I

INTRODUCTION

The ideas underlying this monograph began almost a decade ago while I was Area Psychiatrist for the Billings Area of the U.S. Indian Health Service. Although I had recently come from a university faculty, in my new position I found my skills and intellect strongly challenged by two supervisors who demanded new areas of competence from me. In the academic world, many aspects of mental health services are taken for granted. Assumptions from the academic mental health perspective, such as the unquestioned validity of "personal growth" as a goal for mental health services in the face of scarce resources, or the usefulness of elaborate rehabilitation programs for the chronically mentally ill, were now open to question in my new job. The questioning of established models for mental health service delivery began the development of the model for planning mental health services presented in this monograph.

The driving force behind my beginning to question habits of the established American mental health system was Robert LaFromboise, former Chairman of the Blackfeet Tribe, and at that time my overall supervisor in his role as Assistant Area Director for Health Care Programs for the Billings Area. Mr. Lafromboise was not a health professional by training. His graduate degree was in botany. I also learned that English was his second or third language. He had grown up speaking Blackfeet and Cree, and did not learn English until he was seven years old. I quickly learned that in addition to his linguistic skills (he could speak or at least understand all the Indian languages spoken in Montana by the time I knew him), he was a master of health systems design.

Soon after my arrival in the Billings Area, he called me into his office and began to make me teach him about psychiatry and mental health. His requests for information were relentless, and included subjects as diverse as basic neurophysiology, medical causes of psychiatric illness, psychotherapy, and case management. I learned that he was similarly curious about the other health care areas under his supervision, including laboratory, audiology, dentistry, nutrition and others. At some point, perhaps eight months after we had begun our discussions, the conversations moved from Mr. Lafromboise simply gathering information, to his beginning to question the internal logic of my ideas about service delivery and mental health program design. In applying his knowledge of public health, he demanded that the programs I was putting into place be logical and able to be justified as an expenditure of the scarce funding for Indian health programs. It was this relentless questioning from Robert Lafromboise that first forced me to consider mental health as a field of public

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health rather than as "community psychiatry" or "outpatient psychotherapy" as I has been taught in my psychiatric training. Although he passed away several years ago, Mr. LaFromboise's thinking continues to influence my views of mental health service delivery and the relationship of mental health to the overall health of the population. The logic of this monograph first began to develop in my conversations with him almost 10 years ago.

At the same time as Mr. Lafromboise was questioning the logic of mental health service system design for Indian people, my other supervisor, Margene Tower, Billings Area Mental Health Branch Chief, required that I apply a separate set of skills to my job. Out of her concern for the Indian people of the Billings Area and the mental health problems that shortened their lives and caused them disability, she required that I set up programs and provide training to field mental health staff in the most scientific way possible. She was dedicated to the idea that the Indian people of the Billings Area should have access to mental health services based upon the research literature and the most current mental health service delivery models. As a result of her supervision, I had to constantly review the technical mental health literature for new treatment methods and program design ideas. My job was to adapt these new findings and ideas to Indian mental health, to teach the field staff about these ideas and treatment methods, and to translate the ideas into direct patient care and quality assurance programs. At the same time that Mr. Lafromboise made me examine the assumptions guiding development of mental health programs, Ms. Tower forced me to search for new ideas that would fit her requirements for effective services.

Although the fiscal climate of the early 1980s was grim for Indian health programs, it was a fertile time for the development of new ideas in Indian mental health. Researchers in Indian mental health such as Spero Manson, Jim Shore, and Joe Bloom were conducting critical research and publishing theoretical work in Indian mental health. Their generosity in providing advice and consultation allowed me to do my best in meeting Mr. Lafromboise's and Ms. Tower's requirements. Several years later, I was able to contract with several of these academic experts to help develop programs for the Billings Area. Their ideas are also found throughout this monograph.

The next steps in the development of the model presented in this monograph came with the new Area Director for the Billings Area, James Danielson. He added a new set of expectations to my performance, believing that as Area Psychiatrist I should have a practical working knowledge of organizational psychiatry and administration. As a part of the reorganization of the Billings Area Office, I was made Director of Clinical Services, a job that took me out of direct provision of mental health services for several years, but allowed me to develop a number of new mental health-related programs, such as a program to treat employees with mental health problems. Under Mr. Danielson's supervision, I began to understand the difficulties of weighing diverse health care priorities against each other,

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and the value of open, logical program administration. He was, for example, the first administrator I had known who had a completely open budget allocation process, in which programs competed for funds based upon presentations to a committee about the need for a proposed program and its projected impact upon the health of the Indian people of the Billings Area. He was generous in providing training and outside consultation for me, and I began for the first time to understand the financing of health care, and where mental health could and should fit into the overall scheme of health care services for Indian people. By example, he also demonstrated great leadership in making ethical decisions, at the risk of his own popularity and political support. Many of the ideas for open public hearings for prioritizing mental health care discussed in this model come from Mr. Danielson's ideas and style.

In 1985 I became Mental Health Branch Chief for the Portland Area of the Indian Health Service. In this new job I was delighted to find people with Mr. Lafromboise's style and intellect. Several Indian leaders in the Pacific Northwest had deep commitments to the welfare of their people and a concern about their mental health. Even though few had backgrounds in mental health, I found that the Indian leaders were eager to learn more about mental health. While several of these Indian leaders had backgrounds in human services, the majority came from backgrounds as diverse as fisheries biology and teaching; one woman even was the captain of a tuna boat. From such diverse backgrounds, I nevertheless found these leaders had a good grasp of health systems design and demanded that the health programs for their people be logical and effective. With these bright and concerned leaders, I found that the same arguments developed in my talks with Mr. Lafromboise were needed in order to justify mental health services. At the same time, these Indian leaders shared the same concern for the quality of services that Ms. Tower had voiced and the courage to place the quality of services above political considerations shared by Mr. Danielson.

As I traveled to the tribes in the Northwest, another stimulus for the development of the model was emerging. I found that even though there was great support for mental health programs by Indian leaders, by remaining static at a time of double digit inflation in health care expenses, funding for Indian mental health programs was declining on a national level. (Because of the emphasis on substance abuse programs within Indian Health Service, mental health programs were being further depleted of resources by the moving of qualified therapists and other staff out of mental health-related programs into alcoholism treatment programs, even though these programs had never been proven to be effective.) The writing that became a part of this monograph began at the prompting of some of the Indian leaders in the Pacific Northwest, as a tool for justifying mental health programs against the tide of fashion in Indian health care and the national emphasis on substance abuse by the Reagan administration.

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The final push for the development of this monograph came from several sources. Spero Manson, Director of the National Center for American Indian and Alaska Native Mental Health research, had seen early versions of the monograph and provided the stimulus and resources to develop it into its final form. Several American Indian psychiatrists reviewed parts of the monograph in the early stages of development and provided helpful comments.

Having developed from such a diverse set of influences, this monograph is not intended to be a purely academic document. It is intended to serve several purposes under the overall requirement that it explore the logic of the development and operation of mental health programs for Indian people. Its goal will be achieved if it presents a set of logical guidelines for justifying Indian mental health programs and a set of considerations in the design and implementation of these programs. No specific formula for services, such as a static per capita staffing formula is presented in the monograph. As is discussed at length later in the monograph, each tribe may have unique needs for a specific type of mental health program, based upon tribal differences in psychiatric epidemiology, cultural beliefs, geographic factors, and the size of the groups of people being served. In spite of these individual factors, this monograph proposes that there is a logic to the design and development of Indian mental health programs that will allow the money spent on these programs to save the maximum number of lives and to provide the greatest reduction in disability for the people being served.

In exploring the logic of the development of Indian mental health programs, I have several audiences in mind. If the monograph can inform Indian leaders who have the responsibility for the welfare of their people, my greatest wish for its use will have been met. I know that there are many other Indian leaders on the national, regional, and local levels (both in and out of the federal government) with the logic and dedication of Robert Lafromboise, who would like to know more about mental health programs for Indian people and demand that these programs be logical and effective. I present the model developed in this monograph both as a general guide to organizing these services, and for weighing the need for mental health services against the other legitimate demands upon health care resources available to Indian people. If these Indian leaders will consider the arguments presented in this light, a major goal of the monograph will have been met.

A second goal of the monograph is to stimulate my colleagues in various roles in the Indian mental health system. I hope that the monograph will provide a stimulus for clinicians in the field, for whom I always have the greatest respect, to examine their methods of practice, their priorities, and their assumptions about mental health service delivery for Indian people. Having been in the field as a clinician, I know that it is easy to fall into habits of practice and to feel as though one is not growing as a clinician. I hope that the monograph, particularly with its list of suggested readings, will help

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field clinicians to find new models of treatment and service delivery about which they can get excited.

Similarly, for my colleagues in academic settings, I hope that the monograph will stimulate interest in the topic of Indian mental health service delivery, whether it be in further developments of the model presented here, or an urge to refute it with gusto. From whatever point of view, entry into the dialogue about Indian mental health service delivery by the academic community can only enrich that system in the long run.

For administrators and managers of Indian health and mental health systems, I hope that the model presented here will provide a way of fairly prioritizing and developing mental health services for Indians. I propose that when weighed against other health care priorities for Indian groups, mental health programs should be among the highest priority for Indian health expenditures. This conclusion can be reached by considering the morbidity and mortality caused by mental illness among Indian people, and the relative cost-effectiveness of the mental health services discussed in this monograph. These mental health services are, for example, much less costly than the treatment of many medical and surgical illnesses, and much more effective than programs for the direct treatment of substance abuse and many "primary prevention" programs. If the logic of the monograph holds, I hope that other health care programs will be weighed against the standards presented here, and am confident that mental health programs will be funded at a much higher level than they currently experience.

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The Logic of Health Care Priorities

This monograph is organized around an argument for the organization and prioritization of health care services. In the simplest terms, the argument is that a health care program should receive priority according to its proven potential to help save lives and reduce disability in a cost-effective way. The first portion of the monograph includes a definition and brief discussion of major mental illnesses that are found in Indian country. Next, the monograph provides an exploration of the cost of these illnesses to Indian people in terms of death and disability. Because of the complexity of measuring of death and disability, several different ways of looking at death and disability are examined. A survey of different mental health diagnostic groupings as applied to Indian populations is a major part of this exploration, and it is particularly important as a "bridge" between general figures for death and disability and ways of attacking the causes of death and disability. Diagnosis is the key to understanding the treatment outcome research literature, and so is a tool in understanding the logical organization of service delivery. For this reason, a good deal of space in the monograph is taken up with a discussion of diagnoses.

Once an estimate of death and disability from an illness or group of illnesses in a population is obtained, the second consideration in planning

a service delivery system must be a realistic examination of the technology available to treat or to prevent the problem. In this monograph, this discussion takes several forms. I have attempted to summarize the current thinking about these problems from the non-Indian mental health literature as accurately as possible, but without distracting attention to the level of detail found in some of the technical literature. Where the Indian mental health literature deals directly with a particular problem, I have tried to make note of this work and have listed the reference in the "suggested readings." For those who are interested in pursuing a particular subject summarized in this monograph, I have tried to provide a list of readings that will allow the reader to order overall summary references from the library. The reader can then follow these summary references to find further articles in order to obtain the needed level of detail about a particular subject. I have included a list of "suggested readings" rather than a standard bibliography with the Indian leader, the health administrator, and the field clinician in mind. I apologize to my academic colleagues for this untraditional approach to references, but ask them to keep in mind the frequently heard critique from field clinicians that the usual academic bibliography provides many references which are less than useful because of their level of detail.

The third point that this monograph attempts to make is that based upon what can be surmised about the mental health problems of Indian people and the treatments available for these problems, there are logical goals for the development and structure of the mental health programs. Achievement of these program goals may be easy for some tribes, given staff and resources already on hand. Other goals may be more difficult to reach, not because they are less important, but because the people, technical skills, and financial resources are not easily available in the existing world of Indian mental health. For example, the monograph tries to make a case for starting a new, nation-wide program for the treatment of depression in adults and the creation of a system to provide children's' mental health services. In the case of the treatment of depression, all that may be needed to save the lives of perhaps hundreds of Indian people each year across the country is a coordinated detection program, and a program to educate health professionals about the detection and competent treatment of depression. The costs of such a major public health program would be very small in relation to the benefits.

On the other hand, even though competent mental health services for children would have a major impact on morbidity and mortality throughout Indian country, there are so few trained children's' clinicians currently working for Indian mental health programs, so little targeted money, and so few training opportunities for this vast and complex array of problems, that it is likely that the development of these services will be a long-term, very costly affair. These two areas of need in turn contrast with the treatment of inhalant abuse and personality disorders, which cause substantial death and disability, but are relatively untreatable given the existing resources and level of knowledge in the field. The monograph

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attempts to define the considerations that may make a particular program practical or impractical to implement on a particular reservation in order to give the planner or administrator an idea of how to prioritize specific programs.

Finally, the monograph discusses the types of resources that mental health programs can use to develop and organize the interventions needed to solve the problems identified earlier in the monograph. Generally, the resources fall into three categories: people, training, and program design. It is perhaps the "people" section of the discussion of resources that will prove most controversial to mental health professionals. I have tried to summarize for health program administrators and Indian leaders the strengths and weaknesses of the various mental health disciplines as potential tools for implementing their mental health program goals. In each Area of the Indian Health Service there is a different set of values regarding the use of each of the mental health disciplines. In one Area, for example, there are almost no social workers or clinical psychologists. The mental health staffing consists almost completely of psychiatrists and mental health technicians. In at least one other Area, there is almost no use of psychiatrists or psychologists. Instead, this Area uses social workers and mental health technicians to provide mental health services. In another Area, several tribes are strongly dedicated to the elimination of the mental health technician role, insisting upon either social workers or doctoral-level mental health professionals as the primary providers of mental health services. In most Areas, the roles of nurses and some other types of mental health professionals are overlooked almost entirely.

Given such a diversity of beliefs among the Areas about which of the mental health professions is best able to provide mental health services, it is to be expected that the sketches of the mental health professions and their value in providing services on reservations will evoke strong reactions from all quarters of the Indian mental health world. Strong reactions can also be expected from the mental health disciplines in that virtually all of the mental health professions are currently attempting to redefine their status and functions on a national level. For example, psychologists are seeking the ability to prescribe medications in some states, while social workers have moved from case work and family therapy into other forms of psychotherapy in some areas of the country. Psychiatrists often feel that they should have increased administrative roles and roles as the sole provider of care. Among psychologists, new training programs in counseling and educational psychology stress areas of competence that were previously reserved for clinical psychologists. Given the attempts of the mental health disciplines to redefine their roles, it is inevitable that many will find the monograph's summaries of the value of the different disciplines too simplistic, stereotyped, and limiting.

By way of apology to each of the mental health disciplines, I would offer that the section on these disciplines is written for administrators and

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Indian leaders, and is intended to provide a gross overview of the disciplines rather than an accounting of what a particular individual provider can do. If I have over-simplified or misrepresented any of the mental health disciplines, I urge my colleagues to set the record straight with the leaders and administrators. I will, however, defend the generalizations about the mental health disciplines on the basis of a decade of working in several Areas, for IHS and for tribes on contract, and having had long experience with people from all of the mental health disciplines as they have practiced on at least 30 reservations. Nevertheless, I admit that this section is open to criticism. I can only plead that in practice I have been strongly committed to a multi-disciplinary model of mental health care for Indian people, and have administered the programs for which I have been responsible for a commitment to all the mental health disciplines.

The "program" section of the monograph presents Indian mental health programs from a variety of perspectives. The possible designs for Indian mental health programs are discussed with an eye to treatment, prevention, and rehabilitation. All other factors being equal, it may be a matter of personal values which of these approaches holds the greatest appeal for the planner and the clinician. For example, the planner dedicated to "prevention" may reject programs which focus on the care of the chronically mentally ill, when such programs may hold great potential benefit for a reservation with a high rate of schizophrenia. Likewise, an administrator with an orientation toward "treatment" may miss the opportunity to save money and to have a major impact on the public health that could be obtained through early identification and outreach programs of the "secondary prevention" type. As with the issue of which mental health professional is the best to use for a particular program, I urge the administrator or planner to be broad minded, and to consider objectively the types of program designs that may best meet the needs of the people being served, instead of relying upon habit or fad in program design.

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The Public Health Model of Mental Health Care for Indian People

Throughout this monograph, the underlying assumption is that the optimal Indian mental health program is the program that best meets the public health needs of the population being served. If we pretend that the literature actually provides numerical figures for all of the values we need, we could create a formula that would prioritize mental health interventions on a numerical basis. This hypothetical formula is as follows:

$$\frac{E\ M\ I\ O\ G\ P}{C} = \text{Priority Rating}$$

In the formula, the values are defined as follows:

E = Epidemiology of the condition in the local population, including number of cases in the population at a particular time, number of new cases per unit time, and the average length of time a person suffers from the condition.

M = Mortality and morbidity. Mortality or death rates can be calculated on the basis of number of deaths in the afflicted population versus the general population per unit time. There are no standard ways to calculate psychiatric morbidity or disability. Some factors that enter into the consideration of psychiatric morbidity include subjective distress, loss of ability to earn a living, loss of ability to function in expected social roles, loss of ability to care for oneself, infliction of violence or distress upon others, increased risk of other problems such as substance abuse, and other factors.

I = Intervention. This factor deals with the effectiveness of the proposed intervention. In the case of prevention interventions, effectiveness can be measured by number of anticipated cases prevented from developing by the intervention, number of deaths prevented, numbers of complications prevented, or a reduction of deterioration in comparison with anticipated deterioration. In the case of treatment interventions, effectiveness can be measured by numbers of "cures" per treatment attempt (e.g., 1 out of 3), reduction of symptoms per treatment attempt, and other factors. In the case of rehabilitation programs, effectiveness can be measured by reduction of disability per intervention, improvement of function per intervention, and other factors. This item must be measured against the number of patients who would spontaneously recover or improve in the same time period.

C = Cost of the ideal intervention of a particular type in the ideal setting. This factor takes into account the optimum cost of the intervention independent of program variations. Factors included in this item include costs per unit of treatment, average number of units of treatment needed for a particular result, and rate of response to an average number of treatments. Costs of different types of response must be compared (for example, cure vs. improved function vs. prevention). Factored into this item are issues of cost reduction for the system in comparison with cost outlay. For example, caring for a depressed person as an outpatient with cognitive psychotherapy can be anticipated to be about 60% effective at six months, with between 12 and 20 sessions of therapy, and will have an anticipated reduction to the risk of premature death of the patient. The costs of treatment should be offset against the risks of costs of treatment of the same patient coming to the medical system with medical complaints, or the risk of the patient being treated on an inpatient unit for a suicide

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attempt, both of which can be calculated as a specific risk of cost to the health care system.

O = Organizational factors which may make the treatment intervention more costly or less effective than the "ideal" intervention. For example, the costs of hiring or training a mental health professional with the ability to perform the particular intervention adds to the cost of the intervention in comparison with the "ideal" intervention. This item should be considered as a fraction of the cost-effectiveness of the ideal. For example, an inexperienced therapist might be only 75% as effective in producing "cures" as the ideal, thereby reducing the cost effectiveness to 75%. If developmental costs are included in the factors that reduce cost effectiveness from the ideal, seeing larger numbers of patients will reduce costs per case so that they will be closer to the ideal. Also included in the organizational factors that reduce efficiency are the activities that prevent the mental health program or professional from delivering the treatment full time. This may include paper work for a particular condition, the time spent obtaining consultations, etc.

G = Geographic factors that reduce the effectiveness of the intervention from the ideal. In Indian country, this is a critical element. For example, if the mental health professional's caseload can be kept full because a large number of patients with the condition all come in to the office hour after hour, G would equal 1. If the therapist had to drive for half an hour each way to deliver an hour of the "ideal" treatment, G would equal 0.5. Clearly, the more dense the population with the disorder in question, the higher the G will be.

P = Psychological factors reducing the effectiveness of the intervention from the ideal. Included in this item are a lack of cultural acceptability of the intervention, and effects of stress from the intervention upon the provider. For example, if a particular intervention is so culturally unacceptable that half of the patients discontinue treatment before it can be effective, the intervention would be only half as effective as the ideal. The same factor would apply if the provider had to spend half of his or her time convincing the patient, the family, or the local government that the treatment should be used. Likewise, if the intervention is so stressful to the provider that the provider's position is vacant half of the time (for example, a mental health provider caring for no one but patients dying from AIDS, or with no one except personality disordered patients), the same reduction from the ideal cost effectiveness would apply.

This formula is entirely hypothetical in that for many of the items no universal rating system exists to produce the numbers to plug into the

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formula. For example, a uniform system for measuring psychiatric morbidity is unlikely within the near future, and it would inevitably be a highly political enterprise to try to devise one. Likewise, anticipation of the psychological barriers to the delivery of a particular treatment intervention in a particular location would be almost impossible to approach with mathematical precision. Nevertheless, in many cases reasonable estimates of the figures needed to establish the priority of a particular service are possible or can be reasonably guessed.

The purpose of presenting the formula is not to actually calculate the numerical priority scores for mental health projects, but to define a logical and objective process for prioritizing mental health services from a public health standpoint. Where figures are known, there is better justification for placing a mental health program in a particular priority status. Where figures are unknown (as is more often the case with primary prevention efforts than treatment efforts), the logic of this prioritization process should point to the conclusion that these programs must gather outcome data in order to be justified. Even if figures are imprecise, this formula can be an objective basis for discussion and comparison of programs. If, for example, a particular disorder is very rare in Indian country, it should receive low priority unless it is often fatal without treatment and treatment is easy, inexpensive, and very effective. Likewise, a very common and damaging condition with no known treatment might reasonably be given a priority lower than a rare but treatable condition.

Throughout this monograph, this priority system underlies value judgments about the importance of conditions, treatments, and program components.

<u>Use of the Monograph</u>

The primary purpose of this monograph is to present a system for organizing and prioritizing mental health services for American Indians. There are several secondary purposes. The later parts of the monograph explore program elements for mental health programs designed to serve specific populations and to solve specific problems. The overall design of specific mental health programs for particular reservations is left as a set of guidelines rather than a formula. However, one of the secondary purposes of the monograph is to provide something of a "how-to" guide to design Indian mental health programs. This secondary purpose will be met if the monograph can become a stimulus for mental health professionals, administrators, and tribal leaders to sit around a table discussing the logic of their mental health program designs. Too rarely in any health organization does this sort of strategic discussion take place.

Another secondary purpose of the monograph is to provide a source of information on possible solutions to specific mental health problems found on reservations. It is not intended to be a comprehensive review of all mental health problems found on Indian reservations. Rather,

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the intention is to provide a key to the literature as it relates to Indian mental health. If mental health professionals, technicians, or administrators use it as a reference to gather more information about how to attack a specific mental health problem, another purpose of the monograph will have been served. For example, if a clinician, having read the description of sleep apnea suspects that he or she has a patient with that disorder and can find more information on the problem through the suggested readings, another purpose of the monograph will have been met.

Although this monograph is not intended to be a comprehensive review of all mental health problems found on reservations, I hope that it will provide enough information to improve clinical practice of the mental health providers working in the field. This purpose is the result of urgings of professionals such as Henry Pretty On Top, Katherine Eder, Ralph Russell, Chris Peterson, Frank Cooper, Phyllis Old Dog (Cross), and others to publish a summary of technical information on how to care for patients with specific major mental disorders among Indian people. These professionals have, for years, complained that much of the existing Indian mental health literature did not deal sufficiently with major mental illness and clinical practice. Although this monograph is not sufficiently comprehensive to meet all the needs of these professionals, it is an attempt to begin a dialogue on the major mental illnesses and their clinical treatment on reservations. These dedicated people deal with severe mental illnesses in their practices on a daily basis, and deserve recognition and as much assistance as possible. For too long the Indian mental health literature has ignored issues of major mental illness that confront clinicians in the field in favor of discussions of social stressors and cultural disintegration. For all the serious mental health clinicians working in Indian country, this monograph is intended as a stimulus and a recognition of the problems with which you work so competently.

Finally, I hope that this monograph will support the efforts of the mental health professionals working on a national level to improve mental health programs. In the last five years, as a result of the work of administrators such as Scott Nelson, Maria Stetter, George McCoy and a number of the Mental Health Branch Chiefs such as Margene Tower, Mike Biernoff, and Betty Claymore, many major and positive changes have been made in Indian mental health programs. I am acutely aware of the problems that these dedicated professionals have experienced in defending mental health budgets against the incursions of health care fads that seem to sweep through Indian country on a regular basis. At the same time that Indian mental health budgets have been suffering, these professionals have devised an admirable set of program standards, quality assurance reviews, and training programs that have begun to deal with major mental illness in Indian country. If this monograph can in any way support their efforts to preserve, improve, and defend programs that deal with major mental illness among Indians, another of its purposes will have been served. If the same logic that is applied to mental health priorities could be applied to all health

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programs within the Indian Health Service, I am confident that mental health programs for American Indians would receive many times the support and funding which they currently receive.

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