# IV

# MENTAL HEALTH CARE IN A GENERAL HEALTH CARE SYSTEM

## The Problem

Chapter Seventeen of the Institute of Medicine's recent publication (Hamburg et. al., 1982) recommends that mental health care be increasingly integrated into the roles of primary care practitioners. This orientation is a product of 1) the perceived need to reduce the cost of delivering mental health care, 2) the increasing reliance on the biomedical model as an explanatory device in diagnosis and treatment of mental problems, leading to the dramatic increase in drug therapies, 3) the rapid deinstitutionalization of mental health services that began in the middle of 1950's (Bassuk and Gerson, 1978, [1] and 4) the search for a more effective way of diagnosing and treating the mentally troubled.

We have seen that the Puyallup Tribal Health Authority has historically treated mental illness both within its primary care clinical facility, the Indian Community Clinic, and within its more basic mental health institutions: Kwawachee, Substance Abuse, Children's Services, etc. Thus, the Puyallup Tribal Health Authority is an existing example of both the treatment of mental health within a primary care clinical facility, and the coordination of more basic mental health services with this primary care clinic. The pattern of growth of the latter specialized intervention programs has been concomitant with the development of the primary care institution. Coordination of primary care with specialty interventions has been an explicit goal of the Health Authority.

Thus, an understanding of the evolution of mental health care within the Puyallup Tribe provides us with an insightful case example of the positive and negative aspects of integrating the Institute of Medicine's recommendations within American Indian and Alaska Native communities. Let us now consider the implications of the Puyallup experience for integrating the Institute of Medicine's recommendations within American Indian and Alaska Native communities through an analysis and critique of the Institute of Medicine's suggestions based on the Puyallup experience.

## Mental Health Care within a Primary Health Care Clinical Facility

Several problems have made it very difficult to effectively treat emotional disorders within the primary care clinic. *First*, the two physicians are extremely overloaded with patients; thus, finding enough time to go beyond basic treatment of expressed symptoms is made very difficult. The crowded conditions caused by the heavy flow of patients through the small rooms in the clinic exacerbates this problem by forcing physician-patient

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communications concerning personal and family problems to occur in a context not conducive to informal dialogue.

*Second*, the biomedical training of the general practitioners who have worked in the clinic often leads to the treatment of symptoms of emotional distress rather than the treatment of the psychological and social causes of individual dysfunction. Few primary care practitioners receive little more than an introductory exposure to psychiatry, and even this exposure emphasizes biomedical interventions rather than alternative forms of nondrug healing. The medical model focuses the practitioners on definable symptoms of specific organs rather than the identification of individual emotional distress resulting from given sociocultural stresses (Kleinman, 1980). Training programs designed to help primary care practitioners to understand the causes of emotional dysfunction in American Indian and Alaska Native communities might indeed help the physician identify a larger percentage of patients with mental problems as the Institute of Medicine suggests. The probable decrease in return visits to the primary care facility made possible by appropriate therapeutic interventions (Goldberg, 1980; Tessler et. al., 1976) would have a positive effect on the primary care practitioner's patient load. However, without increased staffing the likelihood that practitioners could find the time and energy to expand their involvement with the client beyond the biomedical-clinical model is small indeed.

*Third*, patients often present primary care practitioners with bodily complaints which are symptomatic of more basic emotional distress without verbally expressing to the physician the larger problem or the context in which this problem is occurring (National Institute of Mental Health, 1983). Marsha Ostruske, the past Director of the Puyallup Tribal Mental Health Program, notes that depression, the precursor of suicide, is often masked by somatic complaints such as headaches, stomach problems, colds and back pain.[2] She notes that it is culturally more acceptable for American Indians and Alaska Natives to seek help from the Indian Community Clinic for nonspecific symptomatic illnesses than to seek help from the Kwawachee Counseling Center.[3] Busy doctors, practitioners, and nurses poorly trained in looking beyond these symptoms to the cause of the somatic complaints usually treat only the symptoms even when time permits them to do otherwise. With more training medical clinicians could refer these patients more often for mental health counseling for early intervention, a time when the problem is not so difficult to work through.

The research given in Chapter III confirms the absence of direct psychiatric complaints among a subset of the clinic's population. Extremely few heads of households reported emotional illnesses in their families even though two of the three interviewers were themselves Puyallup. Somatic complaints like those given above were frequently encountered. The somatic nature of the typical patient complaint is supported by the nature of many of the top 30 leading causes for contacting the Puyallup Indian Community Clinic (see Table 1). Individuals in the greater Tacoma

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American Indian and Alaska Native population frequently present musculoskeletal disorders, abdominal pain, and several symptoms related to colds. The only category related to emotional distress which is "overtly presented" to the clinic is alcohol abuse. Ostruske notes that it is culturally more acceptable to be treated for alcoholism either as an inpatient or as outpatient in the Puyallup community than among the society at large. Further, it is more acceptable to be treated for alcoholism than for mental distress within the Puyallup community. However, alcohol problems were seldom reported in the study described in Chapter III. This was most likely due to the stigma that, nevertheless, is attached to the disorder.

Marsha Ostruske also noted that depression in children is seldom recognized by primary health care providers. Children, like adults, often present a somatic complaint without any indication of the underlying mental disorder. Because the American Indian and Alaska Native families are in such trouble in the greater Tacoma area, many children have nonexistent or intermittent male role models. As a consequence, many of the children of this generation face a diverse set of potentially abusive situations precipitating Tribal interventions by the Children's Services Program or State Social Services.

The family situation is caused in part by the economic hardship in following in the traditional male economic role: fishing-hunting, the male occupation common to many of the families that live in the greater Tacoma area. This role is marginal for those who possess local fishing rights and nonexistent for relocated individuals. For much of the year fishermen await the fish runs and many become quite depressed and concerned about income during the off seasons. Even the onset of subsistence activity brings fewer economic rewards than are necessary to maintain a stable economic situation. The low educational attainments and value orientations of American Indian and Alaskan Native men also result in limited job success in non-traditional employment. Men must compete with other urban ethnic men for the existing low-skilled or semi-skilled jobs when their value systems are not based on competition and do not support the enterprises involved. In this context, a Pierce County Public Health employee, a black woman, commented to Rod Smith, the Executive Director of the Health Authority, the following:

> You Puyallup got it hard out there. Our struggle was easy. We knew just what we wanted. We wanted what The Man had. But those Indians--they're different--they just don't necessarily want what The Man got.

Further, it is not uncommon for today's parents to have been raised by parents who have been educated in boarding schools or who have been placed in foster homes, many of non-Indian or non-Alaska Native heritage. Also, the observational and trial-and-error learning styles, and the informal-display oriented teaching styles integral to tribal-nonliterate cultures con-

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trast sharply with their formal-verbally oriented counterparts in high technology societies (Guilmet, 1981, 1979a, 1979b, 1978 and 1975). Thus, some parents have not learned the parenting skills necessary to teach their children to survive and thrive in this unique urban Reservation environment.

*Fourth*, most primary care practitioners who have worked for the Tribe lack the specialized training to identify the cultural nature of emotional dysfunction in American Indian and Alaska Native communities. General practitioners receive little or no exposure to the growing field of cross-cultural psychiatry. The idea that differential beliefs and experiences result in culturally shaped syndromes is foreign to the biomedical world view of most Western practitioners. The mental health disorders in the Tribal community are different from the mainstream. For example, there is an unusually high level of grief work to be done on the Puyallup Reservation. The extremely high death rate due to accidents, a high infant mortality rate, etc., constantly faces members of the community with the death, often unexpected, of a friend or relative. These tragedies are made more severe by the changes in grieving patterns due to acculturation. Marsha Ostruske notes that while American Indian and Alaska Native tribes were not homogeneous, many traditionally practiced open and overt grieving. This is more typical of the female role than for males. She believes that many are now emulating the dominant society's death denying, an inadequate way of dealing with grief by becoming stoic and not crying, as this may be construed as a sign of weakness. She reported significant increases in contacts to the Kwawachee Counseling Center following the loss of several Puyallup families' children in a house fire and the loss of three Puyallup fishermen in a subsistence accident.

Also involved in the trauma due to a high death rate is the persisting traditional Puget Sound area Indian belief that the spirits of the dead linger near friends and family to take their loved ones across with them so the spirit of the dead will not be lonely. People report the uneasy feeling of the presence of their dead relatives, sometimes in physically observable forms such as owls. They at times express the need for a traditional-spiritual cleansing ceremony to assist the dead on their way.

*Finally*, the opportunity for primary care practitioners to begin to understand the cultural and socioeconomic context of emotional distress among their patients is severely inhibited by the extremely high turnover rate of physicians at the Tribal Clinic noted earlier. The effects of this pattern on the provision of mental health care by primary care practitioners is dramatic. By the time individuals begin to build up enough trust in a doctor to share their emotional troubles, the practitioner has moved to a higher paying job. Lower level positions in the clinic such as secretaries, Community Health Representatives, and maintenance workers, also turn over quickly because the pay is so low. Sometimes fishermen will fill the lowest paying jobs in the off-seasons and quit during fish runs. The turnover of low-level positions can be useful *at times* because of the increased contacts and feedback to the community which results. Midlevel-Tribal-community

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paraprofessionals usually provide the continuity of care which the other two provision levels lack.

## Coordination of Primary Care with Basic Mental Health Services

Clients enter the specialized mental health services of the Puyallup Tribal Health Authority in at least five ways: 1) referral from the two primary care physicians in the Indian Community Clinic; 2) referral from the Tribal School; 3) self, family or peer group referral directly from the Tribal community; 4) referral from the Tribal Court; and 5) referral from outside institutions, such as private hospitals, the Washington State Department of Social and Health Services, Western State Hospital (a State mental hospital), Community Mental Health Centers, Remann Hall (the County juvenile detention facility), and various outside courts and jail systems. Thus, referrals from the Indian Community Clinic account for only a small percentage of the clients seen in the various basic mental health facilities. However, clients being seen in specialized services are frequently referred to the Indian Community Clinic for back-up medical care by representatives of the specialized units. The clinic physicians are responsible for the administration of medications; only the part-time psychiatrist with the Kwawachee Counseling Center shares this responsibility within the Tribal system. However, the pharmacy does honor outside prescriptions from non-Health Authority physicians.

The Indian Community Clinic physicians also have the potential option of referring their patients for specialized mental health care to private and public treatment facilities outside the Tribal system. Two difficulties make this option less than ideal. First, many individuals in the Tribal community prefer the more culturally sensitive care which is available within the Puyallup Tribal Health Authority. Second, and much more problematic, funds to pay for such referrals are only available from the Contract Health Services Program of the Indian Health Service or from Public Assistance. However, Contract Care has been severely cut back in recent years. In *all* cases, patients must seek the aid of Public Assistance to pay for referrals before Contract Care support is possible. For the last several years Contract Care dollars have been in "Priority One" which means that Contract Care is only available for life threatening conditions. Further, either patients or providers must apply through proper channels within 24 hours of care or 72 hours on weekends. To further exacerbate the situation the system calls for "prior authorization" for service, a difficult requirement for emotional disorders. As a consequence few seek outside mental health care or follow-up on Tribal referrals. Those who do must generally offer to pay for the care themselves or they are billed repeatedly after the fact.

Indeed, one of the most severe problems facing the entire Puyallup comprehensive mental health system is the shortage of funds to support desperately needed services. The Indian Community Clinic has been attempting to acquire the funding for another physician for the past several

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years. At least one medical social worker is needed who is culturally sensitive to the Tribal community to screen primary care patients and guide them to appropriate facilities inside or outside of the Tribal system. As but one example, this person could improve the coordination between the Indian Community Clinic and the Kwawachee Counseling Center concerning the prescription of medications. Usually, Kwawachee clients' medications are monitored by the part-time psychiatrist or clinic pharmacist. Ideally, any of those patients also medicated by clinic physicians should be tracked through referral to mental health. This coordination process needs to be improved to avoid conflicting interventions. Perhaps an improved tracking system by computer could reduce conflicting treatments and ease the burden of preparing two different sets of reports to two separate funding sources (National Institute of Mental Health and Indian Health Service).

The physical facilities of the Puyallup Tribal Health Authority also need improvement. A proposal to rebuild and consolidate the crowded and in much need of repair health facilities barely failed to pass Congress in 1984. The proposal was approved by the House and defeated by Senate. It is currently number six on the national priority list of the Indian Health Service for the construction of Indian Health Service facilities. The Kwawachee Counseling Center staff is so minimal that when a crisis arises scheduled clients often are necessarily neglected. The outreach treatment program whereby clients are seen in their place of residence further compounds the problem by taking counselors away from the office. Many clients have no telephone or transportation, requiring periodic home visits. Also, more funds are needed to expand the involvement of the part-time psychiatrist.

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The Bureau of Indian Affairs funded Children's Services Program needs at least one more social worker and two more field workers to handle their twenty-four hour crisis program for abused and neglected children. One Caseworker position has just been lost due to exhausted funding. And, the nationally recognized Tribal Alcoholism Treatment Center has a typical waiting list of about forty individuals. The outpatient section of this facility is perhaps the most severely understaffed unit in the Health Authority. One Indian Health Service supported counselor handles the entire Pierce County Indian population. Another situation which interferes with the coordination of primary care interventions with basic mental health services results from the fact that different Health Authority programs are funded by overlapping funding agencies with sometimes conflicting criteria for providing patient care. The task force on Mental Health for the President's Commissions on Mental Health (1978) stated that the service delivery systems offered to American Indians and Alaska Natives are fragmented and have little or no coordination on the local and federal levels.

For example, the Health Authority's Substance Abuse Treatment Center is funded by five different contracts, requiring several different sets of Washington State licensure, and a total of five different sets of client report forms for each individual client episode. The Alcohol Tracking and

Guidance System utilized by Indian Health Service, alone, involves 14 pages of report forms in addition to reports required by Pierce County, Washington State, Washington State Alcoholism Monitoring Systems, Washington Information System for Drug Units Management, and two different kinds of reporting on inpatient days. Unfortunately, the Treatment Center also must report monthly summaries of services to the Health Authority.

The above situation is further complicated by the short-term nature of most Health Authority funding sources. The Indian Health Service is one of the few federal agencies which is concerned with the continuity of care. They provide future funding based on past service records, unmet needs, and past funding levels. Compare this approach to that of the Bureau of Indian Affairs in Indian Child Welfare matters. There exists a limited amount of funding distributed through a competitive-exclusionary annual proposal process which leaves some tribes unfunded and all unsure of continuity in funding each year. This competitive atmosphere increases unhealthy competition between Tribes by inhibiting the exchange of useful and pertinent information, program models, and treatment strategies. During the last four funding cycles the level of Puyallup Child Welfare funding has fluctuated from $28,000 to $7,000 to $l40,000. This has occurred without regard to the fact that the Health Authority has been delegated legal responsibility for the care, support, and supervision of the fifty or more American Indian and Alaska Native children and their families per month, whose cases are the direct responsibility of Children's Services. Each shift in funding level forces the American Indian or Alaskan Native extended family members to cope with different State or Tribal agencies to reunite their families. Drastic differences in cultural sensitivity are represented by these two different agencies. Lack of funding does not decrease the Tribe's legal responsibilities from the perspective of outside courts and social service agencies for those already in care. However, it drastically inhibits the Health Authority's capacity to accept new cases and to adequately tend existing cases.

A further complication is the stratigraphic nature of "minority sensitive" funding sources. The Kwawachee Counseling Center is funded by the National Institute of Mental Health through a hierarchical network including the Washington State Department of Social and Health Services, Pierce County Social Services, a private provider (Good Samaritan Hospital-Mental Health Unit), and finally, subcontracted to the Puyallup Tribal Health Authority. Note that each administrative level consumes health care dollars appropriated for service delivery. The Indian Health Service, the agency generally expected to provide this service, is not involved in this process. The entire Puget Sound Service Unit of the Indian Health Service provided mental health care to only 78 individuals in 1984 (there are ten Tribes in the Service Unit) while Kwawachee provided care to 278 individuals. The Indian Health Service does not even record the mental health delivery of the Puyallup Tribe. How could they be exercising their

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responsibility in this area given this situation? Research should be conducted to determine the extent of this back to back service delivery and the waste of direct service dollars in this structural hierarchy of administrative responsibility on a national level.

The annual allocation of National Institute of Mental Health money to the Health Authority has been eroding at the same time national statistics demonstrate that such sociogenic illnesses as suicide, alcoholism, and family dissolutions are on the rise. Should not the Indian Health Service explore the possibilities of increased funding and coordination of mental health programs given their respectable record in effectively treating various "biomedically-based diseases?"

Research should be conducted to define the extent to which the mental health of individuals is being sacrificed through the short-sighted, bureaucratic boundary maintenance strategies of differing administrative units. How can primary care holism be achieved in a fragmented bureaucratic funding jungle? Further, it is probable that alienation and frustration in the face of several bureaucracies further depletes the coping abilities of individuals already in stress. Another area of research concerns the impacts of changes in federal eligibility criteria for mental health care on the already troubled American Indian and Alaskan Native family unit. For example, appropriations language for Indian Health Service funding severely limited the ability of Indian Health Service support facilities to provide any form of care to "non-Indian" family members. How can any treatment facility expect to effectively support a family in trouble if one or more members are excluded by administrative law from the same facilities and practitioners seen by other members of the household?

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Puyallup Tribal Health Authority family counseling, by funding necessity and the Privacy Act, must occur in at least four physically separate locations-programs, each of which must severely limit the sharing of information: the Indian Community Clinic (direct medical care), Children's Services (crises intervention and foster care), the Substance Abuse Treatment Center (crisis intervention, alcohol, and drug therapy), and the Kwawachee Counseling Center (crises intervention and mental health therapy). Research might be conducted to measure the efficacy and cost effectiveness of a coordinated family support service, defined as one agency, with various licenses and licensed specialists to support cooperatively (under accepted, but shared Privacy Act provisions) individuals and/or families experiencing stress. Also, included in the same support service might be nutritional services, elders support, dental care (including orthodontics), community health outreach, and educational programming.

Could a system be cost-effective and functionally successful in which each client was counseled and triaged through a central admissions point which would refer to available, coordinated and centrally-funded services with reasonable reporting requirements? Further, to what extent would this holistic-comprehensive approach provide an enhanced context in which to incorporate culturally sensitive, natural community helpers and

traditional practitioners in mental health treatment? Research might be conducted to determine the potential of more effective referral to Tribal facilities which should occur due to the involvement of the latter community helpers and healers. Another important question is the effect of such a coordinated-comprehensive approach on the stigma attached to help seeking behavior and client avoidance behavior in general. To what extent does physical isolation of service delivery affect stigma and avoidance behavior?

## Conclusions

The Institute of Medicine's proposal to conduct research on the increased role of the primary care sector in the provision of mental health care is only partially supported by the Puyallup experience. Any augmentation of existing support for the established clinic physicians would be welcome since it would undoubtedly improve patient care. However, this affirmation of the Institute's plan can not be used to justify a decrease in financial and philosophical support for the broader set of coordinated interventions that compose the Puyallup Tribal mental health system. The history of the development of the Puyallup Tribal Health Authority records the recognition of the need for an integrated web of health services in the broadest sense to begin to build a holistic support system for a people whose cultures were fragmented by explicit government policies of assimilation. The mental health of a people who have been forced to face rapid and radical social change will not approach that of the mainstream until all sectors of their culture (occupational, familial, spiritual, educational, and more) are reintegrated. The reestablishment of holism at this level is far too enormous a task to be placed upon two overworked primary care physicians. Indeed, it is too much of a task to be left to any health system as normally defined. All social services (education, job training, family counseling and intervention, substance-abuse therapy, etc.) must be augmented to help primary health care practitioners in their tasks.

The Puyallup experience strongly supports The Institute of Medicine's call for research on the possibilities of enhanced coordination of primary care practitioners with other basic mental health treatment programs. However, their proposal needs to focus on issues more typical of the American Indian and Alaska Native experience: mental health care fragmented by short-term, short-sighted, overlapping, and sometimes contradictory bureaucratic support systems which unnecessarily consume in administrative costs health care dollars meant for direct service delivery.

The undue reliance upon primary care physicians to treat emotional disorder would retard the process of self- determination in health care that has begun to reduce the dependency of the Puyallup community on outside providers. Far too few American Indian or Alaska Native physicians exist to meet tribal needs nationwide, and exceedingly few physicians of any background commit their time or energy to tribal people on a consistent and ongoing basis. Continuity in care is primarily provided by mid-level

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paraprofessionals who are part of their respective communities. Increased financial, educational and institutional support for these individuals would perhaps lead to greater improvement in mental health care delivery than corresponding energy and dollars invested in physician training.

Enhanced support to community paraprofessionals would undoubtedly lead to greater community involvement in the existing mental health care system and the concomitant reintegration of traditional values, beliefs and practices into mental health delivery.

Increased integration of traditional perspectives, in culturally specific and in modified pan-Indian and Alaskan Native forms, can only build, especially in the young, a pride in themselves that becomes the psychological foundation for adult mental health. This relationship between spiritual rebirth and mental health was noted in 1979 by Tim Byers, M.D., the first physician with the Indian Community Clinic on the Puyallup Reservation:

> Probably the most important positive health factor development has been a rebirth of pride and spiritualism. In 1976, when the Tribe decided to reinstate the "First Fish Ceremony" after 100 years of ignoring the once-important rite, there were no living Tribal members who knew how it was done. Joe Washington, an elder Lummi medicine man, knew of the ceremony and taught it to the Tribe. Now the "First Fish," a special spirit, is returned to the river each year, to the salmon run, to increase a thousand-fold. Two years ago, Joe Washington suffered a major stroke. Near death, he recalls that he had one foot in heaven (the non-paralyzed side) and one foot on Earth (the paralyzed side). At that point, he decided to return to Earth to teach his people what he knows. Now, fully recovered, he is talking to the young about the spiritual realities that he has experienced. The embers of a dying people have not been extinguished (1979, p. 27).

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