1978

A Good Day to Live for One Million Indians

Task Panel on American Indians and Alaska Natives President's Commission on Mental Health

A GOOD DAY TO LIVE

FOR ONE MILLON INDIANS

REPORT OF SPECIAL POPULATIONS SUBPANEL ON MENTAL HEALTH OF AMERICAN INDIANS AND ALASKA NATIVES

SUDMITTED TO
THE PRESIDENT'S COMMISSION ON MENTAL HEALTH

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"This is a good day to live"

"Many problems need to be solved. Many new problems are emerging. But with the combined effort of our youth and of our older people, it will be done. Let us look forward to meet this kind of challenge."

From a speech made to

National Indian Youth Council, 1977

by

Regis Pecos

Native of Cochiti Pueblo and
Princeton Graduate, Technical Assistance Advisor for AIO

If I were home
I would be
in the mountains
where the pine trees grow
where the deer play
where the winds blow
where the coyotes howl
I would be
where I am free.

Andrew Joseph, Jr. (elementary grade)
from the Wee Wish Tree, Colville Indian
Reservation, Washington.

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Forrest Gerard, Assistant Secretary for Indian Affairs, for committing a full-time staff position and support for staff person to assist Commissioner La Donna Harris in this effort.

EXECUTIVE SUMMARY

I. The Indian Task Panel was formed of Indian persons who are of Indian tribal affiliation and heritage. They represented persons who are involved with service delivery at the local level, expert in dealing with federal-state delivery systems, experienced in the professional field of "mental health" and in specific areas of concern. A cross-section of Indian persons from Alaska to the East Coast were involved in the study. (See Appendix.)

II. An historical view of the American Indian and Alaska Native was noted with special reference to his/her status as an indigenous person (as opposed to minority) with a unique trust relationship with the U.S. government. The statistical data on American Indians and Alaska Natives is fragmented and unreliable. The American Indian Policy Review Commission (1977) devoted one chapter to "CONTEMPORARY INDIAN CONDITIONS" and states:

> Today, available statistics in the United States continue to paint a picture of widespread deprivation unequalled by any other United States sub-group. Whether men or women, living in the city or country, Indians in the United States suffer from inadequate education and relatively poor health, poor housing, and sanitary conditions generally regarded as unacceptable. (AIPRC, 1977:83)

According to the U.S. Census (1970) these are 792,730 Indians in the U.S. residing in every state. This is an increase of 122 percent since 1950. A figure of one million is considered to be more accurate.

III. A social, political and economic review of the American Indian and Alaska Native is included. It was noted by the Task Panel that the federal policy and treatment of American Indians has changed from exploitation and genocide to coercive assimilation. There were next, periods of

benign neglect along with the establishment of a colonization-approach to Indian affairs. At present the attitude continues to be that of a colonizer-colonized relationship.

IV. The current health status of the American Indian is not a positive one. Statistics and other social indicators show that the incidence of "disruptive behavior" is on the increase. Suicide and other self-destructive behaviors such as alcohol abuse are increasing alarmingly.

V. The abuse of alcohol and its related effects on the community, family and tribe is the major socio-economic and health problem for American Indians and Alaska Natives.

VI. Lack of professional health and social manpower is a serious problem for Indian people today. Strong emphasis must be placed on manpower and scholarship programs for Indian people in order that they can assume responsibility for their own destiny.

VII. Indian people have placed as top priority the want to initiate, develop and control their own programs and service delivery at the local level. Development of local family resource centers for the prevention of disruption and strengthening of families, individuals, and communities is a top priority.

The Indian community has not jumped on the mental health "bandwagon." Therefore, the concept of mental health is somewhat alien to Indian people. The Task Panel feels that this is a positive and that all efforts must be directed to improving and strengthening natural support systems rather than superimposing new ways of doing things in Indian communities.

VIII. Special attention must be directed to either vastly improving Indian boarding schools or shutting them down immediately.

I. COMPOSITION OF INDIAN COMMITTEE AND WORK PLAN

For sake of brevity, the composition and work of the Indian Task Panel has been included in the appendix. The work was accomplished by American Indian and Alaska Native persons who were representative of tribal and non-tribal groups throughout the U.S. (see Appendix page 62).

A. Introductory Statement

It was a difficult, if not impossible task for the Indian Task Panel, to discuss every unique aspect of the American Indian and Alaska Natives when studying services for Indian people. Also, it was not the intent of this Task Panel to single out one single tribal group, organization or community group for exclusion from services. This panel recognizes that each group has a great need and the right for local control and planning.

Legislative language in the past has eliminated some Indian people from eligibility for services; usually the persons left out were Indians living in urban areas, Indians in rural areas off reservations and Indian students at universities and colleges.

More frequently, Indian persons are faced with barriers because of rule-making, administrative decisions and other bureaucratic white-tape. Other barriers are geographic, political, economic and ethno-cultural in nature.

It is the intent of this Task Panel to espouse the philosophy that American Indian people should and must have mental health services

no matter where they reside and have equal priority. This belief is based on the unique trust-relationship that Indian peoples have with the U.S. federal government which is based on treaties and the U.S. Constitution.

II. NATURE OF THE INDIGENOUS PEOPLE OF U.S.

A. Indigenous People

American Indians and Alaska Natives are the indigenous persons of the U.S. History indicates that the indigenous peoples of the U.S. were at first friendly to the white aliens, often providing food and shelter as well as protection. It was not until later that the indigenous peoples were regarded as hostiles and savages.

B. Minority Status: A Fallacy

One of the major problems that face the American Indians when they deal with government is the imposition of the status of minority persons. While the Indian is a "minority person" in the sense that he/she is a person of color, the only commonality the Indian shares with other minorities is that of racism and poverty.

It is the intent of the Task Force that this point be kept clearly in mind by the Commission when it reviews the report and recommendations.

C. Governments Within a Nation

To explain the position and relationship of the American Indian with the U.S. Government, it is necessary that the Commission understand the sovereign nature of tribal governments and the dual citizenships of Indian peoples. The American Indian Policy Review Commission (PL 93-580)

which completed its study in 1977 gives a detailed report on the current status of Indian tribes as sovereigns. The report states. . .

> It is generally believed, mistakenly, that the federal government owes the American Indian the obligation of its trusteeship because of the Indians' poverty, or because of the governments' wrong doing in the past. Certainly American Indians are stricken with poverty, and without question the government has abused the trust given it by the Indian people. But what is not generally known, nor understood, is that within the federal system the government's relationship with the Indian people and their sovereign rights are of the highest legal standings, established through solemn treaties, and by layers of judicial and legislative actions. (P (1)-AIPRC).
>
> For the federal government to continue to unilaterally break its agreement, especially to a people as unique to our history as are the Indians, would constitute moral and legal malfeasance of the highest order. (AIPRC 1977:1)
>
> American Indian Policy Review Commission, Final Report, Submitted to Congress, May 17, 1977.

D. Who Are Indians?

Another difficulty facing any Task Force or other study group when discussing American Indians and Alaska Natives is the issue of exactly who is an Indian. It seems that defining who is an Indian and setting parameters or limits, if you will, is a Herculean Task. One would have to be the utmost of brave, have wisdom yet unknown as well as unlimited foolishness to describe exactly who is an Indian.

This Task Force recognized that while it is a very emotional issue, it is also a legal one. Also it seems the federal government has indulged itself at the expense of the Indian person by defining who exactly is an Indian for often what appears to be bureaucratic and capricious reasons.

For the purposes of this study and recommendations, these are the grouping of American Indians and Alaska Natives considered. It is the intent of this Task Force to reject the euphemism "Native American" in favor of the term American Indian and Alaska Native because many non-Indian persons consider themselves to be "natives." For the purposes of brevity the rest of the report will refer to American Indian with the intent that this includes the Alaska Natives.

The following groupings of American Indians were considered in this report:

(1) Federally recognized tribes;

(2) State reservations;

(3) Non-Reservation Indians

(a.) Urban

(b.) Non-Recognized

(c.) Rural

(d.) Non-Recognized Rancherias;

(4) Terminated Tribes.

Almost all of Indian country is involved in defining Indian. It is the concern of this Task Panel that Indian people themselves be consulted and involved by those agencies and other federal bodies that are "defining" an Indian. No matter which definition is decided upon, some innocent and needy Indian person will be eliminated from service.

If service for Indian people were the direct responsibility of tribal governments, there would be much less need for interference in the definition process by federal persons. Tribal members would become much more involved in their tribal governmental process and more involved in supporting a responsive tribal government.

At present, tribal government is weakened by lack of responsibility for its own members' service. Service comes to tribal members from outside sources and eligibility is decided by federal bureaucracy.

III. HISTORICAL TREATMENT OF AMERICAN INDIANS

The AIPRC titles its final chapter "CAPTIVES WITHIN A FREE SOCIETY" and states:

> The view of American history from the Native American side of the frontier offers a curiously reversed image of the rise and fall of nations. Commonly, historians of the United States describe the period 1607 to 1776 as the "colonial period," for most Indian tribes this same stretch of years represents a period of relative independence and equality between red nations and white colonies. . . . America's rise to "world power" entailed the reduction of the Native Americans to the status of a captive population, euphemistically termed "wards." (AIPRC 1977:47)

Earlier in this report the first Indians were described as friendly and helpful to the alien whites. But as the thrust of acquisition for land and economic control became the primary concern of the settlers, the American Indian became the savage hostile to be destroyed. The policy of the U.S. government was destruction of the indigenous peoples in order to acquire their land.

When the U.S. won its independence from Britain, and the early government was formed, the U.S. Constitution spelled out carefully how the U.S. government was to relate to Indian tribes. This was a period of treaty writing and negotiation. It was also a period of exploitation as well as genocide. Several tribal groups were effectively exterminated during this period.

Following the two important historic occurrences of Custer's defeat and the Wounded Knee massacre, the period of attempted civilization and missionarization was begun. Cultural genocide was rampant. During this period disease, starvation and loss of spirit killed a great many American Indians. It was their lowest ebb.

In the early 20's and into the present, the colonization of the American Indian was begun. The classic pattern of the colonizer and colonized was established. This Task Force will view the effects of this relationship in discussing the current life situation of the American Indian.

Freire, Paulo, Pedagogy of the Oppressed, Seabury Press, New York, 1974.

Memmi, Albert, The Colonizer and the Colonized, Beacon Press, Boston, 1965.

Schumacher, E.F., Small is Beautiful, Harper and Row, New York, 1975.

In the late 40's and into the 50's the melting pot theory of America became very popular. The policy of the government became one of assimilation. Every attempt was made to turn the Red-man (and woman) into a white. Relocation off reservations to large urban cities in the 1950's has created the current situation called the "urban Indian problem." Tribes were "terminated" by the federal government in an attempt to encourage assimilation.

This period saw the formulation of one of the major Indian organizations, The National Congress of American Indians, to combat this federal policy. Many great Indian leaders were developed during this period as well.

Even though assimilation is the intent of many programs provided for Indians, the period following termination policy was that of benign neglect. The colonizers established new strong holds and became, if possible, even more firmly entrenched. A stronger and more extensive cadre of colonized Indians were now available. The Indian had truly become a "captive within a free society."

The Civil Rights Movement, the leaders such as Martin Luther King and Jack Kennedy and the period of protest stimulated and inspired young Indian people. Many young Indians, who frustrated with the colonized atmosphere, who viewed themselves from the position of the oppressed, began to demand attention for Indian people. Indians participated and got attention in the Poor Peoples' March. Fort Lawton, Denver, Alcatraz, the BIA sit in, Trail of Broken Treaties and Wounded Knee brought the American Indian to the attention of the American people.

Young Indian people were becoming educated, they were learning how to deal with the white man, using white man's law in white man's courts. Rights for Indians especially in the area of land, water and minerals became not only possible but an actuality. Other major decisions were favorable to Indians such as the Supreme Court case on Indian Preference which reaffirmed the old law that entitled Indians to govern themselves as political units rather than minorities.

However, the wave of positive and favorable court decisions such as the Boldt Decision in Washington State (supporting fishing rights established by treaty), brought forth a wave of anti-Indian feeling. White groups were formed in Montana and South Dakota to oppose Indian citizens' rights. This movement has become nation wide and is working with

state legislatures as well as the national legislature to oppose American Indian rights.

The latest move in this political-economic arena is the formation of several anti-backlash groups which support Indian rights. The Department of Interior as well as Department of Health, Education and Welfare now espouses self-determination (PL 93-638), but few bureaucrats can change from the colonizer attitude to one of "freeing" the native.

IV. STUDIES AND REPORTS

There have been innumerable studies and reports about the American Indian and his/her needs. Starting with the Merriam Report in 1928 and ending with the American Indian Policy Review Commission Review Report in 1977 fifty years later, the findings and recommendations are amazingly the same. The stark and crushing poverty, the lack of power and economic resources along with a depressing recitation of statistics are repeated over and over again.

Probably no other group in the United States has been more studied and reported on; billions of dollars have been spent by anthropologists, politicians, acadamicians, psychiatrists, and bureaucrats in the name of Indian people. All of these reports have had little impact on improving the quality of life for Indian people.

For instance, the noted Indian author, Vine Deloria says, "Compilation of useless knowledge for knowledge's sake should be utterly rejected by Indian people. We should not be objects of observation for those who do nothing to help us." (Deloria, 1969:98)

Deloria, Vine, Jr., Custer Died for Your Sins, Avon Books, New York, 1969.

Several studies which have been very significant in the area of Indian Mental Health are (1) the Kennedy Report; Indian Education: A National Tragedy--A National Challenge.

U.S. Congress, Senate, Committee on Labor and Public Welfare, Special Sub-Committee on Indian Education, Senate Report No. 91-501, Indian Education: A National Tragedy--A National Challenge, 91st Congress, 1st Session, 3 November 1961.

(2) The report on Pine Ridge Indian Reservation is a classic and perhaps still ranks first as a definitive study on Indian mental health needs. It is titled, That These People May Live.

Maynard, Eileen and Gayla Twiss, That These People May Live, Conditions among the Oglala Sioux of Pine Ridge; Community Mental Health Program, U.S. PHS, Pine Ridge, South Dakota, 1969.

(3) The recent Indian Child Welfare Study which is a thorough analysis with recommendations regarding Indian children and Indian families. The report is a classic in the Indian child welfare situation.

Indian Child Welfare: A State of the Field Study, USDHEW, OHD, OCD, Children's Bureau, DHEW Publication No. (OHD) 76-30095.

There are several other recent studies, some of them made by the United States Commission on Civil Rights, by the General Accounting Office, by OMB, by the American Academy of Child Psychiatry and by the U.S. Senate (Senate Report 94-366). All of these reports emphasize the need for local control, the need for self-determination and the need to relieve the Indian population of oppressive poverty as well as racism and injustice.

In a series of reports, generated by the OMB/FAR Indian Services Report, the NCIO/FIDAP report and the University of New Mexico Indian Law Center follow-up FIDAP reports, it has been repeated over and over

that Indians are not receiving federal services even though they are eligible for them.

FAR - Federal Assistance Review

NCIO - National Council on Indian Opportunity

FIDAP - Federal Indian Domestic Assistance Programs.

V. FEDERAL AND STATE RELATIONSHIPS AND SERVICE DELIVERY SYSTEMS

The AIPRC in its 1977 report to Congress, did an extensive survey of Community Services for Indian people and communities. This is the statement that precedes the reports.

> No recitation of cold statistics can adequately portray the human misery and suffering experienced by the majority of Indian and Alaska Native peoples on reservations and in numerous villages in Alaska. However, when the impact of these statistics is measured against the unfulfilled hopes and aspirations of scores of Indians which have been cut short by unnecessary illness and deaths, and against the alarmingly high number of Indian families which have been devastated by social integration caused by mental illness and alcoholism, then the conditions become real and meaningful. (AIPRC, 1977:367)

In viewing the life situation of the American Indian which in a sense is the situation which eventually affects the health of the Indian, one must regard social, economic and political realities. Years of colonization and neglect has left the Indian with inadequate sources for service. Take any statistic regarding quality of life and the American Indian is the lowest on the scale. Then take any statistic which indicates life distress and the Indian falls the highest on the scale.

The economic situation for the American Indian has always been bleak. The average family income for Indians on reservations is below the poverty level. Unemployment is extremely high, ranking from 60-70%,

unemployed on some reservations to 20% unemployed on the "more prosperous." The average paycheck is not cashed on the reservation and the dollar turns over only once at the reservation level. Lack of jobs leads to countless mental health ills, family disruption and alcoholism.

The effects of colonization and racism has taken its toll on Indian communities. The lack of opportunity to plan for themselves, to have control over their own decision making has eaten away at the self-reliance and stability of Indian people. A wave of "blaming the victim" by federal officials for disunity and unrest is rampant.

Service delivery systems are fragmented. There is little or no coordination at either local or federal level. The fragmentation of services is a severe problem for Indian communities.

The urban Indian has been placed in a very difficult situation. Even though the Snyder Act authorizes services for all Indians no matter where they reside, the lack of funding has caused IHS to limit services to Indians who reside on reservations. This policy severely limits services to so-called urban Indians and students.

State and county relationships with Indian tribes and communities have been difficult. Services are refused to Indian people with the erronous belief that all Indians are eligible for federal programs.

Because of jurisdictional issues between States and Indian tribal governments, services such as foster care placement, nursing home care, juvenile care, food stamps, and other normal county-based service are denied Indians in some States.

State governments receive funds from DHEW and USDA based on state population (which includes Indians) but equitable sharing of those funds

with Indian tribes is not accomplished. Tribes are included in various State plans without their knowledge. Comprehensive community mental health centers describe non-existent services to tribal communities (from testimony from Indian hearings).

A. Trust Related Services

The treaties which are the basis for the trust relationship between the federal government and tribes spelled out the services the federal government would provide in exchange for vast and extensive land, water and mineral rights. The spectrum of human services fall under this aegis.

Again, this right for service based on treaties is often viewed by the uninformed as services provided a group because of minority or poverty status. A more appropriate comparison would be services provided to veterans and military personnel.

B. Bureau of Indian Affairs

The BIA is one of the oldest federal agencies in government. Originally in the War Department it was transferred to Department of Commerce and finally Department of Interior. It has provided care for the American Indian from womb to tomb. It is probably the most controversial agency in government today and is often referred to as a rhinocerous in terms of its flexibility and attitudes. Its chief difficulty at present is its management capability and is probably the next most colonial in its behavior toward Indian people.

The BIA is active in all human service systems including services for children and families, education, handicapped and boarding schools. It also provides services to prisons and other crime prevention and law and order activities.

C. Indian Health Service

Health care is part of the trust relationship between the federal government and Indian people. Even though this relationship is cited as a "mysterious one" (Kane:1969:3),

Kane, Robert L and Rosalie A. Kane, Federal Health Care (with Reservations!), Springer Publishing Company, Inc., New York, 1969.

It is documented that there were physicians on reservations prior to 1900. Treaties spelled out health care and health facilities and the BIA established a medical division in 1873; in 1874 there were physicians in at least one half of the Indian agencies and by 1890 several Indian hospitals were established.

In 1921, the BIA was specifically authorized to expend funds for the "conservation of health" and in 1924, the BIA set up a special Division of Health (Snyder Act).

In 1954-1956, parts of the health service delivery of the BIA was transferred to DHEW and became what is known as Indian Health Service. A large portion of BIA personnel who were in the health delivery system transferred to IHS. This move was coincidental with other "termination" moves of the 1950's. Perhaps, it was hoped but never spelled out that Indians would gradually disappear into the massive DHEW bureaucracy. Kane refers to the situation at the time of transfer as a "sorry mess" (Kane:1969:6).

An area not always completely understood by outsiders is the relationship of IHS to the Public Health Service Corps, or the "Corps" as the IHS personnel call it. Kane describes that "the new Indian Health Service was perfectly able to fit into and expand upon a hierarchial

organization. It is a paramilitary service with a chain of command which extends from Washington down to the health outposts." (Kane:1969:7).

During the Korean conflict and on into the Viet Nam era, physicians were able to fulfill their military obligations by serving on Indian reservations. These physicians served in the Corps for two years and were considered a "boon" by IHS administration. Indian people considered them to be something else. The physicians themselves usually considered Indian reservations as the necessary alternative to active military duty in Viet Nam.

It is only recently that IHS has discontinued wearing military uniforms while serving Indian people. Several IHS staff admit they felt "safer" wearing uniforms and felt that Indians "respected them more because of the uniform." Most Indians were highly resentful of the wearing of uniforms.

IHS facilities on reservations are very similar to the posts found in bases and military stations overseas. Wives of physicians suffer the same stresses; isolation, culture shock and fear, that military wives suffer overseas.

IHS corps personnel enjoy the same benefits any military person does, that is, PX facilities, commissary privileges, Officer Club privileges, free military transportation, CHAMPUS and etc. It is with reluctance that corps personnel accept assignments away from a near-by military base with all its facilities.

The U.S. Public Health Service Corps has <u>not</u> <u>been</u> under the auspices and control of the Civil Service. This has created a situation in which the normal federal system used in employment, discipline and etc., is

not used in dealing with employees. Some persons have labeled it as an "elite corps." Promotions and other fringe benefits are handled differently for PHS corps personnel. Only recently did a court ruling determine that the PHS corps had to comply with a ruling that enabled Indian persons to have consideration in employment in IHS (Oklahoma case-Indian preference).

IHS has had many problems and has come under increasingly severe criticism. The appropriations from Congress have not kept up with the need, recruitment of staff is difficult, retention is even more difficult. Facilities and equipment are substandard. The AIPRC comments that in 1977 it is "kind to say that Indian health is substandard" (AIPRC, p. 9).

Many IHS persons attribute their problems to Congress and the lack of funding. At 638-hearings, a tribal leader said, "Whatever you say about BIA multiply it by ten for IHS."

The AIPRC has recommended that a special GAO audit be done of IHS. This Task Panel strongly supports the recommendation of AIPRC.

An item frequently mentioned by IHS administration is the poor morale at the local level. Tribal persons are asked to work at strategies to help raise morale and thus better recruit and retain IHS personnel. However tribes in rural areas in North and South Dakota, Montana and other remote areas share the same problems any rural area does in recruiting physicians.

To really review the current problems of IHS and Indian people, one has to place the situation in that of the relationship between the colonized and the colonizer (Freire, 1974). The struggle for power and

the increasing resentment of Indian people, the frustrations of the service providers is a classic relationship (Memmi, 1965). IHS personnel in their frustrations often fall into the trap of "blaming the victim."

D. Mental Health Services in IHS

A report written by Carolyn Attneave in 1973 on Mental Health Programs in the Billings area gives a succinct overview of the beginnings of a mental health service in IHS. Frances W. Dixon, a black social worker, was a moving force in establishing the program. It began slowly in 1963, about 15 years ago in the Billings area.

Reading through the literature on medical treatment of American Indians, one finds a state of confusion existed as to exactly what sort of mental health treatment was necessary and appropriate. The physicians seemed more comfortable dealing with acute physical diseases such as infections, contagious diseases and trauma.

Mental health related problems such as alcohol abuse, drug overdose, suicide attempts, depression, obesity, sexual acting out seemed repugnant to most IHS service providers. A sort of classic cycle of dependency and rejection was at times established with increasingly hostile demands for attention on the part of the recipient and more hostile rejection on the part of the frustrated providers. Patients complained of long waits, insensitive care-takers, lack of proper treatment and the care-givers complained of long hours, ungrateful patients and a hostile community. Some of the psychiatric consultants to IHS felt it more appropriate to provide attention and support to care-providers than to the Indian clients (Attenave:1973:183).

In the early 1960's, there was overt and hostile rejection of the Indian patient who had problems with alcohol. There were no "dextox" facilities and often clients were refused admission to IHS hospitals for alcohol-related problems. One two-year physician wrote a bitter letter in a local paper in South Dakota about Indian people and alcohol after he left his service with IHS.

It is estimated that over 70% of the treatment provided by IHS through IHS facilities and contract services is alcohol-related. It is not too grandiose a dream to imagine what those funds could be used for if the abuse of alcohol could be prevented and diminished.

The beginnings of mental health clinics at reservation level was also a dramatic and important event. Audra Pambrun, a Blackfeet nurse, started a remarkable suicide prevention service on her reservation.

There has, however, been a dramatic change in attitude and practice the past ten years. It is theorized that the emphasis and availability of various programs for treatment at the reservation level and in urban Indian centers such as programs through OEO, NIAAA, and other federal resources have created an awareness on the part of IHS service providers.

Also, the Community Mental Health Center movement at the national level may have increased attention to mental health needs of Indian people. Training of mental health professionals was increasingly oriented to community level services and professionals of this orientation became involved. Two such persons were Carl Keener, M.D., who served in the Billings area and Margine Tower, R.N., who later joined the Billings area and brought to IHS a community mental health orientation.

IHS started a program in 1966 under the direction of Bob Bergman, M.D., of training and employing mental health paraprofessionals. Somewhat

controversial, the program has prospered and gained respect of both IHS and tribal people.

In the meantime, psychiatric consultation was stepped up and made available to Indian Boarding Schools. Each IHS facility (SUD) had a mental health oriented person.

The program which is considered to be the beginnings of mental health programs in IHS is the one of remarkable effectiveness which was started on Pine Ridge in 1965. Headed by Gayla Twiss, an Oglalla Sioux, this service has provided help that is culturally relevant and oriented (Maynard:1969).

By 1965, a bona fide mental health division was started in IHS. This program is now headed by H.C. Townsley, M.D., a Chicasaw Indian. Because of chronic under-funding, the program is still in an infancy stage. Many of the staff in the program, especially those in Alaska and rural areas describe their severe frustration in trying to provide service on an extremely limited budget. In places where travel is necessary there are at times not even enough funds to travel to treat clients and offer consultation.

Other psychiatrists who provide services to Indian boarding schools describe the appalling conditions found there. All of them agree that the conditions Indian children experience at boarding schools are the direct cause of several emotional distresses, alienation and other psychiatric disorders in later life (Keener: Letter to Task Force, 1977; Billings Report:1973:190).

Goldstein, George, The Model Dormitory, Psychiatric Annals, 14:9, November 1974, "The American Indian," pp. 85-92.

Krush, T. and Bjork, J., Mental Health Factors in an Indian Boarding School, Mental Hygiene, 49 (1963), pp. 94-103.

There is currently a sharp division in philosophy between the mental health care providers in IHS and the recipients of service at the local level. Indian persons at the local level both urban and reservation want to design, plan and manage their own services. There is an insistence that only this kind of approach will be helpful and successful. IHS service providers still operate in the framework of increased funding to IHS and that service will come from that source.

It is hoped by the Task Force that IHS can come to see and support the desires of the local Indian community. The report of the AIPRC warns that "one of the most serious impediments to the development of Indian self-sufficiency today lies in the Federal Administration" (AIPRC: 1977:6).

VI. MENTAL HEALTH AND THE AMERICAN INDIAN

Mental Health of American Indians and Alaska Natives cannot be viewed in the context of the traditional western mental health world which has no understanding of the Indian world and the unique characteristics and personality structures of aboriginal peoples. Any discussion or definition of mental health as it relates to Indian peoples must take place in the context of Indian peoples' history and in their strengths and culture. This includes all Indian peoples no matter what their setting. Indianess and being an Indian, identification with a tribal entity, identity with a place, with the earth and as having originated from that place is a positive for Indian people. Most Indian people have strong identification with their family groups and extended family. This family also relates to clans and clan systems. Strong support systems are built

into these relationships. The entire relationship and responsibilities are spelled out within these clans and tribal systems. American Indians have basic unique strengths. If it were not for these strengths, they would have disappeared into the massive melting pot of the America of today. For the purpose of this report these strengths will be viewed in the context of natural support systems.

VII. NATURAL SUPPORT SYSTEMS

The Indian Task Panel has concluded that the basic natural support systems of Indian tribes, communities and people should be of major concern of the President's Commission on Mental Health. All efforts, resources and energies should be directed to maintaining and strengthening these natural support systems. Natural support systems of Indian people include the individual strengths of the Indian person; his pride and sense of power as an Indian, his identity with his family, clan and tribe. The extended family and tradition provide strength. Throughout years of dealing with the white man, the missionary, the lawman, the federal bureaucrat, the do-gooder and the exploiter, has enabled the Indian to develop the most exquisite coping and survival skills. Those who could not cope were swallowed up and lost in assimilation.

The very survival skills that have been developed by the American Indian must be those utilized in building on the natural support systems.

H.S. Townsley served on the Support Systems Panel of the PCMH. He developed a separate paper for this panel.

In a study by Westermeyer (1977:32), it was found that ". . . Indians with a low cultural identity are more likely to have social

problems, be imprisoned or suffer mental illness." He went on further to describe that the best adjusted had the highest identity with their culture.

> Westermeyer, Joseph, Department of Psychiatry, University of Minnesota, Akwesasne Notes, September 1977, p. 32.

In the Senate hearings on American families, it was pointed out that diversity is strength and that emphasis should be placed on strengthening families (Mondale, 1973).

> Senate Hearings on American Families: Trends and Pressures, 93rd Congress, Washington, D.C., September 24, 25, 26, 1973, Walter Mondale, Chairman.

A. Extended Families

Over and over, the Task Force found that the Indian people were concerned with strengthening the family, the extended family and the tribe. It was also felt that many of the current service delivery systems weakened rather than strengthened the family. The PCMH Task Panel on Families has specifically discussed this issue and the American Indian Task Panel can only urge that the recommendations of the Family Panel be considered seriously.

B. Children

It would take several thousand pages to adequately discuss the specific needs of American Indian children. The Task Panel felt a great deal of emphasis should be placed on improving the life situation for the child as a prevention strategy for mental health. The American Indian population is the fastest growing in the U.S. with 57 percent of the population under 20 years of age.

In order not to duplicate efforts this Task Panel has utilized two recent reports on Indian children as a basis for making recommendations and fully supports and endorses these two reports. They are, "A State of the Field Study: Indian Child Welfare," completed by the Denver Research Institute in 1977 and "Supportive Care, Custody, Placement and Adoption of Indian Children," which stemmed from the National Conference sponsored by the American Academy of Child Psychiatry in April 1977 at Battle Hollow, Utah. These two reports spell out specific concerns about Indian children and the abuses of the current child welfare system. A specific Indian Child Welfare bill is being studied in Congress. This bill would enable tribes themselves to take steps to prevent further abuse of Indian children. It also would enable tribes to manage their own programs and not depend on outsiders.

> Hearing before the U.S. Senate Select Committee on Indian Affairs, 95th Congress, 1st Session on S1214, August 4, 1977.

The Task Force was concerned that approximately 25 percent of the Indian children born are removed from their homes for some sort of placement.

Tillie Walker served on the PCMH Family Task Force and submitted specific recommendations regarding Indian children. The Indian Task Panel fully endorses these recommendations.

C. Elderly

The elders of American Indians have always been regarded with deep respect and honor. Only recently because of the colonizing effects of the white culture do we see Indian aged treated similarly to the non-Indian. Several studies and reports have been made regarding American

Indian elders. This Task Force fully supports the recommendations contained in the report from the National Indian Council on Aging made in 1977. Also a series of recommendations regarding the mental health of American Indian aged are being developed jointly by the American Indian Physicians Association and the NICA. This Task Force endorses this effort.

It is strongly recommended that the elders be involved with the family resource centers or any other human resource centers at the local level.

D. Traditional Medicine Caretakers or Healers

Both the Indian Health Service and the various Indian populated states have neglected by design and by ignorance the huge potential that medicine men and medicine women can and do play in working with local mental health clients and their families. The wealth of manpower, resources, energies, motivation and dedication is at this point immeasurable in the area of Native American healing applied specifically to those individuals needing various forms of counseling, support mechanisms, spiritual counseling, substance therapy (Traditional), etc. It is important to note that the brief description to follow of various traditional healing practitioners that could be used in mental health services or assistance is a gross generalization executed primarily to emphasize specific reference to those services to be identified as being solely Native American in origin and utilization. Many tribes and medicine people prohibit or discourage specific reference and documentation of Native American healing practices. One must accord maximum respect and caution in citing specific Native American healing indicators and practices.

As distinct evolutionary nations of people, specific tribal healing sciences will vary slightly and absolutely as we move from east to west and from north to south of the continental United States and Alaska native populations. A basic caveat and underlying principle is that in the United States alone there are hundreds of distinct tribal entities and nations. Each tribal entity and nation has its own language, religion, social structures, economic system, and health, education and welfare network (Generic reference to Indians and/or Native Americans is both the product of mistaken identity on the part of Western European explorers and an aboriginal concession to semantic descriptors for purpose of survival and progress).

In addition to the afore mentioned medicine people, the network is augmented by apprentices, helpers, and medicine people with limited ability and rights. Consequently, the healing way or healing rituals/ceremonies involve many members of the local Indian communities in the common resolution of psychological and emotional problems. (Parenthetically, it is noteworthy to point out that in many Indian communities the number of non-Indians utilizing the assistance of local medicine people is growing as these people are helped.)

Specific rituals and ceremonies, as pointed out, vary from tribe to tribe but the primary point this report would like to establish and continue to reinforce is that local tribal medicine people exist and are providing positive services and are not being recognized by any professional medical groups or governmental agencies. Without the involvement of this special group of people any contemporary and subsequent efforts will be limited, if not voided.

Gordon Belecourt has developed a much more extensive position paper on this subject. This Task Force endorses this paper.

E. Indian Managed Programs as Support Systems

There are several Indian managed programs in the U.S. that the Task Force felt were examples of helping systems that could be duplicated. These include the Papago Psychological Service on the Papago Reservation in Arizona, the Urban Indian Children Resource Center in Oakland, the Family Resource Center on Makah Reservation in Washington state. The mental health program on Pine Ridge, while under the auspices of IHS, is still considerably under the management of the people and reflects local concern and control.

There are many other locally-based programs, performing extraordinary skills with little or no federal funding. The staffs of these programs are to be commended for their dedication and perservation.

VIII. THE DEPENDENCY FACTOR: ECONOMICS, POWER AND COLONIZATION

One cannot discuss mental health of Indian people very long before the issues of powerlessness, hopelessness, economics and dependency are surfaced. The concept of the colonized and colonizer relationship found in Indian country is probably the most appropriate way to view these issues (Memmi:1965; Schumacher:1975; Freire:1974; Ryan:1976). The AIPRC final report discusses the dependency factor among Indian peoples and comments that it is increasing.

> The history of social experimentation of the Indians by those who gained mastery over their lives resulted in decades of confusion, hopelessness and poverty, which the Indian

> people have asserted could never be corrected until they themselves could again be allowed to determine their own lives. . .(AIPRC:1977:2).

As early as 1928, Meriam discussed the need for Indians to control their own destiny (Meriam:1928). The AIPRC decries that Indians have been subjected to any method ". . .to force them to cease to be Indians and conform to the dominant society" (AIPRC:1977:1).

The effects of colonization both on the colonized and the colonizer have been discussed by many (Schumacher:1975; Memmi:1965; Freire:1974). In Akwesasne Notes an article on racism described that "Modern colonialism requires that native people participate in their own exploitation."

> Racism: An American Ideology, Akwesasne Notes, September 1977, p. 7.

Several of the authors describe the colonized personality. In the Billings Report on mental health services, Stage reports that one of the problems on reservations is that the ideology of the white way is best is espoused by the white professionals. He further describes that the "young, intelligent Indian" is encouraged to break with the Indian culture (Attneave:1973:18-19).

There needs to be more investigation into the effects of colonization on the American Indian and the resulting stress and conflict. It is a dreadful thing to observe, the need to be colonized to "succeed" and the need to stay Indian in order to survive emotionally.

The Task Force felt that there is a causative relationship between powerlessness, racism and poverty and the increasing incidence of disruptive behaviors among American Indians. Furthermore, any attempt to deal only with the symptoms, i.e., alcoholism and not poverty, racism and other effects of colonization will be useless.

IX. DISRUPTIVE BEHAVIOR

There is grave concern among all Indian people over the increasing incidence of what the Task Panel has called disruptive behavior. It is called this because this behavior is disruptive to the stability of the individual, the family unit, the extended family, the clan, the tribe and the community.

A. Chemical Substance Abuse

The chief problem of disruption among the American Indian and Alaska Native of today is alcohol abuse. The Task Force hesitated to use the term alcoholism but felt that the abuse of the chemical alcohol and its subsequent effects on the individual, family and community was of epidemic nature and the chief public health as well as mental health problem of the American Indian.

> The most severe and widespread health problem among Indians today is alcoholism and its medical consequences, cirrhosis of the liver. The social problems caused by alcoholism creates an environment from which alcohol often seems the only escape.

Alcoholism affects not just the alcoholics, but the total Indian society and family units. A 1970 report on Indian alcoholism made this statement on the widespread effects of the disease:

> Alcoholism is a costly proposition in every sense of the word. Personal health may be impaired by cirrhosis and its complications: neuro-psychiatric disorders and nutritional deficiencies. The majority of accidents, especially fatal ones, are associated with alcohol, as are nearly all homicides, assaults, suicides and suicide attempts among Indians. The loss of personal freedom and productivity, the break up of families, the hardship and humiliation involved are considerable, although not easily measured.

At the six health care units surveyed by GAO in 1973, an estimated 60 percent of the case load was directly or indirectly related to alcohol. During 1972, 1,097 patients made 2,637 visits for episodic and habitual drinking, alcohol addiction, intoxication, and delirium tremors. During the year, 181 patients were diagnosed three or more times for those conditions.

On one Central Plains reservation, 70 percent of the population over 15 years of age reported that they drank--82 percent of the men and 55 percent of the women. Children were reported beginning drinking between the ages of 9 and 17. In the age group from 15 to 19, 60 percent of the boys and 40 percent of the girls reported drinking. In a small Great Lakes community, only seven of the 74 persons over 18 totally abstained.

The National Institute of Mental Health reports that in 1973, 75 to 80 percent of Indian suicides were alcohol related, two or three times the national rate. The National Center for Health Statistics reports that, in 1972, suicide was one of the three fastest rising causes of death among Indians. In the Indian Health Service ambulatory patient care report for 1975, there were 84 cases of battered children on first visits, 32 of which were alcohol related.

Similar to alcoholism is the prevalence of drug abuse. In the first three months of 1974 alone, the number of drug abuse cases in Indian mental health programs jumped by almost 50 percent.

The primary responsibility for prevention, education, and rehabilitation of alcohol and drug users has been with National Institute on Alcoholism and Alcohol abuse. NIAAA has been funding and administering most alcoholism programs since 1972. In 1976 NIAAA was supporting 99

reservation programs at a cost of $12 million and 12 training programs at a cost of $1.6 million.

The preceding quotation is submitted to emphasize the epidemiology of the disease--alcoholism and alcohol abuse within the national Indian community. Without reservation, it is the analysis of this report to emphasize that alcoholism and alcohol abuse affects directly and indirectly the entire national Indian community.

Given preliminary data and statistics, many reservation tribal governments and the Indian Health Service recognized the epidemiology of the disease--alcoholism and alcohol abuse and agreed in substance as to the necessity of program response. However, programmatically the Indian Health Service was unable to respond nationally, regionally, area-wide, or locally in any concerted programer service capacity. Most Indian Health Service hospitals and clinics could not and/or would not respond to alcoholism and alcohol abuse as a disease to be treated medically. Most Indian health service medical responses to alcoholics and alcohol abuse has been to diagnose and treat related medical problems such as cirrhosis, pancreatitis, delirium tremors, etc. The treatment of the disease--alcoholism and subsequent detoxification phase were incidental and occurred coincidental to medical procedures applied to those alcoholism related medical problems listed above.

With the advent of federal legislation creating the National Institute on Alcohol Abuse and Alcoholism, specific Indian alcoholism demonstration grants became available on a multi-year basis to assist local reservation-community groups to respond to the local alcoholism epidemic.

Currently, the program emphasis for continuity of local tribal alcoholism program operation will shift from the National Institute on

Alcoholism and Alcohol Abuse to the Indian Health Service under provisions of public law 94-437, i.e., the Indian Health Care Improvement Act.

The Disease Alcoholism - Current Indicators:

To further substantiate the findings of the American Indian Policy Review Commission's analysis of the epidemic proportions of the disease alcoholism in the national Indian community, it is the intent of this task force of the President's Commission on Mental Health to present the following assessment of additional indicators:

1. Alcoholism and alcohol abuse is responsible for increasing major crimes and subsequent penal incarcerations:
   a. Homicides
   b. Assaults/battery
   c. Larceny/tresspassing
   d. Breaking and entering
   e. Child abuse
   f. Battered wives

   Example: In the state of Montana, Indians comprise less than 3 percent of the state's population. Yet, 25 percent of the prison population is Indian. Of these Indian inmates, 100 percent committed their offenses under the influence of alcohol.
2. Alcoholism and alcohol abuse is the leading cause of all fatal traffic accidents within Indian communities.
3. Alcoholism and alcohol abuse causes the loss of individual productivity and creates an unstable work force.
4. Alcoholism and alcohol abuse is responsible for increased incidences of family disintegration:

a. Divorces/separations

b. Child neglect

c. Child abuse

d. Battered spouses

e. Neglect of elders

f. Emphasis on personal needs and complete disregard for family and tribal needs.

5. Alcoholism and alcohol abuse is responsible for a high rate of unwanted teenage pregnancies within Indian communities.

6. Alcoholism and alcohol abuse has caused an alarming increase in the rate of juvenile delinquency problems within Indian communities.

7. Alcoholism and alcohol abuse has caused an increase in the number of self-identity and cultural awareness counseling sessions.

8. Alcoholism and alcohol abuse is responsible for the decline of Indian culture, traditions and spirituality.

In addition other social, economical, political and spiritual indicators substantiate the prevalance of the disease alcoholism.

B. Violence to Self and Others

Violent acts against oneself among American Indians include alcohol abuse, suicide, self-destructive behavior, self-mutilation, huffing, drug abuse, accidents and obesity. Violence against others includes homicide, rape, spouse abuse, infanticide, child abuse and other physical battery. There is also increasing vandalism as well as harassment of elders in housing units by adolescents.

All of the violent acts described above are on the increase. Suicide, a major problem, occurs more frequently among American Indians at a rate varying from three times to ten times more than the national norm.

Again the Task Panel recommends a strong preventive and epidemiological approach. Only through local planning of resources at the local level as determined by local people can service be delivered. No matter which statistic is considered, be it suicide, crime, arrests, spouse abuse, school problems, boarding school placement, incarceration, homicide, infanticide, almost all are alcohol related. Indian health estimates that 70 percent of its visits to clinic facilities are alcohol related. If the abuse of alcohol could be considered from a preventive and epidemiological approach, a great savings could be realized for other care in IHS.

X. SPECIFIC AREAS OF CONCERN

There are specific areas of concern which the Task Panel feels should be regarded as distinct issues.

A. Manpower Needs

Pat Locke developed a specific position paper for the PCMH on Indian mental health manpower needs. She also served on the PCMH Manpower Task Panel. This Task Force fully endorses the position paper and urges the PCMH to support the recommendations made in the position paper.

Training of Indian people has been concentrated at the paraprofessional level, with very little interest in educating Indian people at

the professional level. It is the contention of IHS that professional training falls under the auspices of the BIA. At present there is a paucity of educated professional Indian people. Until a larger pool of Indian health professionals can be developed, Indian persons will continue to be under the control of the non-Indians delivering services to them.

There have been claims that it matters little what color a mental health care deliverer is. . .this may be true for peoples of color that share the same values, language and belief systems. The point is that specific knowledge is required to appropriately treat persons from cultures where values, languages and belief systems are divergent.

The number of American Indian mental health care deliverers is discouragingly small.

A total of 30 American Indians received a Masters degree in social work in the academic year 1974-75. Only one American Indian received a Doctoral degree in social work in the academic year 1974-75.

According to the Association of American Indian Physicians there are 13 American Indian psychiatrists and only 96 physicians of 1/8 degree or more Indian blood quantum.

There are a total of two American Indian psychiatric nurses. In 1976, a total of 173 Indians had attained a M.S.W. In 1977, there are approximately 55 M.S.W. candidates. There are currently 24 American Indians with a Doctoral degree in social work and only 11 American Indians with a M.A. in psychology.

Indian people are aware of the inadequacies in numbers of our own people in the mental health care professions and because we prefer to be

treated by persons that are fully aware of our tribal specific cultural values, we tend to avoid mental health care that is inappropriately provided.

There is currently only one program in the U.S. that is producing American Indian physicians. That is INMED (Indians into Medicine) located at the University of North Dakota. Even though it is regarded as a prototype and its success touted by the administration, it struggles for sufficient funding and is often caught between agencies who claim no responsibility for education of Indian physicians.

B. Indian Boarding Schools

Almost every report, every bit of information, all testimony presented to the Task Panel which had to do with Indian children, families and alcohol related problems condemned the boarding school system for Indian children as it now exists. The Task Panel found it unbelievable that it was the policy of several boarding schools to expell the young girls (as young as 13) who became pregnant while at school. Other schools expelled youngsters for drug usage, with no attempt at treatment or counseling.

In testimony to the PCMH, the chairperson of the Support Systems Task Panel, Dr. June Christmas, expressed concern about the treatment of Indian children in Indian boarding schools. Documentation from psychiatrists providing services to Indian boarding schools shows that placement in these schools establish the beginnings of disruptive behavior in later life.

Other reports of unsupervised dorms, of alcohol abuse and sexual abuse were presented to the Task Panel. The Merriam Report in 1928

recommended that elementary children not be put in boarding schools. The Kennedy Study in 1969 recommended immediate closure of the schools. Even the BIA study of 1975 supported the findings of the Kennedy Study.

Yet the AIPRC in 1977 finds "little progress." This Task Panel feels that if the Indian community wants to have boarding schools continued, that they be regarded for what they are, that is the outplacement of children for social purposes (80 percent), that education be a secondary purpose and that the institutions be regarded as extensions of community resource systems. It is also recommended that tribal governments assume direct responsibility for "boarding schools" and that placement be arranged and managed by local Indian persons.

C. Adoption and Foster Home Placement

Please see Children under Natural Support Systems.

D. Handicapped

At present there are no facilities or provisions for Indian children and adults who are handicapped.

E. Educational Systems for Indian Children

Even though there is increased awareness of the need for improved curriculum and the need for American Indian teachers, the schools that Indian children attend are inadequate. Children continue to drop out at an alarming rate and disruptive behavior among Indian youth is increasing.

There are inadequate numbers of American Indians in post-secondary education. According to the 1970 census, there are 113,610 Indian students in the 19-44 years of age category. If the national average of 68 percent of high school graduates that attend college were applied to

Indians, then 77,254 Indians might be attending college. In 1976, only 16,000 Indian students were enrolled, while some 500 eligible Indian students were turned away because of a lack of Bureau of Indian Affairs scholarship monies.

While there has been a rapid increase in the numbers of Indians attending college, the 1970 census reveals some alarming data. Only 3.5 percent of all adult Indian males, 16 years of age and older, have completed college. Only 1.5 percent of rural or reservation Indians of this age have completed college, the lowest proportion of college-educated persons of any population group. Only 1.2 percent of rural or reservation females have obtained a college education.

F. Nutrition

The Task Panel recommends increased attention to adequate nutrition for Indian people.

G. Recreation

There is a lack of facilities and equipment for recreation for all ages at local levels. There should be special emphasis on recreation for youth and the elderly.

H. Law and Order/Justice

An overproportionate number of Indian persons are in prisons especially in Montana, North and South Dakota and California. Law and order at the local level needs more involvement with helping persons, especially in dealing with family problems and problems of youth and children.

I. Racism

Indians experience racism and prejudice at all levels of service delivery. Indians are very reluctant to go for service from an agency or person that is unsympathetic or even hostile.

J. Jurisdictional Barriers

One of the main barriers to service is the issue of jurisdiction between State governments and Indian tribal governments. Because of the sovereign nature of tribes and the lack of state jurisdiction within reservation boundaries, services including foster care, aging care, food stamps, etc., have been refused Indian citizens by some state governments.

K. Cultural Barriers

Most services provided by non-Indians to Indian people are not culturally sensitive.

L. Boom Town

Indian communities are experiencing boom town impact in areas where resource development is going on. This impact is social, cultural, economic, political and psychological. There must be greater attention to this phenomena.

M. Research

All research efforts directed toward Indian communities and people must have their sanction. The day of the self-seeking researcher is over (we hope).

N. Arts and Media

The Indian Task Panel was alarmed that the PCMH Task Panel on the Arts did not take into account the rich heritage of the aboriginal peoples of the U.S. American Indians art is still part of his/her whole life, religion and existence. Art developed by the Indian people should be encouraged and its significance in developing pride in one's own self and other people is not to be underestimated.

O. Blood Quantum

The concept of blood quantum is one peculiar to American Indians. It is a source of stress to all Indian persons. This Task Force strongly recommends further study of this issue.

Closing Statement

It is a concern of the Task Panel that yet a new way, a new system will be introduced into Indian communities and tribal groups as a way to handle Indian mental health problems. The Task Panel urges that prevention be of major concern to the President's Commission on Mental Health and that service delivery must be planned, implemented, and controlled at the local level.

Those things which are the strengths and survival tools of the American Indian people must be built upon, introduction of non-Indian concepts, non-sensitive persons, techniques which are not culturally attuned will serve only as disruptions to the Indian community.

Too often, non-Indian service delivery systems are superimposed on Indian peoples and communities. Alien concepts (non-Indian concepts) are utilized and often the white service delivery system is under the control of non-Indians.

For this reason, the Task Panel strongly recommends that family resource centers be developed at the local level, planned to meet local needs and local persons utilized for service delivery. The Task Force wishes to make the point that in spite of the outcry of non-Indian professionals about "low quality" service, that self-determination, self-control must be an absolute priority. To paraphrase one of the Task Panel member's statement, this Task Panel feels that an Indian-run, Indian-managed service, no matter how critical non-Indians are of it, is more highly desirable and necessary than <u>any</u> service provided by non-Indians.

RECOMMENDATIONS

RECOMMENDATION I

FAMILY RESOURCE CENTERS

The PCMH recommends to the administration that there be an investigation of services being provided to Indian families on Indian reservations and communities and that there be a directive from the President to assist all tribes, desiring to do so, in the development and on-going maintenance of (including single parent and extended families) Family Resource Centers to include systematic comprehensive family support services to rebuild directly and not subjected to the haphazard yearly funding cycle.

Components necessary are:

A. On-reservation mental health related service providers for
   1. Diagnosis
   2. Counseling
   3. Follow-up
   4. Training for all other service providers for human needs.

B. Child care, both daily and crisis-related instances to assure families of support services for upward mobility and relief during times of family stress and anxiety.

C. Programs for the handicapped. Increased activity and funds for handicapped children and adults. Counseling and supportive skills development for emotionally and physically handicapped children and adults. Training skills development for service providers who have contact with handicapped people.

D. Foster care and adoption on reservation services with Title XX legislation directives to keep families intact and support them as families. Administrative support for legislation pending (S1214) for social changes in past policies on foster care and adoption of Indian children. Recognizing tribal governments as having jurisdiction over these issues and providing technical assistance and manpower to assume this responsibility comparable to recognition afforded states who receive federal money for this issue. (See testimony from AIPRC, S1214, and S2010.) Retrocession Bill.

E. Special programs for aged with emphasis on their participation as resource persons in cultural activities.

F. Nutritional programs for all residents from unborn to elderly. Research and aid in providing on-reservation stores and food co-ops to provide variety of nutritional foods. Directives from the administration to research and support past efforts of American Indians to improve the nutritional needs of Indians living on reservations. See testimony of recent efforts for the Department of Agriculture food stamp legislation, WIC, breakfast, lunch for school children and nutrition. Programs for elderly are presently under the control of state and county agencies and many recommendations have been made for direct funding to tribes (information from Eugene Crawford, Council on Aging).

G. Group homes, staffing, training and financial assistance for professional staff and IHS assistance in diagnosis and group

therapy and one-to-one counseling. On-going financial assistance to group homes presently located on Indian reservations for young children and adolescents to provide a community based support service to prevent the fragmentation of the Indian family. There are currently buildings being constructed (some are complete) and Indian tribes are finding that no agencies want the on-going responsibility of financial management/maintenance to assure the operation of effective group homes in communities, i.e., Lower Elwha Group Home, Puyallup Group Home, Colville Receiving Home, Warm Springs Group/Receiving Home, Yakima Receiving Home, Fort Berthold, Santa Clara, Papago, Cheyenne River, Fort Totten, Yankton Reservation and many others.

Past policies of state, county and federal agencies have not only fragmented but also caused some Indian families to be destroyed due to negative national legislation such as Title XX of the Social Security Act and PL280 (Indian Child Welfare--A State of the Field Study, completed by Denver Institute, University of Denver). This is legislation passed that has proven to be destructive to the Indian family and it does not recognize the sovereignty of Indian tribes.

Tribal customs, family structure and strengths and cultural aspects have been ignored, criticized and destroyed in the on-going effort by federal, state and county agencies to cause tribes and Indian families to become dependent on them and dilute or destroy the Indian family, causing irreparable mental and emotional anguish to all concerned.

RECOMMENDATION II

OMBUDSMAN

1. Establish an office/position in the executive office to serve as an Indian ombudsman. presidential advisor, program expeditor and advocate for Indian people. This person would also work with all federal agencies, states and other governmental entities that have impact on Indian people.
2. At present services and service delivery systems to Indian people, especially at the reservation level are disjointed, disorganized, wasteful, fragmented and counter-productive. State agencies refuse services to Indian people even though the Indian population is included in allocation of funds. There is no organized system to effectively coordinate Indian programs nor is there any mechanism to insure policy, enforce or evaluate coordination. There is no TA for tribes to produce their own programs. Informations systems are nonexistant.

One of the most damaging and demoralizing problems in Indian country is the constant uncertainty of funding. Each program lives from year to year battling for funds and marching to the music of federal program officers.

RECOMMENDATION III

TRADITIONAL MEDICINE AS NATURAL SUPPORT SYSTEMS

1. A statement of policy should be addressed by the PCMH to recognize the traditional medicine man and woman as healers of emotional, mental and physical disorders. That there be support

services in terms of research, education, coordination and direct payment for services both on reservations and urban rural areas.

2. Most Indian Americans rely on their traditional medicine man and woman in one way or another due to customs and beliefs. Tribal or traditional medicine is practiced throughout the country today.

3. Studies in NIMH and other research indicated positive aspects of traditional medicine man practices. Training of medicine men and women by NIMH on the Navajo reservation has proved positive results; also papers have been written on the Papago medicine men and their utilization as traditional healers and consultants to the Papago Mental Health Program was also proven positive. (Refer to testimony both written and oral as well as Task Force study; AIPRC supports this recommendation.)

1. Kahn, M.W., Lewis, J., and Galvez, E. An evaluation of a group therapy procedure with reservation adolescent Indians. Psychotherapy: Theory and Practice, 1974, 11, 241-244.

2. Kahn, M.W., Williams, C., Galvez, E., Lejero, L., Conrad, R., and Goldstein, G. The Papago Psychology Service: A community mental health program on an American Indian reservation. American Journal of Community Psychology, 1975, 3, 81-97.

RECOMMENDATION IV

RESEARCH INTO TRIBAL MEDICINE AS NATURAL SUPPORT SYSTEMS

1. More research funds should be allocated to Indian programs serving reservation, rural and urban Indian populations for

the purpose of utilizing traditional medicine as a part of their comprehensive treatment program as well as prevention programs.

2. The effectiveness of any health treatment is greatly affected by the belief system of the patient. The importance of traditional medicine and of the belief of American Indians has rarely been included as a vital part of a total treatment plan. The customs, beliefs and traditions handed down through generations of American Indians have played a great part in establishing Indian identity.

RECOMMENDATION V

TRIBAL GOVERNMENT DEVELOPMENT--RESEARCH AND PREVENTION REGARDING THE NATURAL SUPPORT SYSTEMS OF INDIAN COMMUNITIES

1. There is a need for action-oriented research in several areas to foster the growth and development of tribal communities. Since non-Indians contact with tribal communities, individual Indians have, by choice, left tribal communities and severed ties with their tribes; however, for many who choose to live in traditional tribal ways the outlook has been bleak. We could benefit from research of means employed by tribes to survive and prosper as tribal communities. As shown in the Merriam Report and many other studies, Indian communities are here to stay and that regardless of public policy they will survive. We need to find means of increasing opportunities for tribal peoples to develop to their full potential.

2. In dealing with areas of giving assistance we must find means of giving financial aid without creating chronic dependency of the grantee and over administration by the granter agency. Tribal governments must have more responsibility--total and final responsibility in programs that affect the lives of their people.
3. In a related area there is a need for research of communities and their institutions (such as banks, schools, police, chamber of commerce, hospitals) adjoining Indian lands of the value and attitudes that inhibit the full participation of tribal peoples in the non-Indian world.

RECOMMENDATION VI

SELF-SUFFICIENCY

1. All of the recommendations must not be directed to the federal government. The Task Force also recommends that tribal governments and organizations take strong leadership roles in recognizing and dealing with the severe destructive movement of Indian people toward dependency, disintegration of family structures and loss of cultural values.
2. It is the concensus of the Task Force that the Indian people must help themselves; only through their own work and efforts will the seemingly inevitable internal disruption of Indian life stop. Tribal government must develop policy and set up mechanisms to strengthen the positive aspects of Indian family life.

3. Years of inadequate funding and resources--oppression and manipulation by the white power structure along with the colonization behavioral response has led Indian leadership to rely very heavily on federal decision making. Only through self-initiative and perserverence will some of the social and emotional problems be stopped at local tribal and community level.
4. Some tribal governments and organizations have established policy and/or formed bodies to deal with "mental health" or emotional problems of members. Tribal health departments (such as Blackfeet) are in their infancy as far as establishing mental health policy. Some tribes are in the process of developing ordinances in the area of child care, drug abuse and alcohol abuse.

RECOMMENDATION VII

EXTENDED FAMILY AS A NATURAL SUPPORT SYSTEM

1. Too often we neglect looking at the strengths of the American Indian family units. There needs to be extensive and definitive action-oriented research by American Indian researchers or persons who have sanction of Indian government.
2. Investigation should also be focused on the positive aspects and strengths of the extended family system of the American Indians on the reservation, urban and rural areas. These strengths can be regarded as the positive aspects of mental health as well as the natural support system of the Indian family.

3. The extended family and clanship systems are the natural support systems, economically, socially, emotionally, religiously, and politically, of the native American Indian.
4. Child rearing practices, social customs, traditional healing customs, tribal practices, as well as physical and emotional well-being come from the supportive network of the extended family.

RECOMMENDATION VIII

RESEARCH INTO PREJUDICE, RACISM AND THE DEVELOPMENT OF SURVIVAL SKILLS

1. Research funds should be made available to Indian researchers or researchers who have tribal sanction to study the following:
   a. Effects of years of prejudice and racism on Indian children and families.
   b. Coping skills that have enabled Indian children and adults to survive. What are survival techniques developed by Indian people?
2. Research into the coping and survival skills will provide data and knowledge of individual tribal strengths, i.e., cultural value systems, strengths that can be integrated in prevention and human services modalities for the American Indian.
3. On the opposite coin, in opposition all the statistics and data that indicate a growing disintegration of the American Indian family, extended family and clanship there are some

families as well as individuals that "make it," some that survive, some Indians who manage to live peaceful lives in harmony, beliefs and cultural value systems.

4. Studies should be initiated to determine the causes and effects of those Indians seeking to re-enter the tribal systems, i.e., youth, professional and retired.

RECOMMENDATION IX

SERVICE DELIVERY

INTEGRATION OF SYSTEMS

1. There needs to be strong, vigorous and immediate action on the part of the federal government to insure quality, community-based and integrated helping services (health/social/economic) to Indian people: reservation, rural and urban. These services must be based on local need, local planning and local decision making.

   a. There must be the establishment of a coordinating system for an integrative and cooperative service delivery system for Indian people through legislation and policy. Specific language must be included to insure that all agencies involved in service delivery cooperate on a local basis. Top priority must be given to joint-funding efforts to simplify procedures and service delivery.

   b. Every effort must be made to discourage further establishment of centralized centers for training, treatment, etc., by any federal agency for Indian people to prevent alienation of Indian people and loss of local control.

c. There should be immediate steps to insure coordination between the various agencies responsible for PL 94-63, PL 93-641 and PL 93-638 and IHS. At present there is no coordination and the result is chaos and the Indian person is lost in the mess.

d. BIA and IHS must set up a review mechanism for all contracts. The whole contract system is unclear and diffuse and easily abused. There must be accountability for the dollar expended and rationale for the person/firm receiving the contract.

e. The American Indian Policy Review Commission recommends a management audit of IHS--similar to the one done by the AIPRC of BIA. This Task Force strongly supports this recommendation and urges DHEW to proceed with this recommendation.

f. Recommend a GAO audit of contracts done by BIA/IHS for helping services to Indian people.

2. At present helping services provided by BIA, IHS, other federal agencies, states, counties and through federal contracts to private vendors are confusing, duplicated, fragmented, competitive and at times harmful. Many of the federal programs are centralized with decisions made for Indian persons rather than with or by them. Low funding to IHS forces them into positions of centralized programs causing Indian persons to be removed from their communities for care, treatment and education. IHS would like to develop broad based community-oriented programs but feels lack of funding forces them to "become the victim."

3. Contract services provided by IHS contractors are cited by several expert sources as overly expensive because of excessive hospital stays, unnecessary hospitalizations, BIA is often accused of use of a "buddy system" for contracts.

RECOMMENDATION X

COMMUNITY MENTAL HEALTH CENTERS

1. There needs to be specific language and consideration of Indian tribes and organizations included in CMHC rules and regulations. These changes should be flexible enough to allow for rural isolation, unique cultural needs as well as regional differences (such as Alaska). There needs to be a re-evaluation by federal officials of criteria used for funding because those criteria have proved to be a major barrier for Indian tribes and organizations. The criteria utilized for evaluation and monitoring need to be revised to meet the unique needs of Indian tribes and groups. There must be consideration given to direct funding to tribal governments because of the states reluctance to fund Indian programs.
2. American Indians are underserved by CMHC's even though these centers not only include Indians in their catchment areas but also count them for purposes of funding. Over and over Indian people have described their frustrations at being unable to receive help from these centers. At present there is no CMHC on an Indian reservation nor is there an urban/rural Indian CMHC. There is practically no coordination between CMHC service

delivery systems and other helping systems for Indian people. As a result there is duplication of funds and wasted money. Most centers have staff who are insensitive and resistant to Indian people.

3. The current policy of the federal government is self-determination for Indian people, yet in the mental health field, Indian people are denied their right to design their own programs and centers, to apply for funds or to participate in current CMHC programs. Direct funding for such CMHC programs for Indian people is a strong recommendation from this Task Panel. Tribes and urban groups should receive funding on a competitive basis with no intervening layer of control.
4. There is a paucity of data about CMHC services to the Indian population. While some centers utilize various statistics, many Indian people feel that statistics are not reliable and can tell of many rejections and barriers to service. There is not one CMHC on an Indian reservation.

RECOMMENDATION XI

RESEARCH AND DEMONSTRATION PROGRAMS

ASSESSMENT DATA BASE

1. There need to be more appropriations and planning for research and demonstration programs to:
   a. Review and analyze present situation of programs which impact on Indian mental health of Indian people.
   b. Establish standards of service delivery for both Indians and non-Indians.

c. Review geographical/political/social locations of CMHC and effects on service.

d. Investigate needs for different education programs and curriculum for Indians and non-Indians.

e. Develop an R & D project in Indian country reservation/rural/urban as a model for mental health service delivery to Indians. This would serve as a model for future programs in Indian country.

2. The current mental health service delivery system is not reaching Indian people. Services at the reservation level are practically non-existant. There are very few American Indian mental health service centers which serve as carriers rather than facilitating care for Indian people. Service delivery standards for Indian people and different for Indians than non-Indians and prevents services reaching them. Services presently reaching Indians are poor.

3. There is no technical assistance--technical assistance is imposed available to Indian people who wish to start their own programs. The data base to justify service need or extent of problem is not available.

RECOMMENDATION XII

NUTRITION

PREVENTION RESEARCH

1. There should be action-oriented research efforts directed into investigating the effects of poor nourishment, malnutrition,

poverty, cultural variances and inadequate food supply stores on the general well-being of Indian people.

2. Adequate nutrition is a basic need of all people to insure good health. Rapid changes in cultural life style, poverty circumstances, and poor food supplies in reservation stores have led to malnutrition of Indian people.

   Increased availability of welfare, moving into clustered HUD housing, emphasis on buying foods rather than raising food has lowered nutritional status of Indian people. Lack of fresh garden food, wild berries, game/fish and natural preservation techniques has led Indians to rely a great deal on non-nutritious sugar/starch foods. This has led to chronic obesity and other related problems such as high blood pressure, diabetes, poor maternal and infant care, pre-natal care, susceptibility to infection. (See Recommendation I.)

RECOMMENDATION XIII

RESEARCH INTO ALCOHOLISM

1. The problem of substance abuse and the resultant effects on American Indian family life and on the individual abuse is the number one health, social, economic problem of the Indian community. Any data or statistic quoted (included researchers, data and publications, mostly by researchers--non-Indians, non-Indian anthropologists) indicate the diversitory effects abuse has on the daily living of the American Indian, his/her family and community.

a. Direct funding to Indian researchers or researchers with Indian sanction for research and data collection regarding Indian chemical abuse. At present the field is murky, diffuse, and existing filled with myths and stereotypes. Adequate research and development programs on those urban/rural Indian reservations where no programs exist at all or treatment of any kind is not available. Include definition of various treatment modalities:

(1) Detox - self-explanatory

(2) Primary

(3) Secondary

(4) Out-patient follow-up, self-help, etc.

b. Collect all available alcohol related data from IHS and BIA, tribal and urban programs both in the lower 48 states and Alaska as to what available data and statistics can be collected from these existing programs and agencies as to the extent of the problem, i.e., hospital care, medical complications, primary and secondary treatment available to Indian people. Compile these data into a comprehensive assessment report.

c. Research monies granted to the development of primary Indian alcoholism and drug abuse treatment centers throughout the United States. (Each tribe in the United States and Alaska has its own culture and way of living.)

d. Research funds for the development of troubled employee programs at the tribal government level. (This is to include all programs under tribal jurisdiction.)

e. Research for the extent of the suffering of the family of the alcoholic, i.e., battered spouse, child abuse and neglect.

f. Research and evaluation into programs currently funded to see what is presently working and not working. (Secondary treatment programs) Both rural and urban.

2. Every bit of testimony and other data provided to the Task Force indicates that chemical abuse (alcoholism) is the number one problem of American Indians. Alcoholism and alcohol abuse is on the rise among the American Indian and the Alaska Natives. Much of this rise can and is attributed to several factors:

   a. Socio-economic status of the American Indian in both rural reservation and urban areas.

   b. Poor self-image resulting from racism and prejudice of the non-Indian society, labeling the native American Indian as a second class citizen.

3. In a recent study done by the Aberdeen Area Indian Health Service (Mental Health Staff of IHS), alcoholism and alcohol abuse had increased in the Aberdeen area by 47 percent in the past five years, with the biggest increase being in the younger age group (15-19). The same report also states these startling facts:

   a. The attempted suicide rate is rapidly rising in the age group 15-25 and those that actually do commit suicide are two out of ten.

   b. That the rate of alcoholism and alcohol abuse in both the rural reservation and urban areas is four times the national

average which is one out of ten, where the American Indian rate is two out of five.

c. That all Indian health service--service units, in-patient, hospital admissions and out-patient clinic visits are 60 to 70 percent related to alcohol and alcohol abuse.

4. Law Enforcement Statistics (from the Aberdeen area) also show that of the crimes committed on the reservation 95-98 percent are related to alcohol and alcohol abuse. Also state prison statistics (South Dakota, Montana, Minnesota) show that almost all (over 90 percent) the native American Indians incarcerations are due to alcoholism and alcohol abuse, with many serving time for crimes committed during blackouts. If all prisons were visited in the United States it is expected that of all Native American Indians now serving time, at least 90 to 95 percent are there due to alcoholism or alcohol abuse.

5. Continuing dependency upon federal, state and local governments excluding tribal governments for program start-up and continuation monies creates an attitude and/or atmosphere of external control rather than internal control, which in turn defeats the spirit of PL 93-638, i.e., Indian Self-Determination and Education Assistance Act. This dependency continues the cycle of placing responsibility on outside persons rather than leaders.

(Minnesota Department of Welfare Chemical Dependency Division, Research and Evaluation Section, Indian Health Service, Bureau of Indian Affairs, NIAAA, NIDA, National Indian Women's Council on Chemical Dependency, AIPRC.)

RECOMMENDATION XIV

DIRECT EFFECT ON COMMUNITY

TROUBLED EMPLOYEES PROGRAM

1. Establish Troubled Employees Program both in the Bureau of Indian Affairs and in the Indian Health Service and Public Health Services to make assistance available to tribal governments to establish their own programs for their own employees. The Bureau and Indian Health Service are to set up an active and effective Troubled Employee Program as set forth in the Civil Service regulations H.S.A. regulations and DHEW regulations.
2. Have the Assistant Secretary for Indian Affairs and the Director of the Indian Health Service recognize that there is a severe problem among federal employees and issue a blanket policy statement in reference to the troubled employee (reference--Aberdeen area policy statement) and require that area directors back this policy.

RECOMMENDATION XV

WOMEN AS INFLUENTIAL AGENTS IN

COMMUNITY NATURAL SUPPORT SYSTEMS

1. There needs to be special attention paid to the unique role of Indian women, their contribution to the improved mental health of Indian people and the stressful and anxiety life situations they find themselves in.

   a. Special research efforts in this area

b. More projects for Indian women and children such as centers for battered women and alcohol treatment centers for women

c. Special education incentives for women who are head of single parent families

d. Special services should be provided for Indian women in prisons

2. Indian women have a unique situation in the area of mental health as they experience the double stress of being women in our society and being Indian in the dominant white culture. The effects of poverty and poor socio-economic conditions on reservations as well as rural and urban areas has many Indian women to experience the effects of a welfare culture. Alcoholism has also taken its toll.

Information from NIE--special study session for American Indian Women, 1976.

Information from Indian Women's Caucus - IWY, 1977.

Testimony by Pauline Hayres representing the International Indian Treaty Council and Coalition of Grass-Roots Women to the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.)

RECOMMENDATION XVI

BOARDING SCHOOLS AS COMMUNITY SUPPORT SYSTEMS

1. BIA must be directed to immediately improve situations in BIA boarding schools. This committee suggests that boarding be considered youth advocacy and resource centers with social/emotional orientation rather than under control of educators.

2. Most boarding schools seem to be a "necessary evil" in the life situations of many Indian communities. However, they disrupt family life, destroy self-esteem and identity of Indian children. They are utilized for social placements, for unwanted children, for solving local family and welfare problems. The philosophy is to place the most "troublesome" children and adults in schools the farthest from home.

3. Countless stories of mistreatment, humiliation, destruction of self-esteem, resultant emotional distress, unsupervised activities of children leading to drug usage, alcohol abuse, pregnancy. Eighty percent (80%) of placements in BIA boarding schools are for "social reasons." Over one-fourth of American Indian youths are admitted to boarding schools. The Merriam Report in 1928 recommended phasing out boarding schools (AIPRC, p. 405). Nine thousand Indian children do not attend school at all because of lack of facilities (AIPRC, 1477:405, 407).

   In 1969, the Kennedy Report condemned the Indian boarding school system.

   The AIPRC commission reports no change in BIA boarding schools since 1969 (AIPRC, 1977:408).

   American Academy of Child Psychiatry working paper, 1974 (hazard to M.H.).

   The Indian Task Force heard reports of violence, sexual abuse, drug abuse, alcoholism, sheer neglect not to mention the daily humiliation and ego-destruction activities at the boarding schools.

RECOMMENDATION XVII

MENTAL HEALTH MANPOWER

The Task Force recommends that there be mechanisms set up either through IHS, BIA, or OE, to support manpower power groups to educate and train American Indians and Alaska Natives in the mental health related professions. Self-determination will never be achieved if we must continue to rely on non-Indian persons for mental health service.

RECOMMENDATION XVIII

The Task Force recommends that greater attention be directed to American Indians and Alaska Natives who are prisoners in state and federal institutions. This specific recommendation is made because of the disproportionate number of American Indians in prison.

COMPOSITION OF THE AMERICAN INDIAN AND ALASKA NATIVE TASK PANEL

Included in this report is a list of those American Indian persons who served on the Task Panel which was charged with making recommendations to the President's Commission on Mental Health. A brief explanation is included in order that the reader will understand how the panel was formed.

The PCMH was formed by executive order on February 17, 1977. La Donna Harris (Comanche) was appointed by President Carter to serve as a commissioner; she was the only Indian person on the commission. Phyllis Old Dog Cross was detailed from the Bureau of Indian Affairs in July, 1977 to assist Ms. Harris in her special concerns for Indian people and their mental health needs.

The first task was to prepare for the series of national hearings held by the commission. Information regarding the PCMH and the hearings was sent to all major Indian organizations, Indian persons, key IHS staff, IHS area offices and NIHB. Meetings and follow-up telephone contacts were made. The names of persons who might be tapped for testimony, and utilized as task panel members as well as consultants on special concerns were submitted to the staff of the PCMH. The list was compiled by listing those persons nationally known for work in "mental health" with the American Indians, persons nominated by NIHB, H.C. Townsley, and several other sources.

Several Indian persons were self-identified and contacted the PCMH on their own. Several persons were assisted in preparing testimony.

Contacts were made to increase good regional representation. Eight (8) Indian persons gave oral testimony at the national hearings.

A series of mini-hearings were held by Commissioner Harris at Zuni Pueblo, Oklahoma City, Rapid City (for the four-state Indian health Bd) and California. Several national organizations asked for a report from Commissioner Harris during an annual meeting and several national Indian newsletters carried information on the PCMH.

After the national hearings the PCMH decided to appoint a task panel on American Indians and Alaska Natives. The panel was to meet as soon as possible to start its work. The first meeting was held in August, 1977.

The Task Panel on American Indians has utilized both American Indian health (and mental health) professionals and American Indians who are involved in human service delivery programs at the local level. The chairman was chosen because of his training as a lawyer and his vast experience in the Indian world and in dealing with the federal government. Also, Indian persons who have had experience in specialized fields such as alcoholism, child welfare services, etc., were involved in the Task Panel's deliberations.

The panel would like to emphasize that every attempt was made to involve persons from the local level because of the belief that only from the local level can services be determined. The Indian world has for too many years had services and decisions imposed from above. It is time for this process to stop.

Besides developing a report from the panel itself regarding American Indian concerns, every effort was made to get Indian representatives and input to the 30 other task panels of the PCMH. We were able to get

the following representation on these panels:

Support Systems: H.C. Townsley

Manpower: Pat Locke

Family: Tillie Walker

Women: Wanda Frogg

Alcoholism: John Buehlman and Gordon Belcourt

Barriers: Carolyn Attenave

Family and Children: Marlene EchoHawk

Ed Bates was appointed to the Rural Task through his own initiative.

The panel met twice after August under close deadlines and developed a draft report which was due January 1, 1978. The chairman presented the report to the PCMH on January 16, 1978. It was accepted by the PCMH.

APPENDIX

TASK PANEL ON AMERICAN INDIANS AND ALASKA NATIVES

PRESIDENT'S COMMISSION ON MENTAL HEALTH

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