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Indian Health Service, Rockville, MD.

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A ROUNDTABLE CONFERENCE

ON

INDIAN ADOLESCENT WELLNESS

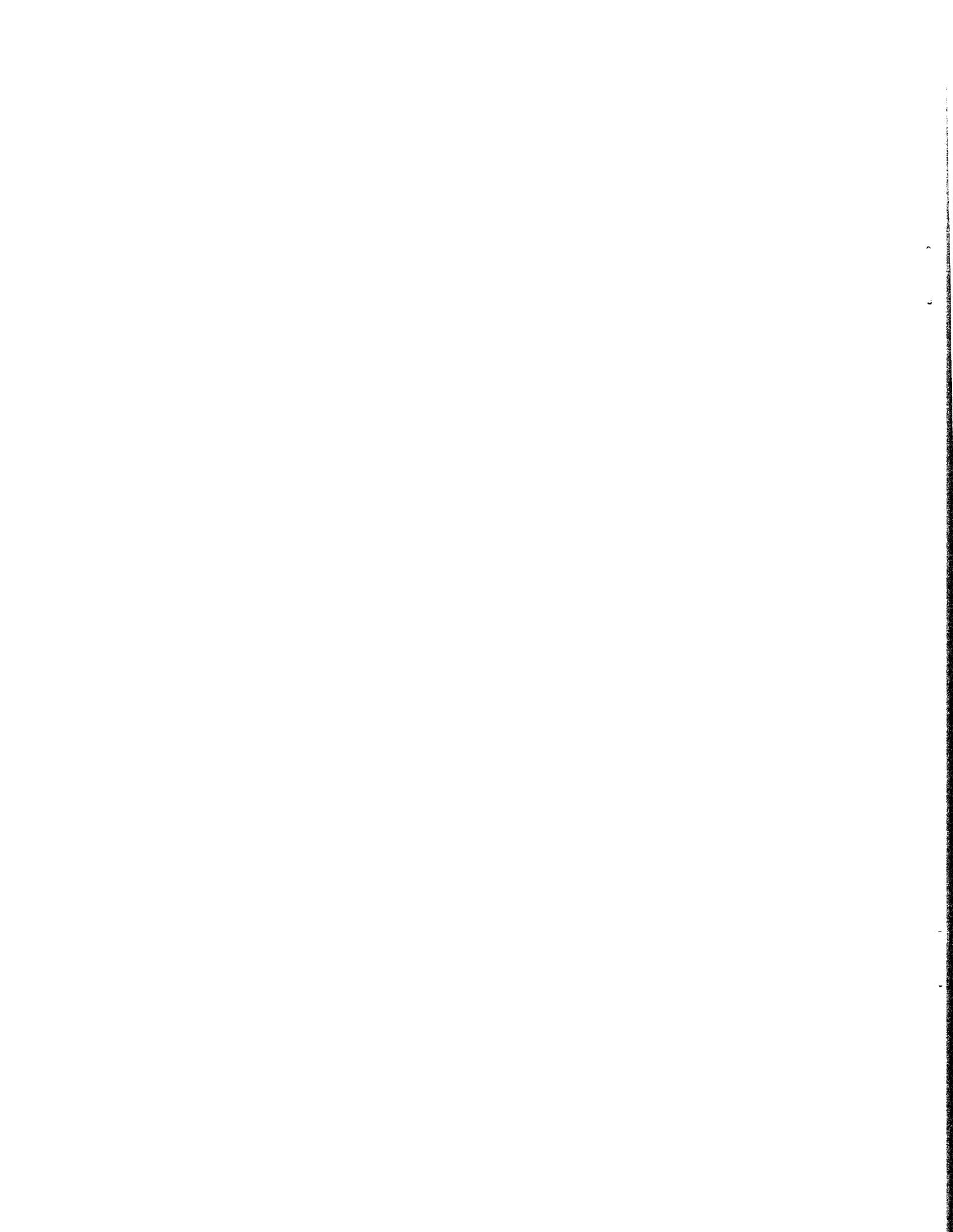
IN A HOLISTIC CONTEXT

**A CONSENSUS STATEMENT
FINAL REPORT**



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Indian Health Service





A ROUNDTABLE CONFERENCE
ON
INDIAN ADOLESCENT WELLNESS IN
A HOLISTIC CONTEXT

**A CONSENSUS STATEMENT
FINAL REPORT**

**November 6 and 7, 1991
U.S. Indian Health Service
Rockville, Maryland**



**THIS REPORT IS AN INDEPENDENT STATEMENT OF THE ROUNDTABLE
GROUP AND IS NOT A POLICY STATEMENT BY THE INDIAN HEALTH
SERVICE OR THE FEDERAL GOVERNMENT**

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TABLE OF CONTENTS

I.	INTRODUCTION	4
II.	CONSENSUS STATEMENTS	5
III.	ADOLESCENT HEALTH ISSUES	16
IV.	WELLNESS IN A HOLISTIC CONTEXT	22
V.	BIBLIOGRAPHY	32
VI.	AGENDA	35
VII.	PARTICIPANT LIST	36

INTRODUCTION

The Indian Health Service (IHS) Office of Planning, Evaluation, and Legislation (OPEL) initiated a series of "Roundtable Conferences" to address contemporary Indian health issues. The IHS brings together experts in from the community, clinical, academic, and health policy settings to examine important, topical, and controversial issues related to Indian health issues. On November 6 and 7, 1991, a group of experts in the area of Indian adolescent health and wellness gathered in Rockville, Maryland, for the Roundtable conference on "Indian Adolescent Wellness in a Holistic Context." Participants represented a broad spectrum of experience and perspectives. The discussion was lively and over the course of 2 days, the group produced the consensus statement described in this final report.

The IHS adapted the consensus statement model from the National Institutes of Health (NIH). The NIH has used this method of consensus building among health science professionals in developing standards of care and generating guidance in the health field. Though the issues examined by the IHS Roundtables are of a health policy nature rather than a clinical nature (as in the NIH context), the process is the same. It is intended to be a means of bringing together a variety of perspectives and forming a statement of consensus on controversial topics of concern to the IHS. A consensus statement does not require that the group reach consensus on the issue. Rather, the consensus statement is supposed to describe the overall position of the group, including descriptions of disagreement or dissent.

As the first order of business, the Adolescent Health Roundtable participants refocused the mission of the roundtable from "Adolescent Health" to "Adolescent Wellness." There was agreement among the participants that the term "health" is too often defined with statistics of morbidity and mortality indicating the absence of health. The group took the position that Indian adolescent wellness is much more than disease and death statistics; the wellness of Indian adolescents is very much influenced by other aspects of family and community life. Understanding the historical, cultural, spiritual, and psychosocial factors affecting Indian adolescent wellness was the foundation for this Roundtables' consensus statements.

**CONSENSUS STATEMENTS
REGARDING
INDIAN ADOLESCENT WELLNESS IN A HOLISTIC CONTEXT**

The following statements were developed by the Roundtable participants and reflect the major areas of priority:

I. DATA AND INFORMATION SYSTEMS:

The Roundtable participants were concerned that the current method of describing Indian health data eliminates a means to examine adolescent health and wellness, without requesting a special computer run. The IHS data divides the adolescent population down the middle. All age specific data in the IHS Trends Book (an annual report on Indian health data) break age categories between ages 5-14 years and 15-24 years. The Roundtable felt strongly that the IHS should initiate a change in its standard method of reporting age breakouts, so that the health status of adolescents could be better examined and understood. While the group did not arrive at a specific age range which defines "adolescent" years, numerous suggestions were made; generally, the ages covered were between 10 and 20 years, depending on emotional growth and development. The Roundtable agreed that the quality of data was of primary importance to secure the necessary priority attention and funding to address health issues. Specifically, the following recommendations were made:

- A. Better data on Indian adolescents is needed. The IHS should immediately remedy its data reporting system to better display existing data by age to accurately describe the adolescent years of life.
- B. The IHS should train local level communities in data collection, use of data, and data retrieval analysis. The IHS should develop the public health capacity of tribes and Indian communities to better use and apply the data. This will in turn build better programs for Indian adolescents.
- C. Regional analysis of Indian adolescent data should be required to better allow for targeted prevention and intervention efforts. National data often masks local or regional problems.
- D. Evaluation and replication of quality adolescent programs should be initiated. A means for quality evaluation and documentation of successful models is needed to acquire funds needed to continue efforts in Indian adolescent wellness.
- E. A clearinghouse is needed so that tribes, Indian organizations, and urban Indian communities can access current research data, innovative models, seek out technical assistance, and share resources and information regarding Indian adolescents. Competition for limited funding often contributes to decreased sharing.

- F. Research on Indian adolescent health should lead to Services and Solutions and not be isolated and meaningless to Indian adolescent populations. The IHS should take a policy position to require all research to be connected to the development or improvement of services to the Indian population.

2. INTENTIONAL/UNINTENTIONAL INJURIES (Homicides, Suicides, Injuries):

The Roundtable participants recognized that Indian youth are at the greatest risk for death or injury due to violent accidents and intentional injuries. For this reason, a focused effort on this age category by the IHS and other concerned agencies is necessary. It was pointed out that the IHS limitations on emergency medical response care has a disproportionate impact on Indian youth. For example, the lack of ambulance services in rural remote communities is a hardship for all Indian patients, but it has a disproportionate impact on Indian adolescents who are more likely to be involved in serious car accidents. Emergency response could make the difference between survival or death for many Indian teens each year. Specifically, the Roundtable made the following recommendations:

- A. Comprehensive prevention campaigns targeted at Indian adolescent intentional and unintentional injuries is needed to make a difference in increased mortality. The IHS and Indian communities should focus prevention on all three levels:
- Primary: Seek no injuries through information and education campaigns. For example: Students Against Drunk Driving (drink/drive).
 - Secondary: Emergency Medical Services (EMS) are needed in rural Indian areas; the IHS should take a lead in developing those services.
 - Tertiary: Rehabilitation services for Indian teens with permanent or long-term injury is needed. Currently, the IHS has no national program, but depends upon local initiatives to meet this need.
- B. The IHS needs to respond quickly when suicide clusters are developing in Indian communities. The IHS should initiate a program to identify those at highest risk for suicide and intervene in a meaningful way. The IHS should incorporate into its prevention effort recent research by Grossman, et. al., regarding risk factors for teen suicide. Specifically, these risks are: 1) a history of mental health problems; 2) alienation from family and community; 3) having a friend who attempted suicide; 4) weekly consumption of hard liquor; 5) a family history of suicide or attempts of suicide; 6) poor self-perception of health; 7) history of physical abuse; 7) female gender; and 8) sexual abuse.
- C. Indian Child Welfare Act (ICWA) authority administered by tribes, Indian organizations or the Bureau of Indian Affairs (BIA) need to coordinate more efficiently with the IHS on matters of child abuse and child protection. The protection of children should be top priority. The IHS should develop a more effective surveillance system to evaluate the prevalence of domestic violence,

including child neglect, physical, emotional, and sexual abuse, and its impact on adolescent health.

- D. The IHS, in consultation with tribes and Indian organizations serving Indian adolescent populations, should initiate a means to thoroughly analyze the University of Minnesota (U of M) Adolescent Health Survey comprehensive data to better understand and address Indian child abuse issues and its long term effects on Indian adolescent mental health and wellness.
- E. According to Roundtable participants, violent rape, rape while intoxicated or unconscious, and child sexual abuse, are common experiences of female and male Indian adolescents. Despite anecdotal information common among tribal and urban providers of care to Indian adolescents, there is absolutely no data which addresses Indian teen rape. Surveillance of Indian teens through intake or other instruments is needed to better assess this type of violence.

3. MENTAL HEALTH:

The Roundtable participants were in agreement that a stigma exists around mental health services; this stigma should be addressed. The IHS, tribes, and Indian organizations need to become more creative and culturally sensitive when attempting to address the mental health needs of Indian adolescents. Specifically, the Roundtable makes the following recommendations related to mental health:

- A. Adolescents do not go to providers of mental health to talk. The IHS system places too much emphasis on 1 to 1 "encounter" and needs to refocus on the power of "groups" and cultural activities. The group process can be a safe way for adolescents to begin to talk about their experiences and pain. Peer support groups can work with adolescents and are more meaningful in many ways than the traditional 1 to 1 authority-based counseling approach. In addition to groups, cultural ceremony and ritual rebuilding can provide structure to rebuild faith and trust. Traditional medicine people must be brought into the mental health care system, whenever appropriate.
- B. Developing services for Indian adolescents must incorporate the ongoing input and involvement of Indian adolescents themselves. They know what the problems are (incest, violence, and alcoholism in the community) and are more willing to break the denial process than adults are about these and many other issues. Adolescents are also less likely to be swayed by the politics of jurisdiction in developing innovative approaches.
- C. The Roundtable strongly recommends that the IHS and the National Indian Health Board (NIHB) seek consultation from traditional Indian people and spiritual leaders on ways to improve cultural/spiritual values in the delivery of health care. To accomplish this, it is recommended that the IHS support a special national gathering to discuss with tribes and Indian leaders the topic of traditional Indian values, traditions, ceremony and ritual, as a means to foster

improved health for all Indian people. The Roundtable feels this effort will benefit efforts to improve Indian adolescent mental health, as well as other ages.

- D. The IHS, tribes, and Indian organizations should look to schools as a means to get needed help to Indian adolescents in-need. While it was recognized that many of the most in-need adolescents will not be in the classroom, the Roundtable identified the school as a primary vehicle to disseminate information, and to identify Indian children at risk.
- E. The "Systems Child" has no family base, is in and out of court, is in and out of foster homes, boarding schools, on the streets, and is the hardest to reach. Since systems children are so hard to reach, and able to manipulate the system, they are often written off as un-treatable by community workers and the system which is supposed to help them. The IHS, tribes, and Indian organizations need to recognize and find ways to support systems children through innovative programs.
- F. The Roundtable found there are no tribal laws, IHS policies, or local programs to deal with children who are child sex offenders. Participants reported that more and more, child sex offenders are themselves children, ages 10-15 years. Sexual abuse is a cyclical problem. Perpetrators are most likely victims. The emergence of younger and younger offenders is an indication of the severity of the problem; the long overdue need to intervene in the cycle of sexual abuse, is further indicated. There are inadequate services to intervene and provide treatment for either the victim or offender. The IHS should set the initiative of a nationwide child sex abuse prevention and treatment model which incorporates treatment and support for both victim and perpetrator.

4. ADOLESCENT SEXUALITY:

The Roundtable agreed that among adolescents, "sex happens," and the sooner that fact is recognized the more likely teens will be provided the services and support they need to protect themselves from related health problems and unwanted pregnancy. The U of M Adolescent Health Survey found that by the 12th grade, 66 percent of Indian boys and 59 percent of Indian girls have "gone all the way." Indian teen sexuality is very much connected with their experiences in the family. Cultural rights of passage which used to be a part of adolescence are no longer available for many Indian teens. The Roundtable discussed the need for a restoration or creation of ritual to bring meaning, honor and ceremony, and a sense of responsibility to the onset of puberty. Without understanding the responsibility of adulthood, pregnancy, parenthood, and the health risks of sexually transmitted diseases, many adolescents are becoming sexually active. The following specific recommendations were made:

- A. **Reach Adolescents Early:** Early outreach is important to establishing empowerment among Indian girls and boys to know it is in their own interest to protect themselves and use condoms. Indian adolescents need to understand the reproductive process, and consequences of unprotected sex, such as pregnancy,

Sexually Transmitted Diseases (STD), Human Immunodeficiency Virus (HIV) infection, and cervical cancer. Indian adolescents need to understand that oral contraceptives may protect against pregnancy, but they do not protect against STD/HIV. The IHS and Indian providers need to invest money and human resources into a campaign to educate Indian children that “You need both condoms and birth control to be safe from unwanted pregnancy, STD, and HIV infection.”

- B. **Reach Parents:** The IHS and tribes need to support community education efforts which involve parents. Parents need to be able to talk to their children about sensitive issues, such as sexuality and its risks. Parents need help. The IHS, tribes, and Indian organizations need to help parents develop the skills and knowledge to accurately and effectively talk to their children.
- C. **Reach Community:** Communities need to talk about sexuality issues. Schools, tribal leaders, school board members, coaches, and counselors all project their own attitudes about sexuality issues. The community can significantly improve male responsibility in issues of safe sex and birth control through males role-modeling responsible behavior regarding sex and parenting.
- D. **Provider Education:** Health care providers need to be more caring and sensitive toward Indian adolescents and their reluctance to talk about sex. Health providers must begin discussions of contraception and sexuality, honesty, and confidentiality at an early age; this will also help to build up confidence. The IHS, tribal, and other medical providers should initiate protocol which requires that asymptomatic women/girls are routinely tested for STD. The IHS, and Indian clinics should increase the availability of female health care providers to improve health care for Indian teen girls. Providers should also encourage teens to talk with parents about issues regarding unprotected sex. The IHS and tribal clinics should also increase the number of male health educators.
- E. The IHS, tribes, and Indian organizations must try to keep pregnant and parenting teens in school. More programs are needed to make sure pregnant and parenting teens finish school and develop productive lives and healthy environments for their young, and to reduce repeated unwanted pregnancies.
- F. Adolescents from dysfunctional families are at risk for low self-esteem. Issues of low self-esteem effect increased or inappropriate sexuality and early pregnancy. The Roundtable agreed that for many troubled boys and girls, pregnancy and teen parenthood often becomes a rite of passage. Girls tend to think a baby will provide unconditional love which they may have lacked in a dysfunctional home. Surveillance of Indian pregnant teens should be conducted by the IHS to better understand the risks and develop intervention models.
- G. Tribes and the IHS need to develop an effective educational campaign to help Indian girls and boys to protect themselves against rape and sexual abuse. Intervention and treatment is needed for those survivors of rape and sexual

abuse to prevent the onset of mental health problems, self-destructive behavior, promiscuity, and related health risks.

- H. The needs of gay and lesbian Indian adolescents are completely and totally ignored in the IHS, tribal, and Indian service delivery system. There is little recognition that Indian gays and lesbians exist by the service delivery system. These adolescents need support, because they often exhibit high risk behavior, need acceptance in the delivery system, are isolated from family and extended support, and are less likely to seek help.
- I. The Centers for Disease Control (CDC) has STD prevention and training centers which should be accessed by the IHS and Indian health care providers. Such a service would be a cost benefit opportunity for the IHS and tribes to effectively train providers on issues of sexuality and STD.

5. SUBSTANCE ABUSE ISSUES:

While recognizing that there are many theories advanced as to origins of Indian substance abuse, the Roundtable feels that alcohol and drugs occur among Indian adolescents as a result of unresolved traumas and the lack of healthy, nurturing family support or (in some cases) no family at all. The Roundtable took the position that to effectively address adolescent substance abuse, Indian adults need to set examples for the younger generation by exhibiting healthy, sober lifestyles themselves. The Roundtable made the following specific recommendations:

- A. Indian adolescents need transitional housing to continue in their recovery process. There is a need for better aftercare; recovery houses can help in these cases. Kids or children in recovery do not have anything to do and need a support network. Treatment must also be available in the community. Peer counselors can provide valuable assets to prevent adolescent substance abuse; such models should receive priority consideration.
- B. More regional treatment centers are needed to ensure that inpatient treatment is available to all Indian adolescents. This care must be integrally tied to a community-based recovery and aftercare program. Evaluations should be conducted of all regional treatment centers to see which treatment models seem to be the most effective. All adolescents should have the full "continuum of care" available to meet their recovery needs. The IHS should evaluate current criteria for the certification of substance abuse counselors to be sure that counselors are knowledgeable about the history and culture of the community they serve.
- C. After school programs should be initiated in tribal and urban Indian communities. Adolescents often have nothing to do after the day's activities, and become drawn to substance abuse due in part to a lack of home structure. It is a responsibility of the community to fill this gap in structure, when the family structure is not functional or is unable to support its adolescent members.

- D. Substance abuse prevention should occur as early as possible, continuously from kindergarten through the 12th grade. Schools and communities need to be dedicated to creating and preserving a safe and drug free environment. Tobacco and inhalant abuse should be incorporated in these prevention efforts. Cultural sensitivity with regard to tobacco use is encouraged by the Roundtable.**
- E. The physical health of teens in treatment and recovery should be addressed by providers. Pregnancy is a time when Indian girls may be more likely to address their substance abuse problems and enter a treatment program. Cultural and high energy activities, such as dancing, sweats, and music are encouraged to help teens balance the various aspects of their beings during the recovery process. Recovery must include empowerment, social skills, financial management, physical health, cultural rebuilding, spiritual strengths, intellectual pursuits, and sexual responsibility.**
- F. Community education and health care provider training is needed to help family and friends try to prevent the substance abuse of teens and to learn how to intervene in a way that supports recovery. Communities and health providers need to understand the dynamics of teen substance abuse. Communities and health care providers need to coordinate their resources (IHS, BIA, schools, tribes, parents) to improve services to Indian adolescents.**

6. SCHOOL-BASED PROGRAMS:

The Roundtable defined “schools” as anything from pre-school to college. School-based intervention serves as an opportunity for prevention and intervention strategies. It also provides a forum to foster wellness and self-esteem among Indian youth in a safe environment. The Roundtable was also concerned about “drop-outs” (those who drop out of school). The statistics on drop-outs are not available; these children become lost. The Roundtable found that BIA Off-Reservation Boarding Schools (ORBS) receive many of the most troubled Indian adolescents, but do not have the resources to provide the therapeutic environment needed. Specifically, the following recommendations were made:

- A. The five ORBS funded by BIA receive many Indian children who have been abandoned by providers at home. Of the Indian children attending ORBS, 80 percent come from alcoholic homes, 67 percent are clinically depressed, and 73 percent are actively drinking. The therapeutic support needed by these children is not available. The Roundtable takes the position that the IHS and the BIA should work together to create model institutions at these schools which will meet the educational, mental health, physical health, and cultural well-being of these troubled children. A joint agreement between the IHS and the BIA should provide the sharing of information, such as health records and other resources, to begin to address the holistic needs of Indian adolescents attending ORBS. If a demonstration project is needed prior to a larger undertaking, then, the Roundtable encourages the IHS and the BIA to develop this concept.**

- B. Curriculum development is needed to improve the relevance of basic school health classes from the perspective of the Indian adolescent. Health classes need to address issues of sexuality, STD, including HIV infection, substance abuse, mental health, as well as physical health. Teachers and school administrators need to be better informed on these issues. For example, increased training is needed regarding the rights of HIV infected students to attend school in a safe and confidential environment.**
- C. The IHS should initiate a special study to assess the needs of Indian adolescent school drop-outs, to get a better profile of their environments, needs and to develop services for Indian drop-outs and those at risk for school drop-out.**
- D. Indian children with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE) require special attention in the school setting. The IHS and BIA should embark on a cooperative effort to identify FAS and FAE children and to develop the special education they need in a cultural context.**
- E. Transitional programs to bridge Indian students into college should be provided in urban, reservation, and boarding school settings. Indian adolescents must be reinforced to excel and achieve educational goals.**

ADOLESCENT HEALTH ISSUES

Statistics from the 1990 IHS Trends Data Book for the 15-24 year old age group show accidents, suicide, and homicide are the leading causes of death; these rates are higher for American Indians than for the U.S. All Races population. Deaths due to chronic liver disease and cirrhosis, to complications of pregnancy, childbirth, and puerperium occur at a higher rate in American Indians in the 15-24 year old age group than in the U.S. All Races population of the same age. However, the numbers for Indians are small and subject to the limitations of sample size.

Five Leading Causes of Death Among Indians Ages 15-24 Years of Age for 1985-87 (rate per 100,000 population)			
Cause of Death	Indian & Alaska Native	U.S. All Races	Ratio Indian to U.S. All Races
All Causes	157.5	102.3	1.5
Accidents	88.6	51.2	1.7
motor vehicle	61.3	39.0	1.6
other accidents	27.3	12.2	2.2
Suicide	24.0	13.1	1.8
Homicide	20.1	14.2	1.4
Malignant Neoplasms	3.6	5.4	0.7
Diseases of the Heart	2.0	2.8	0.7

Substance Abuse - From a compilation of studies (Office of Technology Assessment (OTA) Indian Adolescent Mental Health Report 1990) which compares substance abuse rates among American Indian adolescents compared against Minnesota White adolescents, the percentage of American Indian adolescents that ever used alcohol or a variety of illegal drugs (seven different classes) was consistently greater than for White adolescents. How these rates compare to White adolescents living in other geographic locations and other minorities has not yet been documented.

Though peer influence is the strongest predictor of Indian youth involvement in the use of alcohol (Oetting and Beauvais 1985), family sanctions against alcohol use and family intactness (both parents living with the Indian youth) were significant predictors of low use. The authors of this article concluded from these findings that Indian youth who believed that their families would try to stop them from drinking and getting drunk were less likely to get involved in peer clusters that used alcohol heavily.

Based on diagnostic groups of family functioning developed by Olson, Smart reports that families classified as "extreme" are more likely to have adolescents who abuse drugs or alcohol. An "extreme" family was defined as one that was on either end of a four category spectrum for cohesion and adaptability. Also, within "extreme" families, the

presence of a drinking problem among other family members was predictive of substance abuse by adolescents within the family unit.

Oetting and Beauvais looked at reasons Indian youth gave for drinking alcohol. Over 30 percent of the adolescents stated that they used alcohol "to get rid of unhappy feelings." One in four Indian youth surveyed stated they used alcohol to get rid of feelings of anxiety. The authors felt these responses had serious implications for the future development of alcoholism in this group. Using alcohol as a coping strategy to relieve anxiety is a practice the authors felt impeded these Indian youths' developmental process toward learning how to deal with feelings.

Suicide - Suicide is the second leading cause of death for American Indians in the 15 to 24 year age group; these rates are 1.8 times as high as that found in the U.S. All Races population for this age group. Some facts relevant to this issue were reported by May in a 1987 article. He stated that the large majority of all Indians who attempt suicide are under age 25 and most are under 20 years of age. Those who attempt suicide are considerably different, both in a qualitative and a quantitative sense, than those who complete suicides. The attempted to completed suicide rate is approximately 13 to 1.

Males are more likely to complete a suicide than females. This sex difference in completion rate is due in part to the choice of suicide method. Males tend to choose more lethal methods such as guns or hanging. In general, though, Indians tend to use more lethal methods than other groups in the U.S. population. Tribes that are experiencing rapid change and have a loose pattern of social integration where a high degree of individuality is emphasized, have higher rates of suicide.

May considers suicide completers, suicide attempters, and sufferers of single vehicle crashes somewhat independent populations that overlap to a certain degree in their self-destructive intent. He estimates 20 to 40 percent of Indian suicide attempters are similar in intent and motive to those who actually succeed in killing themselves, while from 2 to 20 percent of drivers in single vehicle crashes may be highly suicidal.

A recently reported analysis (Grossman, Milligan, Deyo 1991) of the Navajo component of the Indian Adolescent Health Survey examined risk factors for adolescents who reported attempted suicides. Factors that indicated high risk for attempted suicide among the Navajo adolescents surveyed were as follows: a history of mental health problems; alienation from family and community; having a friend who attempted suicide; weekly consumption of hard liquor; a family history of suicide completions or attempts; poor perception of own health status; history of physical abuse; female gender; and, sexual abuse.

Sexuality - Higher rates of live births are experienced by American Indian women under the age of 20 (19.2 percent) compared with U.S. All Races (12.6 percent). However, infants of American Indian teenagers experience low rates of low birth weight (6.3/1000 live births for mothers 15 to 19 years old) compared to U.S. All Races (9.3/1000 births).

By the 12th grade, 66 percent of the boys and 59 percent of the girls, surveyed in the Indian Adolescent Health Survey, have had sexual intercourse. Since teen pregnancy is more common in the American Indian population than in the general U.S. population, one could assume American Indian teenagers are more sexually active than other teenagers in the general population, increasing their opportunity for exposure to STD.

According to a study by Toomey, Oberschelp, and Greenspan, reported case rates of gonorrhea and syphilis among Native Americans are higher than rates for non-Indians in similar geographic locations, in some areas up to 5 times the rate for non-Indians. These researchers have called for an improved effort in the STD prevention and education among Indians. Alarming increases in the rates of reported Acquired Immune Deficiency Syndrome (AIDS) cases in the Native American population have frightening implications for the adolescent population. From personal communication with Dr. Emmett Chase, the CDC reports a rate of increase in Indian AIDS cases to be 91 percent from 1988 to 1989. This compares to only 8 percent for Whites, 13 percent for Blacks, 5 percent for Hispanics, and 17 percent for Asian and Pacific Islanders for that same year.

Physical and Sexual Abuse - The American Indian Adolescent Health Survey conducted by the IHS and the U of M supported the findings of other authors that the prevalence of American Indian child abuse and neglect does not appear to exceed rates in the White population. The results were reported as follows:

Percentage of Indian and Minnesota Adolescents Who Indicated Ever Being Physically or Sexually Abused			
	Physical	Sexual	Both
Indian Males (n=1,297)	6.0%	1.1%	1.2%
Indian Females (n=1,360)	9.9%	6.3%	7.8%
Minnesota Urban Males (n=6,300)	5.1%	2.1%	N/A
Minnesota Urban Females (n=11,538)	14.5%	15.5%	N/A

Though the reported rates of child abuse among Indian adolescents surveyed appears to be lower than is observed in the White population, the socioeconomic and psychosocial risk factors for abuse and neglect are more prevalent in the American Indian population. Several studies have examined the issue of child abuse and neglect in American Indian communities.

As in the general population, child abuse and neglect is on the rise in American Indian communities. Prevalence rates of child abuse and neglect in American Indian communities have so far have not been reported to be higher than the general population. However, Lujan, et. al., indicated that, particularly for sexual abuse,

considerable underreporting of cases occurs. Research conducted by Dr. DeeAnn DeRoin, an Indian family practitioner, studied child abuse reporting in Indian communities (as per personal communication 1988). She found that while the overall rate of child abuse reports does not exceed that of the general public, the rate of convictions of Indian child abusers far exceeded the number of convictions of child abusers in the general public. These findings suggest a problem of underreporting where only the blatant and more severe cases are coming to light in Indian communities.

From two surveys conducted in the Albuquerque and Phoenix IHS Areas, descriptive information has been generated on some of the major family characteristics common to households where child abuse and neglect took place. Alcoholism among family members, (particularly parents and grandparents) was a common feature of households where child abuse and neglect took place. Family disruption, as a result of divorce or a death in the family due to accidents or alcoholism, was more common among the children who were more severely abused and neglected (Lujan, Piasecki). Adults in the household where abuse and neglect occurred were frequently victims of child abuse themselves (Lujan). In both studies, a combination of abuse and neglect was the most common diagnosis for children in the study (Lujan, Piasecki). Children experiencing both abuse and neglect were more likely to abuse non-alcohol drugs and to be poly-drug users than children who only suffered from neglect (Piasecki).

Mental Health - In 1990, the U.S. Congressional OTA published its findings and recommendations related to "Indian Adolescent Mental Health." This report represented information which led to the enactment of P.L. 101-630 the Indian Health Amendments of 1990, which provides for a Comprehensive Mental Health Prevention and Treatment Program. The in-depth study found that Indian adolescents have more serious mental health problems than other races in the U.S. in the following areas:

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

The OTA report cited the following stressors as suspected to be of significance for the disproportionate health and mental health problems of Indian adolescents:

- recurrent otitis media and its consequences for learning disabilities and psychosocial deficits;
- FAS and its consequences for mental retardation and less severe forms of developmental disabilities;
- physical and sexual abuse and neglect;
- parental alcoholism;

- family disruption; and,
- poor school environments.

The study further cited the lack of resources in being able to respond to mental health needs. There are 397,000 Indian children and adolescents in the IHS services areas, and the IHS funds only 17 mental health providers trained to treat children and adolescents. This is a ratio of one provider to 10,000 children.

WELLNESS IN A HOLISTIC CONTEXT

In 1989, the World Health Organization developed a definition of family which stated: *"...the health of each family member, interactions among family members and interactions between family members and the external environment. Many factors affect these interactions which are mediated through the ability of the family to cope with internal and external stresses and to maintain cohesion. Prerequisites of healthy interactions between family members include the possibility of active informed choice (not only passive consent), empowerment to serve as agents for change for other family members and the capability and resources to achieve healthy relationships, including those related to sexuality and parenting."*

It is likely that the functions and influences of the family on the individual within that ecosystem are similar, to some degree, in American Indian families when compared with mainstream White American families. What is of significant difference in the American Indian family as opposed to the majority culture family, is the number of participating family members in the system, their perceived roles and how the individual member fits in that system (Attneave 1982, Ho 1987). Many external and some internal factors have interacted to impair the functional capacity of the American Indian family's ability to provide a protective buffer against environmental and internal stressors.

SOCIOECONOMIC STRESS AND HEALTH STATUS:

Certain demographic comparisons made in the 1990 IHS Trends Data Book are indicative of the socioeconomic characters of American Indian families. They are as follows:

	American Indian	U.S. All Races
Median Age	22.6	30.0
Average Number of per Family	4.6	3.8
Per Capita Income	\$ 3,600	\$ 7,300
Median Family Income	\$13,700	\$19,900
% of High School Grads	55.4%	66.5%
% of College Grads	7.4%	16.2%

Compared to the U.S. All Races, the American Indian population is younger with more members per family unit and one-half the per capita income. High unemployment and large family size may be the factors of significant influence affecting this disproportionate picture. When American Indians are employed, their lower than average educational attainment will result in many of them having to take lower-paying positions. Thus, the economic resources available to the average American Indian family are considerably more limited than the average White American family.

Living Arrangements:

American Indian adolescents surveyed were less likely to be living with both of their biological parents when compared with White Minnesota adolescents (49 percent vs. 64 percent); their parents were more likely to be divorced or separated when compared to the same group (34 percent vs. 22 percent). Only 45 percent of these American Indian adolescents lived in a two-parent household, and 16 percent lived with neither parent for one reason or another. Sixty percent of the adolescents surveyed were in the seventh to ninth grades (U of M report).

Inadequate Income:

The financial stress produced by a situation where a few adults support a large number of dependent individuals (young children, unemployed adults, and the elderly) can be an important contributing factor to health problems that arise in American Indian families.

Manson and Callaway illustrated this situation well in their comparative analysis using a dependency index to compare the U.S. White population to the American Indian population. In this analysis, American Indian adults of working age (15-64 years old) living in rural areas of the U.S. carried a particularly heavy burden of dependents. For every two adults in this age group, one dependent is supported (over age 64 and under age 15). On some reservations in the Southwest, the ratio of dependents to employable adults is nearly one to one. This is comparable in their estimates to some of the poorest Third-World countries.

Because less than 60 percent of the adult American Indian population is employed, it is quite likely that in some areas, one employed adult could be supporting two other family members on the average. May also concluded that high birth rates in American Indian communities along with the decline of mortality, is producing a situation where Indian adults of working age are increasingly being faced with a greater burden of providing for their dependents.

Traumatic Loss:

Added to the intra-family stress of coping with a larger number of dependents and inadequate financial resources are the effects of sudden loss of family members due to trauma-related death. Death rates for American Indians exceed the U.S. All Races rate up through the 55-64 age group. The highest death rate ratios are seen in the 25-34 age group where the Indian to U.S. All Races is 1.9. The leading cause of death in age groups 1 to 44 years old are accidents. Accidental death rates for American Indians exceed the U.S. All Races rates in age groups throughout the life cycle. Homicide and suicide as causes of death in American Indians have rates that exceed U.S. All Races for age groups 15 to 24 and 25 to 44 years old. Though the IHS regional differences in death rates due to these causes result in some regions having lower rates for homicide and suicide than the national average, other regions have rates three to four times the national rates.

The disruption of the family that can occur with the loss of a close family member creates significant stress on adolescent family members. The real possibility of American Indian adolescents suffering the loss of a parent has a serious impact on their concern about a parent dying. This was made apparent in the American Indian Adolescent Health Survey carried out in conjunction with the U of M and the IHS.

American Indian adolescents reported more often than Minnesota White adolescents that one or more of their parents was dead (12 percent vs. 3 percent). This real possibility of parental loss due to death most likely had an impact on how the American Indian adolescents responded to another series of questions covering their concerns and worries. When these adolescents were asked about family problems that worried or concerned them, more than 50 percent indicated having one of their parents die was a serious concern. Next to worries about school performance, worry about the "potential" death of a parent garnered the greatest percentage of "quite a bit" and "very much" responses among those American Indian adolescents surveyed.

Chronic Illness as a Consequence:

When age-adjusted death rates for American Indians are compared to U.S. All Races rates, American Indians suffer from not only higher rates of accidents, homicide and suicide, but have a higher proportion of deaths due to liver disease, diabetes, tuberculosis, and pneumonia/influenza. These later conditions are primarily chronic, in nature. Like alcoholism, Type II diabetes observed in American Indians, is believed to have a genetic component predisposing an individual to the condition. However, diabetes has mediating environmental factors affecting its expression and severity, similar to alcoholism.

Pine, in his article on diabetes and behavior, builds a strong case for the role of stress in the production disproportionately high rates of diabetes among American Indians. Stressful events (emotional, physical illness, trauma) are well recognized precipitators of "diabetic crisis" that often signals the on-set of overt diabetes (Institute of Medicine). The role of obesity in the on-set and perpetuation of Type II diabetes is well supported by the research in the literature. Anxiety and stress-induced overeating and its role in obesity is an avenue of continuing scientific investigation. Some studies have linked certain eating disorders to substance abuse (primarily alcohol abuse) in first degree relatives of the sufferer (Pine). In addition, being a victim of sexual abuse may be implicated as an etiological factor in eating disordered patients. Pine discusses the effects of low socioeconomic status on the incidence of both obesity and diabetes and provides some evidence that the link between low socioeconomic status, obesity, and diabetes, might be stronger than the one between family history and diabetes.

According to a 1982 Institute of Medicine report, individuals develop coping strategies in order to keep the distressing situation within tolerable limits, maintain self-esteem, preserve interpersonal relationships, meet requirements of new situations, and prepare for the future.

Sagan outlines six mechanisms through which families operate to support and assist members in coping with stress and its negative impact. These mechanisms are identified as functions that the family performs as: 1) a collector and disseminator of information about the world; 2) a feedback guidance system; 3) a source of ideology; 4) a source of practical service and concrete aid; 5) a haven for rest and recuperation; and, 6) a source and validator of identity. Sagan adds to this, the statement: "Just as families can be a source of support and a mitigating factor for stressors and disease, they can also create tensions that exacerbate disease, a fact often ignored by our medical system."

CULTURE, ROLES, FAMILY, AND ITS IMPACT ON ADOLESCENT HEALTH:

According to Attneave in 1982 and Ho in 1987, traditional American Indian values imparted to individual family members center around the concepts of collaterality, being-in, becoming, right for choice, and noninterference.

The right of choice is the right to chose one's own actions and be the kind of person one chooses. Whether this is applied to a child or an adult, the consequences of one's actions, be they positive or negative, are expected to teach their own lessons. In today's world, consequences of one's actions might not always be apparent or may have a cumulative effect.

Non-interference involves valuing and respecting other individual's "right to be and to do their own thing." Attneave comments on the American Indian value of noninterference as follows: "Perhaps as a reaction to the highly manipulative non-Indian social controls, perhaps for other less obvious reasons, non-interference has been idealized by many Indians to a point of paralysis of all social assertion and control. This is sometimes extrapolated to apply to non-intervention in self-destructive behaviors as well as in those in which intervention or correction are age appropriate."

While these basic values represent the ideal elements of Indian family systems, they must be viewed in light of cultural loss, poverty, acculturation, excessive mortality and alcoholism on any system. The shift from healthy functioning family systems to unhealthy "dysfunctional" family must also be addressed.

The Child's Role - Attneave paints a picture of a child's role in the traditional American Indian family as one of an individual within the family who is perceived as being capable at an early age of making important decisions about his or her life. Given the extended family tradition in American Indian cultures, the child may receive discipline and is taught by numerous family members besides his or her biological parents. The child-parent relationship was less pressured and more egalitarian then is observed in the majority culture as a result of this arrangement.

Parental instruction to the child usually was in the form of observation and participation, because a parent viewed herself as only one of a number of the child's teachers in the family. Thus, a child was infrequently told directly what to do. Often he was left to his own devices and decisions. Attneave states, "While there are firmly set

limits concerning proper and life-threatening behaviors involving others, the child is still free to choose when and whether to engage in a wide range of activities." Combined with this traditional Indian child-rearing strategy, the impacts of alcoholism, poverty, cultural and family loss, American Indian children are bound to suffer developmentally from the loss of healthy parental guidance.

Both Attneave and Ho state that the parent-child interaction within American Indian families frequently is defined by sex role. Thus, female members of the family are responsible for parenting the girls and male adults are responsible for parenting the boys. In fatherless homes, this could lead to sons being left without parental guidance. In addition to the fact that increasing numbers of American Indian children are growing up in fragmented, nuclear households with a single woman at its head, a large percentage are also growing up outside of their biological parents' homes (Brown and Shaughnessy as cited in Ho).

Sibling relationships in traditional American Indian cultures can extend beyond biological relationships of brothers, sisters, and cousins to clan brothers and sisters. Sibling relationships with biological or clan relatives could in some tribes constitute important peer relationships for a child that continue on into adulthood.

The Adolescent's Role - Traditional American Indian adolescents in most tribes had tangible and valued "rites of passage" to demarcate their departure from childhood into adulthood. Puberty rites such as vision quests, naming ceremonies, puberty ceremonies for girls upon reaching menarche, etc., still play a part in some of the more traditional tribes. These rites provided signposts by which American Indian youths could be guided through important transitions in their role within the family and community.

Post World War II changes in the majority culture produced a distinct youth subculture. According to Gitlin, the youth subcultures that evolved during the post-war period responded initially to the "consumer society" with the use of drugs as a tool of rebellion against authority and the conspicuous materialism of the times. The use of drugs in the White American majority culture is distinctly different from other cultures that use drugs. In American majority culture, drugs are not sanctioned and in many cases, use is illegal. Whereas, most other cultures infuse drug use with religious meaning. Drugs, in these cultures, are sanctioned for religious and ceremonial purposes.

Thus, when drugs are used for other than religious reasons, there is likely a confusion of values surrounding their use that occurs in societies where traditionally, they had a sanctioned place. This may very well be the case for many American Indian cultures. Since adolescence is a physiological and psychological transition period, the loss of "rites of passage" traditions in Indian communities, may leave a void for adolescents that drugs, including alcohol, can easily fill. Yet, the use of drugs and alcohol do not aid adolescents in making the transitions from childhood to adulthood effectively. The effect of substance abuse leaves many adolescents in both majority and Indian cultures wandering in a protracted period of youth without a well-defined role or purpose within the family or community.

The Adult's Role - Attneave indicates that the "parental" role of biological parents is often relieved by grandparents. If grandparents are not available, aunts, uncles and other adult relatives are frequently called upon to share the responsibility. Young adults are expected to bear the burden of the family's economic welfare.

Traditional roles and responsibilities within the American Indian family fall along gender specific lines. However, according to a review of the literature by LaFromboise, Heyle, and Ozer, Indian women in many tribes had more flexibility in assuming gender-related roles and responsibilities within the tribe and family. In some tribes, women could function in a male gender role and be both accepted and respected by the tribe. In many cases, women who functioned in a male gender role could not marry a man because she did not perform the functions of the female role in tribe. Yet, women who took on these cross-gender roles often had considerable power and standing because their families tended to be economically better off. Even if an Indian woman did not assume a cross-gender role, many tribes are matriarchal in character and women traditionally had a more equitable standing and source of power within the tribe and family than they do today.

As social and economic change has occurred, it is the observation of Attneave and Ho that American Indian women have fared better in adapting to those changes. This could be related to the economic niches in which women were more easily accepted, such as service-oriented jobs, nursing, domestic help, and their previous traditional gender-specific roles in their families and cultures. Yet, as LaFromboise and colleagues relate:

"With men's increased participation in off-reservation employment, there was a shift toward independent families. Some families moved to the out-skirts of the reservation or to border towns. Women became more dependent on their husbands--characterized by Hamamsy (1957) as often erratic and irresponsible providers--for cash income. Men, however, began to claim that their wage labor earnings belonged to them and not to the family group. Complementary roles disintegrated. Women's troubles were compounded by the erosion of the extended family network because they no longer had extensive family help in raising their children."

INSTITUTIONS AFFECTING THE HEALTH AND WELL-BEING OF ADOLESCENTS:

The destruction of Indian culture and tradition was national policy in the U.S. well into the 1950s. The BIA and other agencies of the government proscribed a number of religious and cultural practices (letter from the Commissioner of Indian Affairs, Department of Interior 2/24/23). Indian children were often sent to boarding schools, White religious institutions, foster care, or adoption agencies in an effort to promote the Indian's acculturation into White society. The Dawes Act of 1887 created economic situations that forced Indian men and women into new occupational skill areas and expectations which had a particularly devastating impact on the Indian male identity. The removal of elders and parents to Tuberculosis (TB) sanitariums for treatment from the 1930s into the 1950s also added to the disintegration of the traditional Indian family roles because of the prolonged absence of family members.

Then, as unemployment on the reservation became a problem after World War II, the BIA instituted a program of relocating heads of households to urban areas through their direct employment program. All of these policies had the clear intent of "acculturating" Indians into the dominant culture, economy and value system, and had a negative impact on the self-esteem of Indian people.

LaFromboise, Heyle, and Ozer discuss the findings of several studies conducted in the 1970's and early 1980's that attest to the psychological trauma and adjustment problems caused by experiences within boarding schools. Studies confirmed that many boarding schools were extremely regimented and girls were given less classroom instruction than Indian boys. In some circumstances, Indian girls' education was relegated to domestic labor for the school and for community homes and businesses.

According to Attneave, it was not uncommon in the early 1950's, to encounter parents who had never experienced family life after early school age. The school-taught models of family life were Victorian and inflexible. Though many Indians raised in the boarding school environment tried to follow the nuclear family model (perfect in every way), the majority culture is now finding itself in need of evolving a more tolerant view of family life. Some of the disintegration of the traditional Indian family has been offset with the reversal of some of the most damaging Federal policies, and with the availability of a growing number of activities that are helping Indian families reconstitute traditional and informal community networks, develop parenting education, and form support groups. Perhaps, as Attneave puts it, "the Indian traditional family will become a more viable alternative," in the future as the majority culture wrestles with the need for greater tolerance of diversity in family life and values.

Institutions have increasingly intervened in the family system as not only providers of financial and medical assistance, but caretakers of children in an attempt to fulfill some of the functions of parents. When individuals and families suffer crises that threaten their health and well-being, formal and informal social support networks within the community have shared the burden of responding.

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A G E N D A
IHS ROUNDTABLE CONFERENCE ON
INDIAN ADOLESCENT HEALTH IN THE CONTEXT OF FAMILY

NOVEMBER 6 - 7, 1991

Wednesday, November 6, 1991:

- 9:00 Opening Remarks
Luana Reyes, IHS Associate Director, OPEL
- 9:15 Introductions
Leo Nolan, OPEL
- 9:30 Consensus Process
JoAnn Kauffman, Kauffman and Associates, Inc. (KAI) Consultant
- 10:00 Adolescent Health Issues
- 10:15 Overview of Adolescent Health Status
Dr. Jerry Lyle
- 10:45 Homicides/Suicides/Accidents
Dr. Steve Helgerson
- 11:15 Break
- 11:30 Mental Health
Mr. Ken Hunt and Ms. Betsy Yazzie
- 12:00 Lunch
- 1:00 Reconvene and review progress with agenda
- 1:30 Sexuality and Pregnancy
Dr. Toomey and Dr. Chase
- 2:00 Substance Abuse
Ms. Sandy Sukforth and Mr. Verzola
- 2:30 School-Based Issues
Mr. Gray and Mr. Wetzel
- 3:00 Break
- 3:30 Discussion of any added Adolescent Health Issues
Ms. Valerie Montoya and Ms. Donna Leno
- 4:30 Adjourn for the day

Thursday, November 7, 1991:

- 9:00 Reconvene with Announcements and Progress with Agenda
- 9:15 Discussion of Adolescent Health in the Context of Family
Ms. Cynthia LaCounte and Ms. Agdameg
- 9:45 Development of "Consensus Statements"
- 1:00 Adjourn Roundtable Conference

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