VI

MENTAL HEALTH PROVIDERS

In order to provide the therapeutic interventions discussed in this monograph, the services of a variety of different kinds of mental health providers are needed within the health care system. In the hypothetical formula presented in the first chapter, the theoretical optimum outcome is modified by issues of the ability of the system to deliver the treatment. In large part, whether or not the treatment for a particular disorder is ideal depends upon the skill of the provider delivering the intervention. Similarly, the training and preferences of a provider for a particular group of therapeutic modalities (such as individual psychotherapy) or a particular structure of the service delivery system (such as the office-based clinic model) may determine how closely the therapeutic intervention comes to the ideal when it is put into practice on the reservation.

In many areas of the IHS there has been a tendency to hire mental health staff from a single professional discipline for service units, such as psychiatrists, social workers, or psychologists. This unfortunate trend does not provide the diverse skills needed by both the patient population and the service delivery system. As we shall see, a healthy and logical mixture of different kinds of providers lends the best support to the creation of a comprehensive mental health system. Each mental health discipline brings its own unique strengths and limitations to the treatment of patients and to applying particular treatment interventions. In planning a mental health system, staffing should be arranged to provide both a broad range of skills and technical depth.

The following descriptions are of the most common mental health disciplines, and include a discussion of the strengths and weaknesses of each in Indian mental health programs. The discussions are based upon the author's years of working with such programs, as well as some of the literature describing the training of the disciplines.

Social Workers

Unlike psychology, nursing and psychiatry social work did not arise out of the medical world; instead, it developed in the last century out of the need to provide a variety of non-medical services to the poor. The first social workers worked among immigrants and the poor in urban ghettos during the last century, attempting to alleviate the squalid conditions of the peoples' lives. As the discipline developed, social workers in these environments worked with children, establishing such institutions as the famous Toll House in Chicago.

From the first, the roles of social workers were very different from those of psychologists, psychiatrists, and other more medical providers. Social workers attempted to improve the lives of people by helping individuals change their functioning in the social environment. From the first, social workers worked with disadvantaged children, orphans, juvenile delinquents, and other "street people." They have often functioned in a strong advocacy role, working with the courts, jails, hospitals, and other institutions serving the poor.

Social workers have devised a number of powerful tools to deal with the complex and chaotic environment of the disadvantaged. Case work involves the organization of the resources from whatever source that may be brought to bear to help the individual in trouble or in disadvantages circumstances. A case worker may, for example, obtain medical care for a poor person, find welfare funding for the person's family, help another family member find a job or receive technical training required for a job.

Because many of the disadvantaged are mentally ill, a wide variety of skills for dealing with the mentally ill have been developed by social workers. The general orientation of social workers is to view the individual in the context of his or her social environment; as a result, social workers have developed forms of therapy that utilize this orientation. Although family therapy was not initially invented by social workers, this discipline has used it perhaps more consistently than other fields of mental health, with the possible exception of child psychiatrists.

Social workers have developed a variety of therapeutic interventions which utilize the patient's social environment. One of the most powerful of these therapies is the use of "natural helping networks" to provide support and "healing" for the person. The therapist evaluates the person's environment to find natural helpers to provide the special support the troubled person needs. This form of therapy is currently being used extensively because of the cuts in funding in programs for the mentally ill over the last decade. It has the advantage of being relatively inexpensive, but has the disadvantage of being oriented toward support and prevention of deterioration rather than "cure." Other mental health disciplines--particularly psychiatry--have taken much from the natural networks approach of the social workers, and the significance of the approach is clear as one reviews the models of community mental health developed by the JCAH and others, which are very heavily influenced by social mental health concepts.

Social workers also pioneered a number of other approaches to mental health. Community organization efforts which were invented initially by social workers have become a staple in the work of other health care disciplines, most recently health education. Work with hospitalized medical inpatients has become the field of medical social work, which has been borrowed extensively from by several of the clinical nursing specialties.

Social workers have adopted other approaches to therapy. In recent years, many social workers have adopted psychotherapeutic

practices in contrast to an earlier emphasis on work in the non-clinic setting. Some modern social workers are completely office-based and provide psychotherapy in much the same general manner as psychiatrists and psychologists. Perhaps even more than psychiatrists and psychologists , social worker psychotherapists tend to work with families and couples, focusing upon relationships and communication within the relationships. At one time, it was far more common to encounter social workers performing gestalt therapy or transactional analysis than either psychiatrists or psychologists, for example.

Social workers train for two years after receiving their Bachelor's degree. They take course work and perform a supervised clinical placement in one of a number of possible settings, depending upon their intended specialty. At the end of this period, a Master of Social Work (M.S.W.) degree is awarded. Increasingly, social workers are obtaining the Doctor of Social Work (D.S.W.) degree. The type of training that social workers receive varies greatly with their choice of school and specialty track.

In recent years, specialties within social work have become increasingly prominent. Case work is one specialty that perhaps most closely resembles the traditional role of social workers. Case workers are trained to work with welfare systems, child custody, welfare, placement, and with the courts and probation systems. A variant of this role, that of the case manager, has become the mainstay of care for the chronically mentally ill. Case management extends the role of the case worker to active coordination and advocacy for comprehensive care of the patient in complex service delivery systems.

The social worker may specialize in medical social work. This specialty works in inpatient and ambulatory health care facilities by obtaining alternate resources to pay for health care, arranging for the patient's care after hospitalization, providing support for patients and families from the emotional trauma related to death and serious illnesses, and undertaking a variety of other activities. The role of medical social workers has become popular with hospital administrators because they save and generate money for the health care organization.

Other social workers train in community organization, although this is a less popular field than in the early 1970s. The theoretical orientation of this group suggests that one should mobilize communities to get them to solve specific problems, and to "empower" communities with a sense of their ability to accomplish major tasks through their own organizational strength and enthusiasm. In its pure form, community organization social work is the clinical application of the science of sociology.

Yet another specialty of social work is that of program administration. Because of their broad understanding of human services technology, social workers have frequently been used to run public agencies. Child and family welfare agencies and similar public institutions are often administered by social workers with this special training expertise.

From the perspective of mental health programs, however, psychiatric social work as a specialty has the most immediate application. Psychiatric social workers are usually trained in either office-based therapy or in the care of the seriously mentally ill. Those whose training involved community mental health centers or inpatient hospitals gain a broad perspective of the care for the mentally ill. Usually these social workers are trained in diagnosis and a wide variety of therapeutic modalities, including formal diagnostics and structured psychotherapies.

After obtaining the M.S.W. degree, the social worker may take a variety of fellowships and other specialized training experiences, such as child psychiatric social work.

If the social worker has received the appropriate specific training, he or she may be among the best choices as the front-line general mental health professional for reservation communities (along with Master's level psychologists). In comparison to doctoral-level mental health professionals, social workers are often less expensive to use. In addition, they are oriented toward providing an overall package of services to the patient which they can orchestrate perhaps better than most other disciplines (such as getting psychotherapy from one source, free medical care from another, and social security disability from yet another). For the reservation community that is very complex and whose citizens are under-served by mental health programs, hiring a social worker with a mental health background makes a great deal of sense because of their ability to arrange service delivery programs with very few resources.

One major disadvantage of the use of social workers stems from the wide variability in their training. Well- trained psychiatric social workers are able to use the same diagnostic and treatment technology as psychiatrists and psychologists (with the exception of some tasks which social workers do not perform, such as the use of standardized testing and prescription of medications). Some social workers without training in major mental illness strongly maintain the non-diagnostic, non-treatment orientation that marked the earlier eras in the history of social work. Rather than using the systems of knowledge that made modern mental health technology more effective than placebo, it is possible to hire social workers with entirely non-clinical training for mental health jobs. In the worst cases, this staffing decision can result in the patient suffering from a high-risk, debilitating major mental illness being denied access to potentially life-saving interventions because no systematic evaluation was performed and no modern treatment technology was ever brought to bear. Fortunately, the trend of some social workers to find research-based mental health technology offensive has declined over the last decade.

On the other end of the spectrum are social workers whose depth of knowledge and ability to use a wide range of treatment technology and diagnostic tools makes them sometimes even more effective than many psychiatrists and psychologists for meeting the spectrum of average patients' needs. They not only share some of the basic information of the

other disciplines, but can use the effective network and community technology to develop broad-based, comprehensive treatment plans for patients. The most effective psychiatric social workers know the field of mental health, and are among the mental health professionals most willing to ask for the assistance of other disciplines when needed. The author, a psychiatrist, has had the privilege to work with a number of these social workers on rural reservations throughout the West.

Social workers are often able to enter a community system quickly and effectively, particularly because of their training in providing care outside the office setting. Community-based psychiatric social workers understand the need to provide services in a wide variety of settings, from jails to a patient's home, and they often do so with much more comfort than other disciplines because of their training.

Social workers are very cost-effective for reservation mental health programs. Quality control efforts, however, appear to be necessary to ensure that the social worker is providing the diagnostic and "medical model" treatment that is most effective for major mental illness. An active quality assurance review and training program is necessary for reservation mental health programs to make certain that patients have access to modern treatment and diagnostic technologies.

On the other hand, a strong Area social work program is needed to train psychologists and psychiatrists in the highly effective community and network interventions developed by the discipline. Good, aggressive social work consultation can increase the access of patients to services provided by the other disciplines, and can also help the other disciplines learn to deliver their services in a community setting.

Psychiatry

Like cardiology, neurology, or obstetrics and gynecology, psychiatry is a specialty of medicine. As with any medical specialty, psychiatrists must first be trained and certified as general medical doctors. After becoming medical doctors, psychiatrists undergo additional training to become psychiatrists. All psychiatrists hold the Doctor of Medicine (M.D. degree) or Doctor of Osteopathy (D.O. degree).

The education of a psychiatrist begins with four years of college culminating in a B.S. or B.A. degree. The psychiatrist must then attend medical school for four years, taking all the courses required of any physician. At the end of medical school, the physician receives an M.D. degree. At this point two choices are available to the young physician. He or she may take a general, medical or surgical internship, or may take a psychiatric internship, with internal medicine, neurology, and rotations in other specialties. The internship year is a year of intense work, that focuses upon patient care supervised by residents and faculty. At the end of the internship year, the physician is qualified to practice medicine, and may be

hired by an organization such as the IHS to serve as a General Medical Officer.

After internship, the physician changes programs once again (although the internship may continue directly into a residency). The young physician who applies to a psychiatric residency program is accepted on the basis of test scores, grades, recommendations, and interviews. The residency is an apprenticeship of three years during which the resident takes academic classes and serves as a psychiatrist on a variety of community, inpatient, child, outpatient, neurological, and other "rotations." The primary focus of the teaching program is supervision, in which a senior resident, a faculty psychiatrist, or a psychologist, sociologist, or social worker reviews all cases with the resident. Usually the psychiatric resident follows a number of outpatients in psychotherapy throughout his or her residency.

During the residency, the resident may choose from a variety of different tracks if they are offered by the particular residency program. A research track requires after-hours work learning psychiatric research techniques. Other tracks are in psychotherapy, neurology, inpatient psychiatry, or transcultural psychiatry. Following a residency program of three years of supervised clinical work, the psychiatrist may take a fellowship of one or two further years in order to get special training in a sub-specialty area, such as forensic (legal) psychiatry, child psychiatry, geriatric psychiatry, transcultural psychiatry, or research methodology.

At the end of a psychiatry residency, the psychiatrist is eligible to take the psychiatry specialty certification examination given by the American Board of Psychiatry and Neurology. If the written examination is passed, the next year the psychiatrist is eligible to take the oral examination the following year. This oral exam takes roughly a day of examination by a panel of psychiatrists. About half of the people who take the examination pass both portions on the first try. Other additional Board examinations are required for those who have passed the general examination; these are in forensic psychiatry, child psychiatry, administrative psychiatry, and--perhaps soon--geriatric and consultation/liaison psychiatry.

Although psychiatrists are responsible for mastering a basic core of knowledge, there are large differences in theoretical orientation among psychiatrists. Biological psychiatrists are closer than the average psychiatrist to neurologists in their understanding of the mechanisms and causes of illness as related to the functions of the brain. Social and community psychiatrists tend to be more oriented toward sociology and social work models of psychiatric problems, while outpatient psychiatrists tend to be oriented toward psychotherapeutic techniques and models.

Psychiatry began somewhere in antiquity. If physicians dealing with major mental illness are involved with psychiatry, then surely the ancient Greeks practiced psychiatry. Hippocrates, among others, wrote about psychiatric concepts and was the first to record suspected

connections of the brain and behavior. The first American psychiatrist was Dr. Benjamin Rush, one of the signers of the Declaration of Independence.

As a general rule psychiatrists in the United States tend to be more psychoanalytic than the average clinical psychologist. For many years in the middle of the twentieth century psychiatrists were usually trained in psychoanalytic dynamic therapy. In the same period psychologists received a broader orientation to therapy and research. In addition, psychiatrists are likely to be more oriented toward major mental illness than clinical psychologists, who may generally be better trained in quantitative measurement techniques and in normal behavior. Psychiatrists use a "detective-like" deductive assessment process based upon interviews, while clinical psychologists use both interviews and paper and pencil testing that is much better standardized for the general population than the standard psychiatric interview. Because psychiatric care is oriented toward a standardized diagnostic system and tends to use effective and inexpensive biological therapies, third party reimbursers tend to pay for such care with more regularity for psychiatrists than for care provided by other disciplines. Third party reimbursers tend to study results and actuarial tables closely; thus the payment provided for psychiatric services is something of a testimony to the effectiveness of methods used. However, psychiatrists trained in an apprenticeship model may rely more on "word of mouth" about treatment and diagnostic technology than psychologists and may have more of a tendency to adopt techniques and theories without a solid basis in scientific proof than psychologists. For example, the willingness of psychiatrists to apply diagnostic labels which the research literature suggests may be of questionable reliability, such as that of Narcissistic or Borderline Personality Disorder, is a cause for concern about the practices of many psychiatrists. In contrast to the practicality and power of psychiatric treatments, there is little doubt that clinical psychology is better based on scientific methods in diagnostic technology in particular.

A disadvantage of psychiatry in community mental health programs is the expense. Psychiatrists' hourly fees in the country often range between $80 and $150 an hour. Consequently, most other mental health practitioners are less expensive than psychiatrists. The suspected epidemiology of Indian communities include high rates of grief reactions, situational problems, and similar problems. It is not reasonable to expect psychiatrists to provide primary, first-line services to the large numbers of people suffering from these problems when other disciplines can perform the same functions with the same (or some would propose better) outcome, and with less expense.

However, psychiatrists must be used in several types of cases. Patients such as those with severe psychotic illnesses or organic mental syndromes really require the attention of a psychiatrist because of the need for medical diagnostic procedures. In addition, psychiatrists are generally the group best equipped to treat conditions in which medications are a critical and central part of the treatment. Because serious major mental

illness is present and common on most reservations, in most cases it is reasonable to have a consultative relationship between a psychiatrist and each of the programs in the field. This relationship should be consultative in nature (rather than having the psychiatrist take primary responsibility for patients). This professional should have an active relationship not only with the mental health program, but with the primary medical care program and other specialized programs on the reservation. In addition, psychiatrists from inpatient and emergency programs should be known to all mental health programs on reservations in order to help handle mental health emergencies such as acute psychotic conditions as they arise.

Although psychiatrists are often well trained in one or several of the psychotherapies, effective use of their time usually limits their use as psychotherapists on reservations. Both psychiatrists and clinical psychologists are often good supervisors of the psychotherapeutic practices of other staff members, and are effectively used in this way. Administrators and planners should be aware that both clinical psychologists and psychiatrists feel that their own way of teaching and learning psychotherapy is the best. In fact, the psychotherapy skills research has not demonstrated the psychotherapy of one group to be superior to the other.

Clinical Psychology

Clinical psychology as a discrete discipline began in the third quarter of the last century. The first psychological clinic was founded at the University of Pennsylvania in 1896. At first, psychology was focused chiefly upon the measurement of mental and cognitive characteristics of individuals and populations. In particular, in the early years psychologists contributed significantly to the mental health field by focusing upon the measurement of intelligence. The first serious intelligence test, the Binet-Simon, was published in 1905.

From the first parts of the twentieth century, several approaches to psychological practice were in evidence. Psychologists typified by the work of Lightner Witmer were concerned with intelligence, while William Healy and those who worked with him were more concerned with personality factors. From the first, psychologists established a solid working relationship with other members of the mental health team, including social workers, psychiatrists, neurologists, and others.

Clinical psychologists have contributed significantly to the thinking in the mental health field over the last century. While psychiatrists have used a case-focused diagnostic technology, psychologists have based their studies on statistical methods and data derived from the measurement of larger populations. Psychologists have a long tradition of looking at the diagnosis of the individual in relation to the general population rather than as a unique case (as has been the trend among psychiatrists). This is a subtle distinction to those who have not worked extensively in mental

health, but has had profound implications for the development of thought in the behavioral sciences. In the first part of this century, while the diagnostic work of psychiatrists was based upon psychoanalytic models of presumed causes of symptoms, psychologists maintained a more objective system of diagnosis based upon actual studies of the population rather than generalizations from specific cases to the general population.

Using a more scientific approach to mental illness, clinical psychologists are responsible for much of our understanding of variations and functions of normal people, and for providing a more quantitative understanding of the limits of normal behavior and function. Because of this strong tradition in scientific statistical methods, psychologists have been able to bring a systematic, scientific approach to many fields that were previously a matter of unscientific lore and myth.

To understand modern psychology, one must understand that it has differentiated into a number of specialty areas. If anything, the differences among specialties within psychology are even more pronounced than the specialties within psychiatry.

Experimental psychologists generally work in academic settings trying to elucidate fundamental principles of behavior. They may work with people, although many of these fundamental advances in this field have been made working with rats and monkeys.

Psychologists who have specialized in management and industrial psychology have created a body of knowledge about motivating and managing employees, and a variety of techniques that make organizations more effective. Unfortunately, much of the real science of industrial and management psychology finds its way into the teaching of managers only as second-hand material and is grossly under-utilized. Much of the scientific basis of management psychology has yet to find its way into the day-to-day practice of management of business or health care. In one of the more interesting developments in recent years from the IHS perspective, is the first scientific literature dedicated to managing multicultural organizations by psychologists such as Norman Dinges and others.

Educational psychologists were an early specialty within psychology. This group has a long history of work in testing intelligence, aptitude evaluation, and counseling regarding vocational choices and academic careers. In Indian programs, the potential of educational psychologists has not been fully utilized. One major problem for educational psychology of Indian people has to do with school dropout problems and the difficulty that many young Indian people have in completing their first year of college. The role of educational psychologists has also been misunderstood in the IHS, in that educational psychologists have been hired as general therapists for reservations. With rare exceptions, educational psychologists are not trained in either the diagnosis or treatment of the major mental illnesses that are commonly found by mental health programs on Indian reservations.

Clinical psychologists are perhaps the most clinically useful specialty of psychology for reservation based Indian mental health programs. Clinical psychologists are trained as psychotherapists and receive extensive training in testing and evaluation. Unlike psychiatrists, clinical psychologists routinely administer paper and pencil tests that are standardized against a normal population. Familiar psychological tests include the MMPI (Minnesota Multiphasic Personality Inventory), WAIS (Weschler Adult Intelligence Test), and others. Standardized testing in diagnostic psychology holds particular promise for producing screening and early identification tools for work with large populations. One major problem in the use of these instruments is that few have been standardized for Indian populations, and their inappropriate use with Indians can lead to gross misdiagnosis. Clinical psychologists, like psychiatrists, use clinical interviews to confirm diagnoses suggested by paper and pencil testing.

Clinical psychologists are also trained to work as therapists and may have training in particular types of therapy. This training in psychotherapy usually lasts throughout the four year program required for a Ph.D. (Doctor of Philosophy) degree in clinical psychology. Before beginning this program, the student must have a Bachelor's level degree. Most of the Ph.D. programs in clinical psychology require two years of classroom work, one year of work writing a dissertation on an original research topic, and a variety of supervised clinical experiences in a clinical internship year. The type of work done during the internship and the subject of the psychologist's dissertation indicate particular areas of expertise for the beginning clinical psychologist.

Master's level psychologists may also be part of a mental health team if their training has included supervised clinical experiences. The education of the Master's psychologist differs from that of the clinical psychologist at the Ph.D. level in that they usually have only two years of training after the Bachelor's level. This usually means that they have not had the same amount of supervised clinical training as the doctoral level psychologist, nor are they required to put the same level of effort into a Master's thesis as a Ph.D. dissertation requires.

As psychotherapists, clinical psychologists tend to use different psychotherapeutic techniques than psychiatrists. Perhaps because of tradition, psychiatrists tend to be more strongly based in psychoanalytic approaches to therapy, while psychologists may be more strongly oriented toward therapies with a learning theory or behavioral basis. However, with the wide variations in therapeutic style and orientation in both disciplines, the distinctions between psychiatry and psychology on the basis of presumed therapeutic orientation may be trivial. The types of therapy more commonly used by psychologists for several specific disorders (such as behavioral treatment of phobias and cognitive therapy for depression) have been proven to be more effective than the general psychotherapeutic techniques often used by psychiatrists (such as psychodynamic psychotherapy for depression). For most disorders, there are no proven

differences in the psychotherapies used by psychologists and psychiatrists, in spite of both groups' assertions to the contrary.

Sub-specialties of clinical psychology, often the product of a post-doctoral fellowship or residency, provide additional skills of the clinical psychologist. Neuropsychologists are highly skilled in diagnosing both general and localized problems of brain functioning using sophisticated testing batteries. Using this skill, they may be very accurate in localizing brain lesions, and have the ability to carry their testing material with them. Child neuropsychologists understand the development of the growing brain and the normal and abnormal development of different parts of the brain. Many of the fundamental questions about the growth and development of Indian children (for example, is there is a large variation in the relative development of language and spatial skills in Indian children?) could be answered by performing neuropsychological investigations of the question. Unfortunately, there are very few trained child neuropsychologists in the country and usually none working with American Indians. Similarly, adult neuropsychologists could add greatly to our understanding of issues such as what constitutes effective alcoholic detoxification and what detoxification practices lead to brain damage.

Community psychologists, trained in clinical psychology and a variety of social and community skills, appear to offer a particularly valuable set of skills. For example, programs for the primary and secondary prevention of major mental illness in Indian communities designed by Candace Fleming, an American Indian clinical psychologist with specialty training in community psychology, appear to be among the few proven effective programs of their type for Indian communities.

Like psychiatrists and all the other mental health disciplines, clinical psychologists do not offer the ultimate solution to all Indian mental health problems. One severe limitation is that if they are not trained in community psychology, their preferred mode of working may be in office settings, much like their psychiatric counterparts. In Indian communities, where patients may be initially reluctant or unable to seek out the psychologist in his or her office in a clinic, this may result in a very long period being required for the psychologist to adapt to the community. Often clinical psychologists with good training and impressive work backgrounds have come to work for the IHS, have started an office practice, but have found that no one comes to see them, even though there are desperate mental health needs in the community. These skilled people appear to be "lazy" to other health professionals and to tribal governments, and are fired as a result. Community-trained clinical psychologists rarely have this problem in IHS. Strong Area Office programs can help clinical psychologists make the critical transition to leaving their offices and working in the community in "non-traditional" settings such as homes or in the workplace.

While clinical psychologists are generally paid less than psychiatrists (from half to two-thirds of the hourly rate for psychiatrists on the average), they are often significantly more expensive than social

workers and other non-doctoral therapists. If a program does not plan to use their skills appropriately, is perhaps best advised to hire a non-doctoral therapist to perform "front-line" generic mental health functions. However, the depth that clinical psychologists can provide to a larger Indian mental health program, including much more efficient and cost-effective use of other non-doctoral therapists, make clinical psychologists who have survived their initiation periods both valuable consultants and good senior clinicians.

Unlike psychiatrists, psychologists are not medical doctors and cannot prescribe medications. Most psychologists who have worked in clinical settings and follow the treatment literature are well aware of the needs and appropriate uses for medications. As a result, psychologists usually work in a relationship with a psychiatrist in urban areas or with an internist or family practitioner in rural areas who follows the patient's medication while the psychologist provides psychotherapy.

In general, psychologists offer a highly valuable set of skills to Indian mental health programs. However, their use may not be completely understood in the overall health system. Although there is a national group of Indian psychologists, this group has not been very active in recent years. In addition, there is a decided need for the skills and particular knowledge of clinical psychologists in each Area of the IHS. Unfortunately, only a few Areas utilize this expertise or the expertise of psychologists appropriately on a routine basis.

General Medical Practitioners

It is estimated in a wide range of studies, particularly those of the National Institute of Mental Health, that less than half to one-fourth of the people in the nation needing help for a mental disorder ever see a mental health professional. The majority of patients seek help from a variety of other sources, primarily non-psychiatric physicians. Studies from the other side of the question find that over half and up to 75% of patients coming into a general physician's office do so for emotional rather than physical reasons. It is increasingly clear that the majority of mental health services in the nation are provided by general physicians and the clergy, and that the majority of a general physician's practice is composed of mental health problems.

The general medical practitioner takes courses in psychiatry in medical school. These courses include patient interviewing, a survey course in psychiatry, and a supervised clinical experience in a psychiatric facility. For most physicians, relatively little is remembered from the basic courses in the first two years of medical school, and the majority of treatment technology is learned in the clinical rotations of one to two months in the psychiatric facility. Usually, however, the clinical psychiatric rotation takes place in an inpatient setting that deals with very serious and chronic illness, such as schizophrenia and bipolar affective disorder. As a result, most

physicians receive little training in the disorders that are seen most commonly in outpatient or ambulatory medical facilities. In addition, the knowledge received in the basic science courses is usually at least six years out of date by the time the physician has finished a specialty residency. With the rate of change of the knowledge in psychiatry, one may expect that at least half of the general physician's psychiatric knowledge will be outdated by the time he or she has an opportunity to use it.

Of great concern, are studies of the ability of general physicians to recognize and treat mental illness. For example, one study at a prestigious teaching hospital found that internal medicine physicians were able to recognize less than one-fourth of the psychiatric illness on their inpatient service (this in spite of the several hours of diagnostic examination of the history and physical examination at that institution). One would suspect that the rate of recognition of psychiatric disorders in an outpatient or ambulatory care setting, with visits lasting 15 minutes or less, must be lower, although study of this question remains to be performed.

Other studies appear to confirm the inadequacy of general health care providers in detecting and diagnosing mental illness. Studies of the elderly suggest that over half of supposedly "demented" patients have a treatable and unrecognized cause their illness.

If the rates of recognition and correct diagnosis of mental illness are low among general physicians for the general American population, it is even more questionable that correct diagnosis of Indian patients is taking place in the Indian Health Service's general clinics and ambulatory care facilities. Adding to this concern is work by Manson, Shore and others on depression among American Indians. In that work it was shown that depression among the tribes studies fits a different set of diagnostic parameters than depression among non-Indians. If the average medical practitioner has difficulty diagnosing depression among non-Indian patients, the rate of correctly diagnosing depression among Indian patients must be very low, indeed. If depression is the most common major mental health problem on reservations, one can only imagine the effectiveness of the diagnosis of less common disorders among Indian patients.

As a result, one might expect that a very small fraction of the Indian patients coming into a general medical clinic run by the IHS receive adequate or appropriate diagnosis and treatment, perhaps as little as 10% or less.

Several possibilities exist for improving the quality of care for mental health problems in IHS medical facilities. Family practitioners are often better trained in certain areas of psychiatry than are specialists from other fields of medicine (except psychiatry, neurology, and behavioral pediatrics). Family practitioners receive from one to six months of additional training in psychiatry in the family practice residency program. In IHS programs that use family practice physicians, it is likely that the quality of the mental health diagnosis and treatment is better than in those facilities

staffed with internship-level practitioners or by physicians from other specialties such as surgery.

The first question that must be faced is the one of why we are not doing better at addressing the problem of training non-psychiatric physicians to deal with psychiatric problems. After all, we have demonstrated that mental health problems are perhaps the greatest untreated cause of morbidity and mortality in the Indian population and must be a concern for any health care provider. The health impact of psychiatric problems on the population is particularly serious if one considers addictive problems (that the medical system includes in psychiatry) as a component of the mental health picture of Indian people. For many of these conditions, treatments are as effective as most kinds of treatment in medicine, and are relatively low in cost. The benefit to the Indian population of a general medical staff trained in modern psychiatry is potentially so great that an insightful planner would strongly question why we have not made a major emphasis on this area of public health before now.

One major reason for the lack of up-to-date psychiatric skills in Indian and non-Indian health systems must be faced. Physicians do not generally like psychiatry as a medical specialty. General physicians are usually frightened or made uncomfortable by the group of patients that they most often identify as needing psychiatric treatment. In medical schools there are a number of high-appeal specialties that to the medical student appear to present the best opportunities to use all the skills that they have spent so many hard years learning. These glamorous specialties include internal medicine, surgery, and emergency medicine; psychiatry is rarely included. In spite of programs designed to enlist more medical students into psychiatry, many psychiatry residency training positions remain unfilled in the country each year. Psychiatry remains a national shortage specialty in spite of the growing surplus of physicians in America. Once a non-psychiatric physician enters practice, however, there is an opportunity to reintroduce psychiatric material to the physician. Most physicians entering into a general practice quickly learn that most of the people that they see do not have "glamorous" conditions, and that a large number of the difficult patients suffer from chronic illnesses and psychiatric conditions that require the application of psychiatric skills. As a result, many practitioners in the field welcome further training if presented in a way that will provide maximum practical usefulness to them. Most practitioners are eager to learn differential diagnostic skills and effective treatment skills once they have left the training environment and have encountered the realities of medical practice in the real world.

Other medical specialties in the IHS provide training courses in deficient specialty skills for General Medical Officers with good success. Examples of this training in the IHS include obstetrics and emergency life-support. It would make sense to provide basic psychiatric skills in the same way for at least one practitioner per Service Unit, in order to ensure that at least one physician per reservation is able to diagnose and treat mental

illnesses. This is particularly clear when one considers that mental illnesses may pose a greater threat to the well-being of Indian people than other groups of disorders about which IHS physicians are trained. A good, comprehensive course for primary care physicians in psychiatric skills would probably take 10 days, although a single week of very intense training, with follow-up "refresher" educational programs could accomplish the goal of supplying each reservation with a bare minimum of psychiatric skills.

The role of the primary medical professional in providing good psychiatric care for patients in the average service unit is a critical piece of the system of mental health care for Indian people. Very few Service Units in the IHS have on-site psychiatrists, and even those which do have a psychiatrist cannot have that specialist available for emergency care 24 hours a day, seven days a week. In the ideal case, there is a need for all general physicians on reservations to have a base of psychiatric skills, in the same way that they have skills in internal medicine, pediatrics, and in some places, obstetrics. It would be easy for the IHS to provide high quality training to this end, but it currently lacks the means and the mandate to do so.

Nurses

Probably since the first psychiatric physicians, nurses have been providing care to the mentally ill in hospitals. The role of nursing in the delivery of inpatient mental health services has been so critical that it is almost impossible to imagine an inpatient program without them. Psychiatrists, psychologists, and social workers see the patient for a few minutes to an hour a day, but nurses provide supervision and therapeutic interventions around the clock, every day of the week. Because of this, psychiatric nursing has developed a very different set of skills in comparison to the other mental health disciplines, integrating "medical" and interpersonal skills on a practical and interactive level.

However, until relatively recent times, inpatient psychiatric nursing has been more of a matter of oral tradition and learning in the apprenticeship model, rather than a substantial written literature. The 1960s and 1970s witnessed the advent of milieu therapy, which finally gave overt attention to the therapeutic environment of the inpatient psychiatric unit. This movement contributed to the development of a more substantial literature of inpatient psychiatric nursing.

Many inpatient psychiatric nurses are skilled therapists, with training in one or another forms of therapy. In particular, nurses with skills in group therapy are commonly leaders of inpatient groups. Other therapeutic skills of inpatient psychiatric nurses tend to be oriented to practical coping skills for patients. Inpatient nurses usually have an effective knowledge of the basic uses and effects of medical treatments for major mental illness.

Inpatient psychiatric nurses usually have a Bachelors of Science or Bachelors of Arts degree in Nursing, although an increasing number hold Master's or Doctoral level nursing degrees in various types of psychiatric nursing.

For the IHS and tribal programs, there may be little use for inpatient psychiatric nurses, simply because there are so few Indian psychiatric inpatient facilities. However, a number of roles exist for nurses in outpatient, ambulatory, and community settings. Nurses with training at the Master's and Doctoral levels have filled a variety of valuable roles in Indian health programs, and still other roles remain to be explored.

The psychiatric nurse practitioner and nurse administrator have been successful roles for psychiatric nurses in the IHS. Most of these nurses began in community and outreach roles, but later assumed administrative responsibilities. The psychiatric nurse practitioner in the community generally has particular skills in working with seriously ill patients and integrating the medical and psychological aspects of treatment for them. Particularly in sub-specialty fields such as the care of the chronic mentally ill, the elderly, and multiple-problem children, nurses have exercised a leadership role, both in the IHS and in the nation.

Other common skills of the psychiatric nurse practitioner have not been utilized by the IHS to any significant extent, but would appear to provide the combination of the correct set of skills and reasonable wages to solve some difficult service-delivery problems. For example, some psychiatric nurse practitioners specialize in emergency psychiatry. Usually only psychiatrists provide the medical diagnostic and treatment services in the emergency room. The psychiatric nurse practitioner is perhaps the only other professional with the physical diagnostic skills to sort out drug withdrawal or intoxication states from acute psychotic conditions (based upon physical findings) or to differentiate these states from poisoning with insecticides, for example. Increasingly, programs that require 24-hour a day coverage of an emergency room, but that do not have the volume of patients required to support a full-time emergency psychiatrist, utilize nurse practitioners with physician backup.

Psychiatric nurse practitioners who specialize in the care of the chronic mentally ill in the community provide a uniquely valuable service; they are able the care for the entire patient at a primary care level in settings other than hospitals and clinics, but with particular attention to the patient's changing mental status and psychotropic medications. Similarly, psychiatric nurse practitioners may specialize in areas such as the mental health care of the elderly, and provide service that can be both life-saving and highly cost-effective. All of these specialized roles, like the roles of a medical specialist or the psychiatric nurse practitioner, depend upon a large enough population of patients to justify the special expertise of these providers.

The role of the psychiatric nurse in IHS and Tribal mental health programs has been limited. In part this limitation is due to the historic

association of nurses with inpatient psychiatric programs. However, the success of several psychiatric nurses in IHS programs suggests that perhaps their broader potential role in general mental health programs is not fully understood by mental health program planners. There may be appropriate roles for psychiatric nurses in a variety of Indian mental health programs. As the medical needs of mental health patients are recognized, there may be an increasing number of roles for which psychiatric nurses are the appropriate practitioners. However, it may be that the creation of specialized positions for psychiatric nurses in Indian mental health programs will require more sophisticated role definitions.

Mental Health Technicians and Community Health Representatives

In contrast to trends toward professionalization in the rest of the American mental health system, a number of roles for non-professional staff (i.e., those without professional level degrees) are both possible and hold a measure of unrealized potential for Indian programs. Since the beginning of Indian mental health programs, an exciting role for community members has been to provide services in mental health programs. The first of these roles began with the secretary to a mental health professional on a reservation in the Southwest. Because there was no one else to do the work, she continued to provide mental health services after the professional had left the reservation. This person's work became the prototype for the role of community mental health worker, which was later expanded beyond the mental health role as the early Community Health Representative (CHR) program developed. In Indian mental health programs, the role of the paraprofessional has since developed into that of the mental health technician.

Mental health technicians have been active in the Indian mental health system for several decades. However, difficulties in defining their roles have created a trend of declining numbers and positions for mental health technicians at the same time that there has been an increase in the numbers of Indian mental health professionals. In the light of the decrease in the function of mental health technicians, it is perhaps reasonable to again examine the roles of these technicians and of mental health specialist CHR in Indian mental health programs.

The role of mental health technicians in the non-Indian mental health system is limited for a number of reasons. In the American mental health system, technicians function as caretakers and aids on inpatient psychiatric wards. Technicians escort the patients to activity sessions, watch suicidal or dangerous patients, and provide ongoing, non-technical interactions with the patients. In most states, they are not allowed to provide psychotherapy and may never provide unsupervised primary care therapy for mentally ill patients. One of the reasons for this limited role is the issue of legal liability. If a mistake were made by an unsupervised technician, it

is likely the technician would be highly vulnerable to major losses in court. In addition, the lack of the legal recognition of the technician's role in the form of a licensure or certification process creates uncertainty about the legitimacy of the technician-level provider in state systems. Nevertheless, financially stressed mental health systems in some states find it necessary to use technicians as primary mental health care providers in order to deal with huge patient loads with severely limited funds. These programs make the decision to provide some service despite the risks.

In spite of the lack of legitimate roles for technicians in the non-Indian mental health system, there are unique roles for these technicians in the Indian mental health system. The use of local people as mental health technicians is appropriate to cultures in which there is a difference between the technology of the mental health system and the cultural beliefs of the people being served. When such a gap occurs, local people act as go-betweens for the patient and the technical, often frightening health care delivery system.

In other parts of the world, mental health technicians perform work of screening the population for mental illness according to specially devised criteria in the form of a written questionnaire that is read aloud, or through structured interviews. For example, the technician may be given a flow chart of questions that identify patients with probable depression. This questionnaire is administered to the patient in the community, and persons suspected of having depression then receive an explanation of the disorder and its possible treatments and are referred to the health center. The technician helps the identified patient come to the health clinic and to comply with follow-up treatment. This type of role is perhaps the most common role for the mental health technician in developing countries.

Another potentially useful role for the mental health technician is that of case manager. This role is explored at length elsewhere in this monograph, but briefly can be defined as a person who coordinates treatment for a patient in a complex system involving many agencies and providers.

Mental health technicians hold great promise for Indian programs. One of the most promising roles for technicians is in screening for major mental illness, because so few major mental disorders are recognized in Indian communities. The case manager role, because of the complexity and limitations of the service delivery system on reservations, holds similar promise. Restructuring and clearly defining mental health technicians' roles could increase the usefulness of mental health technicians in Indian programs. However, restructuring will required good training, supervision, and management of these technicians.

One reason for the decline of the mental health technician role in many parts of the country is the ambiguity of the job and confusion of the technician's role with that of the therapist (mental health specialist). Where mental health technicians are used as psychotherapists, there are several problems. If the technician is untrained and it is simply assumed that a good

attitude and worldly experience are all that are required to be a therapist, the patient is deprived of scientific and practical basis of therapy. (The assumption by health care administrators on some reservations that the training and education of a therapist is unnecessary and superfluous is frankly a disservice to the many Indian therapists who have survived the rigors of training and have honed their skills over the years in academic settings.) If Indian patients deserve the same quality of care as non-Indian patients, certainly adequately trained therapists are necessary. For this reason, most of the tribes in the Northwest have chosen to fill all therapist positions with mental health professionals, rather than allowing tribal members to receive therapy from unqualified paraprofessionals.

Although it is probably not appropriate for technicians to act in unsupervised psychotherapeutic roles, appropriate loosely supervised roles clearly exist for technicians who know the cultures in which they are working. Particularly in tribes that are more traditional, technicians may be the single most important mechanism for getting patients into effective treatment. The trusted position of technicians from the same community as the patient is a critical role as IHS and tribal programs develop secondary prevention interventions in the future.

Before the mental health provider role of the paraprofessional community member can be fully developed, several other changes in Indian mental health programs must take place. In the first place, it is unfair and unrealistic to pretend that mental health technicians can do their jobs without an active training and clinical supervision program. If the mental health program has an adequate introductory and ongoing training program, technicians can safely perform the duties expected of them. In addition, careful attention to definition of the role of the mental health technician is vital. Without adequate attention to this definition, there are major risks that technicians or community health representatives acting in mental health specialist roles will be forced to perform work for which they are untrained, thus risking patients' lives and health. Similarly, if technicians' roles are not clearly defined, administrators may try to have them perform tasks for which only mental health professionals are trained, thereby putting the community at risk and depriving the community of effective programs.

Other Mental Health Professionals

A variety of other mental health professionals have held positions in the IHS and tribal mental health programs. The success or failure of these professionals has depended largely upon how well the mental health program has matched the specialized skills of these professionals to their actual duties and the needs of the program. Understanding that not all professions and types of professional training qualify a person for any mental health job has been a difficult matter in the national IHS program. Some of the great programmatic disasters in IHS mental health have resulted from the mismatching of professionals to the work expected of

them. An understanding of the roles of different disciplines is critical to staffing mental health programs.

An example of the mismatch of professionals and jobs has taken place several times in Indian programs in the case of educational psychologists. These psychologists are well trained to work in schools and educational systems where they help students with emotional problems and help students maximize their educational potential in other ways. Educational psychologists may be valuable in helping students cope with adjustment problems, conduct problems, and situational disturbances that interfere with the student's ability to realize academic potential. However, many educational psychologists receive little training in the care and diagnosis of patients with major mental illness. Educational psychologists who have been placed as the only mental health professionals on isolated reservations have often not proven successful. They do not always recognize nor understand treatment for major mental illnesses. Likewise, Masters of Guidance and Counseling psychology graduates have not appeared to have the specialized skills needed to deal with the major mental illness found on most reservations, even though these professionals are useful in other settings.

Professionals who hold degrees in special education are very useful in the school system and in rehabilitation programs. They have reformed the system of care for mentally retarded children and for children with learning disabilities and other educational problems. In these settings, no other professional can match their achievements. However, they are not trained and have not been successful in primary therapy roles for children with affective disorders, psychoses, or other serious emotional disorders unless carefully trained and supervised by a professional with specific training in these major mental illnesses.

Some programs have hired health educators or those with only Masters of Public Health degrees as mental health professionals. There is no training in either curriculum that qualifies the holder of these degrees to be a therapist, even though they have been hired into these roles in the past by the IHS and tribal programs. Both health educators and holders of M.P.H. degrees have legitimate and useful functions in a mental health system, but neither is qualified to provide mental health services without training as a therapist.

One discipline that has had unexpected success in Indian mental health programs is that of the medical anthropologist. Although not trained or qualified as therapists, medical anthropologists have played a critical role in the development of a body of Indian mental health knowledge. In research on Indian mental health medical anthropologists have played a disproportionately great role, in spite of their small numbers. These professionals have proven effective in the planning, research, and evaluation components of the system, and not in therapy or other direct care roles.

Summary

Only a few of the health professions are qualified and trained to be therapists, although there are roles for other disciplines in planning and research. Understanding the potential contributions of the various disciplines to a comprehensive mental health program is critical to creating a system that meets the real mental health needs of Indian people. The successful use of each of the mental health disciplines depends upon careful definitions of their roles. Balancing the need of the Indian community for a specific kind of intervention against the financial costs of a particular type of profession can help to determine which kind of mental health professional or paraprofessional to hire. The practice of some administrators to hire the least expensive mental health professional possible is paid for by the community in untreated mental health problems and, consequently, excessive mortality and morbidity for community members. Too much reliance on expensive professionals may have these people performing tasks which could be performed just as well by less expensive workers.

The ideal service delivery system for most reservation based mental health programs involves a mix of mental health professionals and paraprofessionals from several mental health disciplines. By defining the role of each member of the team carefully, each will do the work for which training and cost best suits him or her. The community benefits from such a team by having a broad range of skills and competence provided by the mental health program.