indian tharapists	Local sarvicas; nearest major city 70 miles	Yas

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Barona, CA 420	Counseling, substance abuse counseling	IHS, County, Federal grants	IHS	26	Health center, ICWA social worker-in home visits	Yes	Distance to off-reservation providers, need more Indien therapists	20-45 miles to Indian Heelth Cneter; 60 miles to lerger city	No
Campo, CA 140	Counseling, substance abuse counseling	IHS, County, Federal grants	IHS	46	Health center, ICWA sociel worker-in home visits	Yes	Distance to off-reservetion providers, need more Indian therapists	20-45 miles to Indian Heelth Cneter; 60 miles to larger city	No
Viejas, CA 180	Counseling, substance abuse counseling	IHS, County, Federal grants	IHS	36	Health center, ICWA sociel worker-in home visits	Yes	Distance to off-reservation providers, need more Indian therapists	20-45 miles to Indian Heelth Cneter; 60 miles to larger city	No
La Posta, CA 14	Counseling, substance abuse counseling	IHS, County, Federal grants	IHS	1	Health center, ICWA social worker-in home visits	Yes	Distance to off-reservetion providers, need more Indian therapists	20-45 miles to Indian Health Cneter; 60 miles to larger city	No
Jemul, CA 60	Counseling, substence abuse counseling	IHS, County, Federel grents	IHS	4	Health center, ICWA social worker-in home visits	Yes	Distence to off-reservetion providers, need more Indian therapists	20-45 miles to Indian Heelth Cneter; 60 miles to lerger city	No

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Cuyepaipe, CA 17	Counseling, substence ebuse counseling	IHS, County, Federel grants	IHS	1	Heelth center, ICWA sociel worker-in home visits	Yes	Distence to off-reservetion providers, need more Indien therepists	20-45 miles to Indien Heelth Cneter; 60 miles to lerger city	No
Manzanita, CA 52	Counseling, substance abuse counseling	IHS, County, Federel grents	IHS	ICWA clients not identified	Heelth center, ICWA social worker-in home visits	Yes	Distence to off-reservetion providers, need more Indien therapists	20-45 miles to Indien Heelth Cneter; 60 miles to larger city	No