The World’s Moving Too Fast

Kids are growing up too fast. They think they’re more mature than they are. TV tells them so. In a hurry to get behind the wheel. Like Junior. Grownups are growing up too slow. Greed. Expansionism. Everybody out to get theirs and everybody else’s. There’s just not enough giving. Too much taking from Mother Earth. Substituting technology for Nature. No Respect. Too many Big Macs. Too much noise. Now they own the moon & they’re not cleaning up Commencement Bay’s Toilet Water Award. Time to remember to remember where we came from & not to be a slave to that clock. That clock keeps you from spending time in the here and now—but worried about where you gotta be. Too many buildings. Ground disappearing. Trees disappearing. Grandmother said she always used to see a lot of fish jumping and it was something to see a plane. Now it’s something to see a fish & there’s too many planes. Social norms are changing with electronic tranquilizer. Cutting up what little ground is left; covering it with concrete & pavement so somebody can move their trailer house out into the woods. The animals just go farther away. Figuring animals ain’t part of the system anymore. Just can’t live without working as a slave to them green frog skins. Not enough living like the old days.

Puyallup Tribal Treatment Center
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MENTAL HEALTH CARE IN A GENERAL HEALTH CARE SYSTEM: THE EXPERIENCE OF THE PUYALLUP

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Chapter 17 of the Institute of Medicine's recent publication (Hamburg, Elliott, & Parron, 1982) recommends that mental health care be increasingly integrated into the roles of primary care practitioners. This orientation is a product of (a) the perceived need to reduce the cost of delivering mental health care, (b) the increasing reliance on the biomedical model as an explanatory device in diagnosis and treatment of mental problems, leading to the dramatic increase in drug therapies, (c) the rapid deinstitutionalization of mental health services that began in the mid-1950s (Bassuk & Gerson, 1978), and (d) the search for a more effective way of diagnosing and treating the mentally troubled.

The Puyallup Tribal Health Authority is an existing example of both the treatment of mental health within a primary care clinical facility, and the coordination of more basic mental health services with this primary care clinic. Thus, an understanding of the evolution of mental health care among the Puyallup provides an insightful case example of the positive and negative aspects of the Institute of Medicine's recommendations for American Indian and Alaska Native communities. This paper presents an ethnohistoric overview of the treatment of mental illness among the Puyallup and an analysis and critique of the Institute of Medicine's suggestions based on the Puyallup experience.

The Puyallup

The Puyallup were originally part of the hunting-gathering peoples around Puget Sound who spoke various dialects of Coast Salish. Through the Treaty of Medicine Creek in 1854 and various subsequent negotiations, the Puyallup Reservation was created on part of their traditional subsistence land around Commencement Bay (American Friends Service Committee, 1975). This reservation is located in Congressional District 6 and Pierce County in Washington state. However, due to the suspect practice of allotting land to individual tribal members, subsequent land auctions and sales, and the growth of the city of Tacoma, most of the Puyallup Reservation (99%) is non-Indian owned. According to the 1980 United States Census, the Puyallup Reservation's total population is 25,188 individuals. Only 856 of these, or 3.4%, were identified as Indian. This is the lowest percentage of Indians on any Washington reservation. The number of Puyallup Indians enrolled in the tribe is currently
1,075. Most reside on or near the reservation. The total number of Indians and Alaska Natives in Pierce County is 5,919 individuals according to the 1980 United States Census.

Thus, the Puyallup are embedded in an unusual social situation. They are a reservation community interspersed in the middle of a city—in fact, four cities. Individuals face both the problems experienced by urban Indians and many of the problems typical of rural reservations. A very high unemployment rate, a median family income lower and less stable than that of the non-Indian population, severe housing problems, high alcohol and drug abuse rates, low educational attainment, and a reservoir of health problems due to the impact of long-term poverty are but a few of the difficulties they experience. In addition, child neglect, child abuse, and family dissolution are major social problems.

A recent study compared the socioeconomic conditions on five Indian reservations in Washington state (Office of Human Development Services, 1981). In contrast to the Indians on or near the four rural reservations, Indians residing on or near the Puyallup Reservation had access to many more job opportunities. However, the Indian people in this greater Tacoma-area had almost as high an unemployment rate (51%) as those associated with two of the rural reservations. Further, of those Tacoma area Indians who were employed, an incredible 75% earned below $5,000. The percentages of employed who earned less than $5,000 in the four rural areas were far lower: Colville, 19%; Lummi, 16%; Makah, 34%; and Quinault, 49%. Also, 73% of the clients of the Puyallup Child Welfare Services reported public assistance as their income source; the five-project client average was 36%.

According to the 1980 United States Census, Pierce County Indians reported the lowest median value of owner-occupied housing of any racial group including Japanese, Chinese, Filipino, Korean, Vietnamese, Hawaiian, and Guamanian. Median contract rent in renter-occupied housing for Indians in Pierce County was reported to be the second lowest of the identified racial groups, with only the Vietnamese reporting a lower rent.

Most of the Puyallup people with middle and higher incomes either work with or for the tribe, or are self-employed under license or sponsorship of the tribe. Included in the former are secretaries, technicians, and managers, and in the latter, smokeshop owners and bingo operators. Fishermen are also self-employed and licensed by the tribe but earn marginal seasonal incomes.

Many Puyallup families are deprived of the extended family networks, the shared cultural tradition, and shared worldview present within a rural reservation community. Thus, Puyallup families live in the middle of an alien majority culture and may feel alienated from Indian culture as well. Because of the erosion of the land base, even extended families who maintain contact find housing separated from other family members, unlike the situations on rural
reservations. Thus, the members of individual households are often forced to employ the social resources that the majority society has created to take the place of kinship. While Puyallups do have their own set of nonkin resources, in many cases they must depend on outsiders: precisely those people that tradition, history, and experience have taught them not to trust.

While the Puyallup maintain many traditional values and symbols, especially with regard to subsistence activities, their aboriginal culture has been profoundly changed. Only a few elders can speak Puyallup with any degree of skill, and there are no younger people fluent enough to continue the tradition. However, a tribally operated school is attempting to make children at least familiar with their language and culture. Frequent powwows are held in Tacoma and on nearby reservations reinforcing tribal identity. More specifically, the Puyallup tribe host an annual powwow to commemorate and celebrate the return of the Old Cushman Hospital site (to be discussed later) to the tribe.

Many Puyallup are members of the Shaker religion, a truly unique Indian Christian religion which first appeared among the Indians of the southern Puget Sound in 1881 or 1882. One church of this religion is located on the reservation. Members of the church have been called upon to perform cleansing ceremonies in the tribe’s programs and facilities. The Shakers will be discussed in more detail shortly.

Ethnohistory of the Puyallup Mental Health Care System

The aboriginal culture of the Puyallup, including their ethnopsychiatric beliefs and practices, was recorded by Smith (1940). From the date of the first recorded contact of the Puyallup with Western culture by the members of the George Vancouver expedition to the southern Puget Sound in 1792 (Morgan, 1979), the indigenous ethnopsychiatric beliefs of the Puyallup began to be challenged by the outsiders. Medical personnel with the first permanent settlement (1833) and the first American expedition to the area (1841) increased the conflict between Puyallup beliefs and practices concerning mental problems and those typical of Western medicine.

As the aboriginal stewards and guardians of their lands and waters, the Puyallup have historically negotiated with several foreign nations including the United States. Relations were first formalized between the tribe, as an independent sovereign nation, and the government of the United States on December 26, 1854, with the Medicine Creek Treaty. After "negotiations" with Isaac Stevens, then wearing three hats as Governor of the Washington Territory, Superintendent of Indian Affairs, and Head of the North Pacific Railroad exploration, the Puyallup and Nisqually Indians (along with several smaller tribes) signed the Treaty of Medicine Creek with its various provisions.
Of nearly 400 treaties negotiated with Indian tribes during the treaty-making years from 1778 to 1871, only about two dozen provided for some kind of medical service (Department of Health, Education, and Welfare, 1978). The Puyallup Treaty of Medicine Creek is one of these. Article 10 of this treaty provides that the United States will ensure a physician to look after the health care of the Puyallup. The tribe maintains that since time immemorial and often under harsh and debilitating circumstances the Puyallup have provided health care to their people. The tribe firmly considers medical care to be a treaty right, and, as such, a service which has already been paid for through the cession of vast tracts of tribal lands. The tribe stresses that as a treaty right, health care should be provided without charge as it certainly has not been acquired without its costs.

The first doctor to remain any significant length of time as the local practitioner for the Indian Service, Dr. Spinning, began his practice in 1863 (Shackleford, 1918). At this time the Puyallup, especially the older members of the community, were continuing their involvement in traditional healing. Dr. Spinning and his successors, all general practitioners with little or no experience in treating emotional disorders, did more to discredit the Puyallup shamans, those traditionally responsible for mental health care, than any other individuals in the Indian Service (Shackleford, 1918). Their strong belief in the "superstitious" nature of traditional therapies combined with strict adherence to their biomedical training motivated their actions. Spinning, for example, mistakenly thought that traditional healing would be readily abandoned:

[As] they associate with the White and witness the superiority of their medication over that of their own, they soon desire to be treated by the physician in charge. They are gradually losing confidence in their own incantations, and will, ere long, abandon them entirely. (Annual Report of the Commissioner of Indian Affairs, 1864)

A ban on "Indian doctoring" in 1871 by the Superintendent of Indian Affairs of Washington Territory (Gunther, 1949) further decreased overt and recorded Puyallup involvement in traditional healing; however, a few instances of the use of the traditional shaman were reported as late as 1899 (Shackleford, 1918). While serving as Indian Agent in 1981 at the nearby Skokomish Reservation, even Edwin Eells (prior to becoming Indian Agent at the Puyallup Consolidated Agency) permitted "the ministrations of an old Indian Doctor...who offered his services" when "confronted with Indian illness for which the agency doctor had no suitable remedies." (Castile, 1982, p. 168)

Many Puyallup later converted to Shakerism and continued practicing spiritual healing without being involved in illegal activities. As noted earlier, Shakerism is a unique Indian Christian religion which first appeared among southern Puget Sound Indians in 1881 or 1882 (Barnett, 1957; Castile, 1982; Gunther, 1949; Mooney, 1896). Even though it advocated spiritual healing, Shakerism was
enough of a blend of Christianity and aboriginal shamanistic beliefs and practices to be accepted by Western authorities. Castile (1982) noted that the tolerance of Catholicism to Indian religious ideas and practices helped spark the emergence of this movement.

The first physician to reside on the Puyallup Reservation arrived in 1878 (Sicade, 1927). The Puyallup Indian School, initially opened in 1864, became a boarding school in 1873 (Shackleford, 1918). The first hospital on the reservation was built for the schoolchildren. The Puyallup Indian School, renamed the Cushman Trade School in 1910, changed from a reservation to a non-reservation school in 1912. Consequently, children from all parts of the United States, especially the Northwest and Alaska, began to enroll. Kin of the children moved to the Tacoma area to be next to their loved ones. Thus, the Puyallup tribal facilities began to be providers of medical services for American Indians and Alaska Natives of diverse cultural backgrounds. This pattern was intensified by the rapid hospital development which followed shortly. Currently, the tribal community includes tribal members and American Indians and Alaska Natives from at least 142 tribes and bands.

The Cushman Indian Trade School was expanded by 1918 to meet the needs of up to 350 pupils (Shackleford, 1918). The Puyallup were without special hospital facilities or Western practitioners between 1920 and 1929, when the facility was rented from the tribe by the Veteran’s Administration to provide hospital care to veterans. The Interior Department opened the facility in 1929 as the first Indian hospital in the Northwest. It contained both general wards and wards for the treatment of tuberculosis. When the facilities were bought from the tribe by the Interior Department in 1939, the Cushman facilities were the largest Indian health facilities in the entire Indian Service (House of Representatives, 1939). A new hospital was completed in 1943 featuring both general and tubercular care (National Lawyers Guild, 1973). It was still the only Indian hospital in the Northwest. The general wards were closed in 1954, and it became a tuberculosis hospital exclusively.

Even this facility was closed in 1959 despite serious Indian health needs and protests by several tribes including the Puyallup, leaving the Northwest without an Indian hospital to this day. The facility was eventually sold to the state of Washington in 1961 for $1. The largest building was remodeled and other facilities were built. The entire site was used as a state juvenile center called the Cascadia Diagnostic Center.

Thus far we have not been able to identify one Western medical practitioner who was either specifically trained in mental health care or was employed as a specialist to offer mental health therapy during the previously discussed period. At the same time, the role of the only other practitioner who could provide such services, the Puyallup shaman, was being attacked by Western authorities. The
rate of emotional illness among the Puyallup during this time is unknown. However, given the rapid cultural changes that they were experiencing, emotional disorders surely existed. For example, 8% of the 4,599 cases treated by the three physicians on the main Sound (Tulalip, Puyallup, and Skokomish Agencies) between 1883 and 1885 were "nervous diseases of which headache was the most common" (Eells, 1887, p. 274). No cases of "mental illness" were reported. However, an extremely high percentage of cases involved what we now call somatic complaints. Also, St. John (1914, p. 14) stated that in the year following the 1905 Heff decision of the United States Supreme Court which opened up the sale of liquor to Indians, there was a striking increase in the amount of drunkenness, crime, and death on the Puyallup Reservation which "...spelled almost absolute ruin and prostration for the Puyallup Indians."

The extent to which the Puyallup would have utilized mental health specialists is also unknown. Traditional shamans and Shaker healing ceremonies were important alternatives to seeking Western mental health care at differing periods of time. Further, many of the Puyallup avoided seeking Western medical care because of the stigma attached to Western medical institutions on the reservation. For example, preliminary interviews with former patients and Indian staff of the Cushman Indian Hospital conducted by the authors of this work indicate that the hospital was feared and avoided because it was believed to be the place where people went to die. The existence of tuberculosis wards, the delaying of seeking Western practitioners until sickness became serious, the yanking of children off the streets to perform tonsillectomies, and the practice of hauling dead bodies from the hospital to kin (even to other reservations) in the open back of pickup trucks undoubtedly added to the negative perception of the facility. Older people told us that relatives used to cry over people who went to work there. This perception was also expressed to the first physician (Dr. Byers) to work for the "self-determination" Indian Community Clinic to be described later:

The hospital was a source of pride for the Puyallup Tribe. Nonetheless, distrust for "white" medicine still remained under the surface. One woman told me, with obvious bitterness, that "the ones who went to the hospital died, but the ones who stayed home lived." (Byers, 1979, p. 23)

After the general wards of the Cushman Indian Hospital were closed in 1954, all health care of the Puyallup community was acquired through private physicians, emergency rooms, the Public Health Service Hospital in Seattle (25 miles distant), or Contract Health Care funded by the Indian Health Service. Few people used the Contract Health Care system. By 1974, the local list for Contract Care was about 45 individuals,\(^3\) about 7% of the tribal service population (Puyallup Tribe of Indians, 1975). The tribe also conducted a survey in the mid-1970s of the health care providers in the Tacoma area concerning the
extent of Indian and Alaska Native utilization of existing facilities. They found that few Indians and Alaska Natives were being seen by any of these providers. The above data is confirmed by the first physician for the Indian Community Clinic: "A Tacoma obstetrician told me that as late as 1970, the majority of Indian births were to mothers presenting to the emergency room in labor with no prior prenatal care" (Byers, 1979, p. 24).

The Puget Sound Indian Health Board was initially formed in 1972 including representatives from local tribes; the Puyallup continue to be members. The ongoing discrimination against Indians seeking health care and the failure of non-Indian-run institutions to provide sufficient care in such areas as maternity, geriatrics, alcoholism, and mental health led to a campaign organized by the Puyallup in 1973 to recover the Cushman Indian Hospital site and transform it into a tribally controlled medical center (National Lawyers Guild, 1973). The tribe had conducted unsuccessful negotiations with the state of Washington since 1971. A group of Puyallup, including the tribal chairwoman at that time (Ramona Bennett), staged an armed but peaceful occupation of the Cascadia Facility in October of 1976 (Puyallup Indians, 1976). After a second occupation of the facility in June, 1980, Judge Tanner of the Federal District Court ruled that the Cascadia site belonged to the United States Government, that it had been held in trust for the Puyallup, and that the transfer of the property to the state of Washington in 1961 was invalid. A somewhat orderly transfer of the site to the Tribe was accomplished in September of 1980.4

The efforts of the Puyallup to re-establish medical care for their people and the other American Indians and Alaska Natives who migrated to the greater Tacoma area continued throughout the period of controversy over the Cascadia facility.5 In the late 1960s, the tribe organized a Social and Health Concerns Committee. During this time the first IRS-funded dental trailer began to appear. The trailer was parked in the tribal cemetery as this was the only ground available.

The Puyallup began to operate the first "self-determination" Indian medical clinic in the nation—The Indian Community Clinic—in 1976 on a Tribal site adjacent to the Cascadia facility.6 The beginning was the establishment in 1974 of a Well-Child and Women's Clinic one afternoon a month in a mobile trailer behind the current Elders' building. The first Community Health Representative (Fay Dillon) worked in this clinic. The next development was the hiring of a physician (Tim Byers, M.D., in April of 1976 for half a day, twice a week) and a nurse. The physician's position became full time in October, 1976. The pharmacy was established in the same year. Connie McCloud completed training and started as a women's health specialist in 1976. The present clinic was built, and the Dental-Administrative building remodeled, in 1976. Both were put in use the same year. By April of 1978, the clinic facilities included: a waiting room/reception area, a records room, a central staff room, a laboratory, six exam...
rooms, a treatment room, a storage room, a pharmacy, and an x-ray room. The staff consisted of two full-time physicians, two registered nurses, a pediatric nurse practitioner, a women’s health care specialist, a lab technician, a lab assistant, a pharmacist, a pharmacy assistant, two medical clerks, and a receptionist. The clinic was managed by a director.

The mental health facilities of the Puyallup began in 1975 in the Indian Community Clinic with Indian Health Service funding. Robert Houk, M.D., practiced 1 day a week. John Bopp, from the Indian Health Service Traveling Health Service, provided intermittent care, as did Joanna Thorpe. Mental Health moved to a mobile home by the current Elders’ building in 1976. They shared the trailer with Central Records and Nutrition. As other trailers were acquired, Mental Health received its own trailer. Between 1977 and 1979, Dr. Houk, Lou Matheson, and Director Vickie Sears, comprised Mental Health. They were funded by a start-up grant from the National Institute of Mental Health. An ongoing National Institute of Mental Health grant, funded by way of the Good Samaritan Mental Health Clinic beginning in 1979, allowed Vickie Sears to hire two more counselors in 1979. Mental Health experienced an almost complete turnover in staff in 1980. However, staff stability improved after the move to its present building following the return of the Cascadia facility to the tribe in the fall of 1980.

Mental Health, now called the Kwawachee Counseling Center, includes traditional therapies along with Western interventions. Treatments in the "Longhouse Tradition" of a northern Puget Sound group are the most commonly utilized form of traditional healing. However, the Sacred Pipe Ceremony, sweats, and ritual healings of both Bible-believing and non-Bible-believing Shakers are also used. Money is sometimes given to healers for gas for transportation to Kwawachee. However, money for services is not given to practitioners. Rather, gifts appropriate to the healing technology of the practitioner are given. Manson (in press) reports the type of difficulty faced by American Indian and Alaska Native people seeking traditional mental health care in the greater Tacoma area prior to the development of Puyallup mental health services:

A community mental health center in Puyallup, Washington, authorized payment to a local traditional healer for his involvement in providing care to an Indian patient. Preliminary discussions indicated that the reimbursement needed to proceed in a way that it reinforced the relationship between healer and patient, that their special bond be cemented in some reciprocal fashion. Money, particularly dispersed by an administrative agent far removed from the scene, was clearly inappropriate. The eventual solution was to purchase Pendleton woolen products equal in value to the reimbursable costs of the services and give them to the patient. The patient then presented the scarves and blankets to the traditional healer. Though it initially disrupted the contracting procedures, this mechanism has been employed with increasing ease in several subsequent consultations.
This is precisely the kind of intercultural difficulty that the Puyallup health system was created to minimize. The existence in this area of American Indian and Alaska Native people from a wide variety of cultural backgrounds makes the provision of traditional treatments from diverse cultures a necessity.

The Puyallup initiated an Outpatient Alcohol Information and Referral Program in 1976 in another trailer near the present Elders' building. Being housed in a trailer to the rear of the medical clinic presented some problems that were detrimental to treatment. Leo Whiteford, Manager of the Substance Abuse Treatment Center (the current title of the facility) reports that clients who needed help were reluctant at times to enter the alcohol program for fear of being discovered. The location presented a large amount of patient traffic in the immediate area. The trailer house was far too small, causing group sessions to be cancelled. Problems of confidentiality arose because of inadequate insulation for sound.

When the tribe reacquired the entire Cascadia complex in the fall of 1980, a building formerly entitled the Phoenix House by the state was opened to use by the Substance Abuse Program. This site was an excellent environment for an in-resident facility. This program, along with the existing outpatient services, the combination being known at the time as The Indian Family Alcoholism Program, experienced a high level of staff turnover and management-treatment problems for a time. However, positive changes began in May and June of 1981 that brought nationwide recognition to the existing Substance Abuse Program. The program was selected in February of 1983 to be a model alcoholism program for the Portland Area Indian Health Service Region.

The alcohol and drug treatment facility integrates Western and traditional treatments through the Medicine Wheel approach, a holistic approach to illness which considers the social, psychological, physical, and spiritual aspects of an individual’s illness mixed with a heavy dose of reality therapy. It maintains a sweat lodge which is primarily used by the inpatient program, although former patients may continue to use it. Different tribes employ the sweat lodge for different purposes according to their differing cultural backgrounds. However, it is generally used for spiritual as well as physical cleansing, and as a time for prayer. Counselors also burn sage and fan it over a client with an eagle feather. This process of smudging is a traditional symbol of power among some tribes. Counselors also ask clients to learn and write about their own cultural backgrounds as a way of making them feel more in contact with and proud of their historical roots. Poetry-as-therapy classes are also offered by David Whited, one of the authors of this paper, to allow individuals to express themselves (see the frontispiece). The results show the persistence of traditional values and beliefs, when overt signs of traditionality are absent.
In addition to the above services, the Puyallup Tribal Health Authority (the current name for the entire Puyallup health care system) currently offers a Community Outreach Program, a Nutrition Program, an Elders’ Program, and a Children’s Services Program. Each of these have a developmental history that originated in the revitalization period that began in the late 1960s. Space and time limitations force us to relate these histories elsewhere in the future. It is clear, however, the goal of the Puyallup from the beginning of the revitalization movement was to provide holistic-comprehensive-preventive medical, dental, and psychosocial support services to their tribal members and their larger American Indian and Alaska Native community.

The Puyallup have traditionally been regarded by neighboring tribes as generous and hospitable. That is why they bear the name Puyallup, which means "add more" (Hunt, 1916, p. 23). In the past, Indians came from the north, south, and east, traveling in quest of game, fish, and various vegetable foods. They usually stopped with the Puyallup to replenish their supplies, asking merely for enough to carry them to their destination. The Puyallup not only gave what was asked but added more. This tradition continues today in the modern context through their health care facility.

Broader Medical Context

Kleinman (1980) has made it clear that a cross-cultural study of medicine must start with the appreciation of health care as a system that is social and cultural in origin, structure, function, and significance.

In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal arrangements. (p. 24)

A corollary of this position is the recognition that the aboriginal Puyallup health care system could only be understood in relation to traditional Puyallup culture. The main element of Puyallup culture underlying healing was a spiritual approach to the world. Most natural things possessed spiritual power: animals, people, and trees, as well as such entities as water and thunder (Smith, 1940). Martin (1981) notes that this spiritual orientation influences traditional practice in two ways. First, the healer is concerned with the relationship of the patient to his/her surroundings: spouse, family, neighbors, and village. Second, he/she emphasizes ritual in the healing process incorporating social relationships in a curative ceremony. The reason for the ceremony is the belief that disease and illness are the result of a lack of harmony, balance, or equilibrium between the
sick person and his/her surroundings. Martin concludes that this is similar to the modern psychosocial approach to sickness which includes attention to the patient's family and support system.

Despite the extensive literature on the social, political, economic, and psychological functions of traditional American Indian and Alaska Native healers (Bergman, 1973, 1974; Hallowell, 1941; Handelman, 1967; Jilek, 1971, 1982; Morgan, 1931; Murphy, 1964; Nieuwenhuis, 1924; Opler, 1936, 1946; Whiting, 1950), few medical practitioners realized the function and significance of traditional health care systems until recently. Western medical practitioners have rarely been sensitive to the underlying nature of the biomedical model upon which Western clinical practice is formulated. Kleinman (1980) describes the effect of this lack of sensitivity on modern medical research:

The ingrained ethnocentrism and scientism that dominates the modern medical and psychiatric professions (both in developed and developing societies) follows the paradigm of biomedical science to emphasize in research only those variables compatible with biological reductionism and technological solutions, even if the problems are social ones. (p. 32)

Another bias of health professionals in contact with indigenous health care systems has been the tendency to restructure indigenous health care delivery by copying the idealized model of professional care prevalent in technologically advanced societies (Kleinman, 1980). This fictive view which overemphasizes the role of professional practitioners does not correspond to the actual situation in technologically developed societies where 70 to 90% of all illness episodes are treated solely in the family context (Kleinman, 1980). Further, Western professionals frequently make the mistake which Polgar (1963) labels "the fallacy of the empty vessels." That is, practitioners assume that non-Western people do not have established health customs and thus are empty vessels waiting to be filled with whatever health program is being advocated.

Finally, there has been a long-standing tendency of clinicians to treat healing as if it were a totally independent, timeless, culture-free process to be understood either as an isolated special case or by comparisons with clinical practices in psychoanalytic therapy, hypnosis, biofeedback, or the accepted clinical methods of the time (Kleinman, 1980). Consequently, clinicians have not regarded healing, the most basic of all health care processes, as a core function of health care systems to be studied in its own terms within specific social or cultural contexts. Rather, they have made simplistic reductions or superficial comparisons to fads such as brainwashing or occult forces.

The biased orientation of Western practitioners became a powerful force due to the enormous increase in prestige and power they experienced due to the rising popular confidence in science characteristic of the nineteenth and early twentieth centuries (Brown, 1979; Starr, 1982). Breakthroughs in antiseptic surgery, bacteriology, vaccines, and the diagnostic use of x-rays dramatically improved
the reliability of Western health care. Thus, medicine in the minds of most Westerners was transformed into a legitimate domain of specialized experts. Most other health care practitioners were excluded from practice.

As a consequence of the biases and forces operating in Western medicine, American Indian and Alaska Native healers were viewed as crazy witch doctors who prevented patients from seeking adequate care (Jilek, 1971). Initially, they were thought to be mentally ill people whose cultures enabled them to act out their particular psychopathologies in a prestigious role. Only recently has a small portion of the medical community incorporated traditional American Indian or Alaska Native healers into mainstream practice as auxiliary psychotherapists (Manson, in press).

The Puyallup experienced the transition from a nonliterate, hunting and gathering culture to a marginal subculture within an urban-industrialized society in little more than 100 years. Because of the biases and forces that dominated the medical profession during this period, the traditional health care system of the Puyallup, well-documented in Smith (1940), was discredited by Western authorities and the Puyallup were forced to accept a health care system modeled after that in Western culture. Using Landy’s (1974) terminology, the traditional healing role of the Puyallup was "attenuated."

The historic pattern of consequences of this biased orientation of Western medical practitioners on the Puyallup is of critical concern. Based on a recently completed research project on current Puyallup health care and health care seeking strategies by Guilmet (1984), it is clear that the traditional holistic support for health in Puyallup culture has been impacted and replaced for the most part by dependency on a series of fragmented interventions provided by Western medical practitioners with strictly biomedical orientations. By holistic we mean socially organized responses to sickness that constitute a special cultural system—the health care system—which functions to treat the whole person in all of his/her social, cultural, biological, and psychological aspects. The Puyallup refer an extremely high rate (50%) of all sickness episodes to Western practitioners when compared to other cultures; yet the medical staff displays a superficial understanding of the causes of sickness in Puyallup culture. The turnover rate of physicians at the tribal clinic is extremely high; 33 doctors have worked at the small clinic between 1976 and 1984. Most doctors serve only a short time to fill or partially fulfill their commitment to the federal government which has financed their education. This pattern is typical of most Indian Health Service facilities (U.S. Senate, 1974).

Further, the Puyallup almost never become involved in non-Indian alternative healing: for example, chiropractors, naturopaths, health food store advisors, lay therapists, non-Indian religious healers, or other ethnic folk practitioners (Chinese herbalists or acupuncturists, curanderos, etc.). In a time when
alternative healing is flourishing in our society in ethnic and mainstream sectors of the health care system, it is impressive that the Puyallup do not participate in these phenomena. Due to their particular ethnohistory, the Puyallup are largely isolated from other forms of alternative practice as well as from their own traditional healing system.

As the traditional Puyallup healer's role diminished, a major contributor to individual health and social order was undermined, a fact seldom appreciated by representatives of Western culture. The traditional healer was a prime contributor to dispute resolution, the integration of marginal individuals into mainstream culture, and the maintenance of spiritual values. No outside force, medical, political, or religious, has thus far been able to replace the holistic functions of the traditional healer.

In contrast, the traditional curing roles of other cultures, such as the Taiwanese (Kleinman, 1980), have thus far been both "adaptive" and "emergent," again using Landy's (1974) terminology, in the face of Western medicine. Continuity in traditional systems occurs in these cases because the traditional medical activities occur in a supportive cultural situation which allows traditional beliefs and behaviors to thrive. Less cultural disruption occurs in these situations due to the co-existence of traditional and Western medical systems.

The Institute of Medicine's Recommendations in Puyallup Perspective

We have seen that the Puyallup Tribal Health Authority has historically treated mental illness both within its primary care clinical facility, the Indian Community Clinic, and within its more basic mental health institutions: Kwawachee, Substance Abuse, Children's Services, etc. The pattern of growth of the latter specialized intervention programs has been concomitant with the development of the primary care institution. Coordination of primary care with specialty interventions has been an explicit goal of the Health Authority. Let us now consider the implications of the Puyallup experience for integrating the Institute of Medicine's recommendations within American Indian and Alaska Native communities.

Mental Health Care Within a Primary Health Care Clinical Facility

Several problems have made it very difficult to effectively treat emotional disorders within the primary care clinic. First, the two physicians are extremely overloaded with patients; thus, finding enough time to go beyond basic treatment of expressed symptoms is made very difficult. The crowded conditions caused
by the heavy flow of patients through the small rooms in the clinic exacerbates this problem by forcing physician-patient communications concerning personal and family problems to occur in a context not conducive to informal dialogue.

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

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

A recent study by Guilmet (1984) confirms the absence of direct psychiatric complaints among a subset of the clinic’s population. Extremely few heads of household reported emotional illnesses in their families. Somatic complaints like those given above were frequently encountered. The somatic nature of the typical patient complaint is supported by the nature of many of the top 30
leading causes for contacting the Puyallup Indian Community Clinic (see Table 1). Individuals in the greater Tacoma American Indian and Alaska Native population frequently present musculoskeletal disorders, abdominal pain, and several symptoms related to colds. The only category related to emotional distress which is overtly presented to the clinic is alcohol abuse. Ostruske notes that it is culturally more acceptable to be treated for alcoholism either as an inpatient or an outpatient in the Puyallup community than the society at large. Further, it is more acceptable to be treated for alcoholism than for mental distress within the Puyallup community. However, alcohol problems were seldom reported in the Guilmet (1984) study. This was most likely due to the stigma that, nevertheless, is attached to the disorder.

Table 1

Thirty Leading Causes for Contact: Indian Community Clinic Fiscal Year 1984

<table>
<thead>
<tr>
<th>Cause</th>
<th>Total Contacts</th>
<th>Average Monthly Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Upper respiratory infection</td>
<td>1,408</td>
<td>117.3</td>
</tr>
<tr>
<td>2. Accident</td>
<td>996</td>
<td>83.0</td>
</tr>
<tr>
<td>3. Otitis media</td>
<td>914</td>
<td>76.2</td>
</tr>
<tr>
<td>4. Prenatal care</td>
<td>540</td>
<td>45.0</td>
</tr>
<tr>
<td>5. Physical exam</td>
<td>525</td>
<td>43.8</td>
</tr>
<tr>
<td>6. Bronchitis</td>
<td>501</td>
<td>41.8</td>
</tr>
<tr>
<td>7. Alcohol abuse</td>
<td>436</td>
<td>36.3</td>
</tr>
<tr>
<td>8. Diabetes mellitus</td>
<td>386</td>
<td>32.2</td>
</tr>
<tr>
<td>9. Elevated blood pressure</td>
<td>379</td>
<td>31.6</td>
</tr>
<tr>
<td>10. Prophylaxis</td>
<td>318</td>
<td>26.5</td>
</tr>
<tr>
<td>11. Pharyngitis</td>
<td>281</td>
<td>23.4</td>
</tr>
<tr>
<td>12. Well child exam</td>
<td>268</td>
<td>22.3</td>
</tr>
<tr>
<td>13. Contraception</td>
<td>247</td>
<td>20.6</td>
</tr>
<tr>
<td>14. Viral syndrome</td>
<td>244</td>
<td>20.3</td>
</tr>
<tr>
<td>15. Conjunctivitis</td>
<td>224</td>
<td>18.7</td>
</tr>
<tr>
<td>16. Scabies</td>
<td>223</td>
<td>18.6</td>
</tr>
<tr>
<td>17. Rheumatoid arthritis</td>
<td>210</td>
<td>17.5</td>
</tr>
<tr>
<td>18. Routine PAP</td>
<td>178</td>
<td>14.8</td>
</tr>
<tr>
<td>19. Urinary tract infection</td>
<td>172</td>
<td>14.3</td>
</tr>
<tr>
<td>20. Obesity</td>
<td>150</td>
<td>12.5</td>
</tr>
<tr>
<td>21. Vaginitis</td>
<td>145</td>
<td>12.1</td>
</tr>
<tr>
<td>22. Otitis externa</td>
<td>143</td>
<td>11.9</td>
</tr>
<tr>
<td>23. Sinusitis</td>
<td>143</td>
<td>11.9</td>
</tr>
<tr>
<td>24. Diagnosing Pregnancy</td>
<td>141</td>
<td>11.8</td>
</tr>
<tr>
<td>25. Anxiety</td>
<td>139</td>
<td>11.6</td>
</tr>
<tr>
<td>26. Abdominal Pain</td>
<td>122</td>
<td>10.2</td>
</tr>
<tr>
<td>27. Musculoskeletal Sx</td>
<td>122</td>
<td>10.2</td>
</tr>
<tr>
<td>28. Eczema</td>
<td>121</td>
<td>10.1</td>
</tr>
<tr>
<td>29. Allergic Rhinitis</td>
<td>114</td>
<td>9.5</td>
</tr>
<tr>
<td>30. Pediculosis, Cap</td>
<td>111</td>
<td>9.3</td>
</tr>
</tbody>
</table>

Note. From the Puyallup Tribal Health Authority Planning Department.

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

The family situation is caused in part by the economic hardship of the traditional male economic role: fishing-hunting, the male occupation common to many of the families that live in the greater Tacoma area. This role is marginal for those who possess local fishing rights and nonexistent for relocated individuals. For much of the year, fishermen await the fish runs and many become depressed and concerned about income during the off-season. Even the onset of subsistence activity brings fewer economic rewards than necessary to maintain a stable economic situation. The low educational attainments and value orientations of American Indian and Alaska Native men also result in limited job success in nontraditional employment. Men must compete with other urban ethnic men for the existing low-skilled or semi-skilled jobs, when their value systems are not based on competition and do not support the enterprises involved. In this context, a Pierce County Public Health employee, a Black woman, told the Executive Director of the Health Authority, Rod Smith, the following in 1985: "You Puyallup got it hard out there. Our struggle was easy. We know just what we wanted. We wanted what The Man had. But those Indians, they're different; they just don’t necessarily want what The Man got."

Further, it is not uncommon for today’s parents to have been raised by parents who were educated in boarding schools or placed in foster homes, many of non-Indian or non-Alaska Native heritage. Also, the observational and trial-and-error learning styles, and the informal display-oriented teaching styles integral to tribal-nonliterate cultures contrast sharply with their formal verbally oriented counterparts in high technology societies (Guilmet, 1975, 1978, 1979a, 1979b, 1981). Thus, some parents have not learned the parenting skills necessary to teach their children to survive and thrive in this unique urban reservation environment.

Fourth, most primary care practitioners who have worked for the tribe lack the specialized training to identify the cultural nature of emotional dysfunction in American Indian and Alaska Native communities. General practitioners receive little or no exposure to the growing field of cross-cultural psychiatry. The idea that different beliefs and experiences result in culturally shaped syndromes is foreign to the biomedical worldview of most Western practitioners.

The mental health disorders in the tribal community are different from the mainstream. For example, there is an unusually high level of grief work to be done on the Puyallup Reservation. With the extremely high death rate, due to accidents, a high infant mortality rate, etc., members of the community are
constantly faced with the often unexpected death of a friend or relative. These tragedies are made more severe by the changes in grieving patterns due to acculturation. Ostruske notes that while American Indian and Alaska Native tribes were not homogeneous, many traditionally practiced open and overt grieving.\(^1\) This is more typical of the female than the male role. She believes that many are now emulating the dominant society’s death-denying and inadequate way of dealing with grief by becoming stoic and not crying, as tears may be construed as a sign of weakness. She reported significant increases in contacts to the Kwawachee Counseling Center following the loss of several Puyallup families’ children in a house fire and the loss of three Puyallup fishermen in a subsistence accident.

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

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

Coordination of Primary Care with Basic Mental Health Services

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

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

Indeed, one of the most severe problems facing the entire Puyallup comprehensive mental health system is the shortage of funds to support desperately needed services. The Indian Community Clinic has been attempting to acquire funding for another physician for the past several years. At least one medical social worker who is culturally sensitive to the tribal community is needed to screen primary care patients and guide them to appropriate facilities inside or outside of the tribal system. As one example, this person could improve the coordination between the Indian Community Clinic and the Kwawachee Counseling Center concerning the prescription of medications. Usually, Kwawachee clients' medications are monitored by the part-time psychiatrist or clinic pharmacist. Ideally, any of those patients also medicated by clinic physicians should be tracked through referral to Mental Health. This coordination process needs to be improved to avoid conflicting interventions.
Perhaps an improved tracking system by computer could reduce conflicting treatments and ease the burden of preparing two sets of reports to two separate funding sources (National Institute of Mental Health and Indian Health Service).

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

The Bureau of Indian Affairs-funded Children's Services Program needs at least one more social worker and two more field workers to handle their 24-hour crisis program for abused and neglected children. One caseworker position has just been lost due to exhausted funding. And, the nationally recognized Tribal Alcoholism Treatment Center has a typical waiting list of about 40 individuals. The outpatient section of this facility is perhaps the most severely understaffed unit in the Health Authority. One Indian Health Service-supported counselor handles the entire Pierce County Indian population. Another situation which interferes with the coordination of primary care interventions with basic mental health services results from the fact that different Health Authority programs are funded by overlapping funding agencies with sometimes conflicting criteria for providing patient care. The task force on Mental Health for the President's Commission on Mental Health (1978) stated that the service delivery systems offered to American Indians and Alaska Natives are fragmented and have little or no coordination on the local or federal levels.

For example, the Health Authority's Substance Abuse Treatment Center is funded by five contracts, requiring several sets of Washington State licensure, and five sets of client report forms for each individual client episode. The Alcohol Tracking and Guidance System utilized by the Indian Health Service alone involves 14 pages of report forms in addition to reports required by Pierce County, Washington State, Washington State Alcoholism Monitoring Systems, Washington Information System for Drug Units Management, and two different kinds of reporting on inpatient days. Unfortunately, the Treatment Center also must report monthly summaries of services to the Health Authority.

The above situation is further complicated by the short-term nature of most Health Authority funding sources. The Indian Health Service is one of the few federal agencies concerned with continuity of care. They provide future funding
based on past service records, unmet needs, and past funding levels. Compare this approach to that of the Bureau of Indian Affairs in Indian Child Welfare matters. There exists a limited amount of funding distributed through a competitive exclusionary annual proposal process which leaves some tribes unfunded and all unsure of continuity in funding each year. This competitive atmosphere increases unhealthy competition between tribes by inhibiting the exchange of useful and pertinent information, program models, and treatment strategies. During the last four funding cycles, the level of Puyallup Child Welfare funding has fluctuated from $28,000 to $7,000 to $140,000. This has occurred without regard to the fact that the Health Authority has been delegated legal responsibility for the care, support, and supervision of the 50 or more Indian and Alaska Native children and their families per month, whose cases are the direct responsibility of Children’s Services. Each shift in funding level forces the Indian or Alaska Native extended family members to cope with different state or tribal agencies to reunite their families. Drastic differences in cultural sensitivity are represented by these two agencies. Lack of funding does not decrease the tribe’s legal responsibilities from the perspective of outside courts and social service agencies for those already in care. However, it drastically inhibits the Health Authority’s capacity to accept new cases and to adequately tend existing ones.

A further complication is the stratigraphic nature of "minority sensitive" funding sources. The Kwawachee Counseling Center is funded by the National Institute of Mental Health through a hierarchical network including the Washington State Department of Social and Health Services, Pierce County Social Services, a private provider (Good Samaritan Hospital-Mental Health Unit), and finally, subcontracted to the Puyallup Tribal Health Authority. Note that each administrative level consumes health care dollars appropriated for service delivery. The Indian Health Service, the agency generally expected to provide this service, is not involved in this process. The entire Puget Sound Service Unit of the Indian Health Service provided mental health care to only 78 individuals in 1984 (there are 10 tribes in the Service Unit) while Kwawachee provided care to 278 individuals. The Indian Health Service does not even record the mental health delivery of the Puyallup Tribe. How could they be exercising their responsibility in this area given this situation? Research should be conducted to determine the extent of this back-to-back service delivery and the waste of direct service dollars in this structural hierarchy of administrative responsibility on a national level.

The annual allocation of National Institute of Mental Health money to the Health Authority has been eroding, while at the same time, national statistics demonstrate that such sociogenic illnesses as suicide, alcoholism, and family dissolution are on the rise. The Indian Health Service should explore the
possibilities of increased funding and coordination of mental health programs, given their respectable record in effectively treating various "biomedically-based diseases."

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

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

Could a system be cost-effective and functionally successful in which each client was counseled and triaged through a central admissions point which would refer to available, coordinated, and centrally funded services with reasonable reporting requirements? Further, to what extent would this holistic approach provide an enhanced context in which to incorporate culturally sensitive, natural community helpers and traditional practitioners in mental health treatment? Research might be conducted to determine the potential of more effective referral to tribal facilities which should occur due to the involvement of the latter community helpers and healers. Another important question is the effect of such
a coordinated-comprehensive approach on the stigma attached to help-seeking behavior and client-avoidance behavior in general. To what extent does physical isolation of service delivery affect stigma and avoidance behavior?

Conclusions

The Institute of Medicine’s proposal to conduct research on the increased role of the primary care sector in the provision of mental health care is only partially supported by the Puyallup experience. Any augmentation of existing support for the established clinic physicians would be welcome since it would undoubtedly improve patient care. However, this affirmation of the Institute’s plan cannot be used to justify a decrease in financial and philosophical support for the broader set of coordinated interventions that compose the Puyallup mental health system.

The history of Puyallup Tribal Health Authority development records recognition of the need for an integrated web of health services in the broadest sense, to begin to build a holistic support system for peoples whose cultures were fragmented by explicit government policies of assimilation. The mental health of a people who have been forced to face rapid and radical social change will not approach that of the mainstream until all sectors of their culture (occupational, familial, spiritual, educational, and more) are reintegrated. The re-establishment of holism at this level is far too enormous a task to be placed upon two overworked primary care physicians. Indeed, it is too much of a task to be left to any health system as normally defined. All social services (education, job training, family counseling, intervention, substance-abuse therapy, etc.) must be augmented to help primary health care practitioners in their tasks.

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

The undue reliance upon primary care physicians to treat emotional disorders would retard the process of self-determination in health care that has begun to reduce the dependency of the Puyallup community on outside providers. Far too few American Indian or Alaska Native physicians exist to meet tribal needs nationwide, and exceedingly few physicians of any background commit their time or energy to tribal people on a consistent and ongoing basis. Continuity in care is primarily provided by mid-level paraprofessionals who are part of their respective communities. Increased financial, educational, and institutional
support for these individuals would perhaps lead to greater improvement in mental health care delivery than corresponding energy and dollars invested in physician training.

Research by one of the authors (Guilmet, 1984) has shown that many Puyallup display relatively simple hierarchies of resort when compared with individuals from cultures in which institutional support is given for traditional healing. Nonetheless, given our research since that initial Puyallup study, there is reason to believe the hierarchies of resort reported for Puyallup do not reflect the complexity of health care seeking behavior that actually exists for many Puyallup and other community members. The actual resort complexity may be, for some, similar to that described in Amoss (1978) for a related but more isolated Salish Indian group:

Differential diagnosis is not easy. When an illness cannot be cured by simple home remedies, the usual procedure is first to consult a white doctor. If his ministrations fail, the victim or his family will look for help "on the Indian way." AZ explained her decision-making process: "There's three things we have to help us, the white doctor, the Shake, and the syxwman. If my kids is sick, I go to the white doctor first. If he can't do nothing, I take them to the Shakers; if they can't do nothing, then it's the syxwman." (p. 83)

Because of the complexity (for many) of the hierarchies of resort, enhanced support to community paraprofessionals would undoubtedly lead to greater community involvement in the existing mental health care system and the concomitant reintegration of traditional values, beliefs, and practices into mental health delivery.

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

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

Notes

1. See pages 70 and 71 of Otis, Katz, and Whited (1981) for data concerning the decrease in the percentage of Indians committed to the Oregon State Mental Hospital and the corresponding increase in Indians incarcerated in Oregon state correctional institutions: "Ostensibly this pattern reflects a preference for criminal rather than civil commitments. At issue is whether Native Americans are being singled out for this kind of treatment in preference to less severe alternatives." (p. 71)

2. Data from the 1980 United States Census and the Office of Human Development Services (1981) were used in the above discussion. These data are not specific to the Puyallup, but include other American Indians and Alaska Natives on the Puyallup Reservation, in Pierce County and in Congressional District 6. However, there is every reason to believe the Puyallup and the other Indians and Alaska Natives in their community share similar socioeconomic conditions.

3. Field notes from conversation in January 1985 with Connie McCloud, a current Tribal Council member who has occupied various health care delivery roles in the Puyallup health care system since the early 1970s.


5. Ibid. Note 3.

6. This section based on: Ibid. Note 3; a transcribed interview with Connie McCloud in April of 1978 by Marilyn L. Lebond, a student in one of Dr. Guilmet's university classes; and a 1979 unpublished manuscript entitled "Puyallup Tribal Health History" by Dr. Tim Byers, the first physician with the Indian Community Clinic.

7. This section based on: the written responses of Marsha Ostruske, Director of the Puyallup Tribal Mental Health Program, Kwawachee Counseling Center, to a set of questions constructed by the authors of this paper; and field notes of a meeting with Kwawachee staff, January, 1985.

8. This section based on: Ibid. Note 3; and the written responses of Leo Whiteford, Manager of the Substance Abuse Treatment Center, to a set of questions constructed by the authors of this paper, January, 1985.

9. Written responses of Marsha Ostruske, Director of the Puyallup Tribal Mental Health Program, Kwawachee Counseling Center, to Chapter 17 of the Institute of Medicine's publication (Hamburg et al., 1982), January 1985.

10. Connie McCloud (see Note 3) noted the avoidance behavior of individuals seeking mental health treatment during the period when the Mental Health Center was conspicuously placed as a separate facility in a mobile home in a parking lot near the Indian Community Clinic and the Elders' building.


References


Guilmet, G. M. (1979a). Instructor reaction to verbal and nonverbal-visual styles: An example of Navajo and Caucasian children. Anthropology and Education Quarterly, 10, 254-266.


Puyallup Indians won't yield juvenile building. (1976, October 25). *Bakersfield Californian.*


Discussion

Dr. Hunter: The paper gives a unique point of view in that it’s not really a consumer’s perspective, but a consumer of bureaucracy’s perspective. I didn’t get any sense in reading the paper as to how the patient felt coming into the clinic. But there is a very clearcut sense of frustration by the people who are trying to provide the services in dealing with the bureaucracy. That’s not a perspective that I have come across, or at least been aware of when I did.

The overload of the primary care providers and the delivery of mental health therapies in a primary care setting are discussed in the paper. What do you do when the provider of services is overloaded with patients or clients? What do you do when the person who is providing the services has an M.D. but doesn’t know anything about psychotropic medications, either the appropriate drug for the appropriate illness or the appropriate dosage of the drug that should be prescribed, assuming that one should be prescribed? One of the dangers I have found in having this type of primary care physician be overloaded is that it’s very easy to move to a medical care model. Somebody comes in a little bit nervous, you have a whole bunch of people waiting, it’s easy to give them some Valium and send them on their way. They’re happy, you’re happy, and you can move on to the next patient you’re going to see rather than talk with them. I think this is the type of pitfall that the clinic, the provider, and the client are subject to in some situations.

The paper also addresses service delivery alternatives. What are the problems in referring patients to different delivery settings for mental health care? Many patients have trouble with psychosocial problems, such as when a patient is anxious or has some sort of somatic complaint. How much of this has to do with somatization due to having just lost their job or the rent being due the day before? Very complex, psychosocial problems intermingle with medical and psychological problems.

Again touched upon in a specific way in the paper were the issues of costs, reimbursement, and research allocations. The paper indicated that the paraprofessional group was there relatively steadily. The physicians are, perhaps appropriately, dealt with as technicians hired to come in and do a job since they’re not going to stay there for any length of time. If you know that for a fact, it’s probably enlightened self-interest to utilize them that way and strengthen your group who is actually dealing with the patients.

One of the things that has puzzled me since I have come into the Indian Health Service has been the turnover of not only physicians, but other medical specialties. It’s not something that I can readily explain. I see situations that look like they would be very undesirable, and there is no turnover. Other situations look highly desirable, yet there is a great deal of turnover.
There is a tendency to come up with fairly simplistic answers as to the cause for the turnover. To give you a good example, there is a Southwestern tribe that is located in a lovely area, has plenty of money, has a great deal of area support, a great deal of political clout, and an enormous turnover of every type of physician. I find myself asking if there is some function to this turnover? I don’t have the answer to that, but I get suspicious.

The paper quoted a Black woman, I believe, as to Blacks knowing what they wanted and the tribe not knowing what it wants. I think that’s a very incisive thing to say in that it’s important that tribes know what they want, and that they have the right to be specific of their wants. We in the Indian Health Service are quick to think we know what people may want. Sitting in my office, it’s easy for me to think I know what all the tribes in the country want. Well, I don’t have the foggiest idea what all the tribes in the country want. It’s quite easy for people in the area office to know what every tribe in that area wants. They’re wrong on a scale of magnitude less than I’m wrong only because I’m guessing for the whole country and they have an area. It’s going to be increasingly important for different groups to decide what they want.

This is illustrated by a couple of groups in Maine I visited last summer, which were from the same tribe about 30 miles from each other. One group said they saw no mental health problems at all in what they were doing, but that the vast majority of the problem was with alcoholism. The other group perceived alcoholism as being a portion of the mental health problem. This is the same tribe, different elected governments, different reservations, but the same people. Somebody could be tribal chairman on one reservation, yet be born on another reservation. That sort of difference in perspective and the ability to address that difference is going to be increasingly important in terms of the direction that medicine takes in the next several years.

Mr. Whited: I would like to clarify one thing about that quote. The quote wasn’t about the tribe not knowing what it wanted. It was by a Black social service provider who works for Pierce County speaking to the Executive Director of the Puyallup Tribal Health Authority, who happens to be blonde. She said to him, "You Puyallup got it hard out there. Our struggle was easy, we knew just what we wanted, we wanted what The Man had. But those Indians, they’re different; they just don’t necessarily want what The Man’s got."

Dr. Guilmet: They’ve had pretty firm ideas about which way they’re going. They couldn’t have built a comprehensive system out of nothing and occupied a building with guns against the State Police and Tacoma Police if they didn’t have a pretty good idea what they were facing. The point is that the value systems in the Indian communities are different. You can’t just take the economic models that the outside community would use and assume the Indian community wants to do that.
Interestingly enough, even in this very acculturated community, the value systems are persistent. I was amazed at the continuity in spiritualism, the continuity in family values, the continuity in subsistence values. The language was virtually extinct, and by all observable forms such as Western clothing and Western housing they were acculturated, but the values are persistent. Even in the face of broken families and single parent families with high divorce rates, still the family ethos and the support for elders is there, and it’s strong. So the reason we support the midlevel paraprofessionals is because we think that the direction for the health unit is going to come from that. As you observed, it’s not going to come from the outside.

Dr. Bloom: Could you talk for a minute about the retention issues? You may have set up a self-fulfilling prophecy if you don’t spend too much time with these doctors because they are technicians that come and go. Since you don’t spend too much time with them, you don’t orient them to what you do for them. They do come and go. You then say, well, the thing to do is have a midlevel paraprofessional program.

Mr. Whited: I’m not exactly sure what the retention issue is nationally. Our retention is very similar to retention in the whole Indian Health Service. We currently have two doctors. One of the doctors has been there almost 2 years, and he’s heading for a record right now.

Dr. Bloom: These are privately hired doctors who are not doing any IHS or National Health Service Corps work?

Mr. Whited: No. Since 1976, we’ve recruited all of our doctors under P.L. 638 contracts. We recruit our providers ourselves, screening, interviewing and hiring them ourselves. We design our own provider pattern for each one of the units; it’s not dictated to us. Under P.L. 638, we also design and pick and choose what we report and don’t report. We’re not constrained to use the Indian Health Service reporting system. We’re constrained to provide care on a par with what Indian Health Service would, and we consistently do that.

Dr. Bloom: Let me ask you one question, and make one comment. Are your salaries comparable to Group Health in Seattle?

Mr. Whited: We pay very little. Our salary is about $42,000 for physicians, with a very limited benefit package. We can’t afford to pay any more. Our dollars have been pretty well capped for the last 3 years. Most of the people who’ve been there haven’t had a cost-of-living increase for that long. The people that stick it out are people dedicated to the provision of service. The lead pharmacist and pediatric nurse practitioner have been there since the clinic opened in 1976. The CHRs who are there have been there for 5 or 6 years now. The dental care providers have been there since the dental clinic opened in 1976.
Dr. Bloom: A quick comment. We have been doing some research on this problem in terms of community mental health centers which face a similar problem with physicians. There are some things people can do to heighten retention. The worst thing that you can do for physicians is to bring them in and work them to death, treat them as technicians, not teach them about the culture, and not give them other types of opportunities to learn.

Mr. Whited: But if we don't work our physicians essentially to death we don't serve the population we're mandated to serve. So make your choice: either work 2 people to death or you don't serve 1,000 people.

Dr. Robertson: This may be an average turnover for Indian Health Service some time ago, but for the Northwest, it's extraordinary. I have been with Indian Health Service for 3 years in the Portland area, and it's unusual to have a physician leave before the end of 2 years, and probably eight or nine in the area have been there more than 5 years. There are a lot of amenities in the Northwest. It's just lousy with physicians for that reason. So if they have this kind of turnover in that kind of setting, it is extraordinary. I don't think you should justify it on the basis that these being the average for Indian Health Service as a whole.

Mr. Whited: I'm not trying to justify it. I was just reporting what happened.

Dr. Robertson: I certainly agree with Joe, it's very much a self-fulfilling prophecy you're describing right now. Your salary would be competitive. The benefits would not be competitive, but I think you need to look for some other reasons. That's only one of two or three major considerations. One is the day-to-day activities and how pleasant or unpleasant it is for them to do what they have been trained to do. The expectations of the administrative staff and the patients of the physicians, these are what burn someone out quickly.

Dr. Guilmet: It seems to me that the idea of the Puyallups having choices is pretty funny if you look at the historical record. It was the creation of the largest Indian service hospital in the nation, starting in 1939, and the establishment of boarding schools and tuberculosis treatment facilities that made the Northwest a magnet area to be in. Once you get people in long-term treatment or in boarding schools, the whole in-migration pattern through kinship brings people to the city. They become, in effect, dependents on the Puyallup Tribe, but that wasn't a Puyallup decision. That was an external government decision-making process that landed the Puyallups in this place. At this time, the Puyallups and the other Indians in the community are very well integrated in terms of social interaction. The non-Puyallups, of course, are a bit more migratory, but the amount of need there is the same, no matter what the tribal group.

Dr. Levy: We know the Puyallups are about 800 people. We know Tacoma, on the reservation, is full of Whites. We know that the Puyallups are not responsible to take care of all the White people. There are all kinds of Indians
moving in and out and the city doesn’t seem to be responsible for them. But you haven’t explained very well, to me at any rate, why the Puyallup for some reason now have the responsibility of treating an unknown size service population.

Mr. Whited: One that changes radically. Our Indian Health Service funding is about $1.2 million to provide basic medical and dental care, and that includes our CHR contract.

Dr. Levy: But what is the service population size?

Mr. Whited: I hope they’re using the estimates that I’ve been giving them for about the last 4 years. That’s 7,000 to 8,500.

Dr. Hunter: The Indian Health Service would not say you must serve non-Puyallups. For example, if somebody whose tribe or pueblo was in the Santa Fe service unit would happen to get sick in Mescalero, they would have to go back to the Santa Fe service unit to get treated.

Mr. Whited: I believe that under Indian Health Service guidelines, if an Indian ends up on the step of an Indian Health Service primary care facility, that Indian Health Service facility takes care of them.

Dr. Levy: But in your case, it’s the Puyallup Tribal Health Authority which has to take care of them, not Indian Health Service.

Mr. Whited: Well, we’re providing the Indian Health Service care under a P.L. 638 contract, and we’re supposed to provide comparable care to the Indian Health Service.

Dr. Hunter: In the Albuquerque area, we will not automatically treat an Indian from Oklahoma who winds up sick in Albuquerque. We’ll give emergency treatment, yes, but in order to get further treatment, the Oklahoma area has to authorize it.

Dr. Robertson: I don’t want to belabor this, but that’s not true in our area. Anyone who is Indian and appears on the doorstep will be treated there. But contract services from outside consultants and outside hospitals are different, and you have to be eligible for contract services. I thought that was Indian Health Service-wide. It’s certainly true in our area.

Dr. Guilmet: The difficulty with that is the budget runs out very quickly in this area and there’s no possibility, or very little possibility, for referral.

Dr. Neligh: Just one point. I think that a number of tribes in our area face similar problems with retention and better salary packages, and have managed to reverse that trend. For example, the Crow tribe has managed to completely turn around their lack of physician retention by a couple of simple expedients and tribal initiatives. One is a good orientation based on some of the things we plagiarized from Spero about how to work with people from different cultures. Also, the community’s appreciation of the physician, whether genuine or not, if
expressed, seems to have a massive effect on retaining people. Having a feast for them a couple of times a year, or that sort of thing, and if they are appreciated, they will stay no matter how hard they have to work.

Mr. Whited: I'm kind of concerned we're standing so hard on physician retention. The basic mental health service is still and perhaps always will be provided by mental health care providers, Children's Services, the CHR outreach staff, and the alcoholism treatment staff.

Dr. Trimble: I wanted to redirect the discussion towards the question of the training of mental health professionals who can effectively work in American Indian communities. Spero, Norm, and I and have written quite extensively about these problems. What this means is two things. One, we have an administration in Washington, D.C., which says, and has been saying for the past 5 years, that there will be no more clinical training monies to provide the kinds of people that you need to deliver that kind of mental health service, even to the point where we're arguing for specific training of American Indians to work in that kind of setting.

The second important point is that those institutions responsible for training mental health professionals, specifically the MSW programs, the clinical psychology programs, and the counseling psychology programs, are not responding to the needs of ethnic minority communities. They are certainly not responding to the needs of American Indians and Alaska Natives.

If you're going to retain people, one, and two, if you're going to get competent people, we have to look at those institutions responsible for training. In many cases, the institutions themselves are not willing to take the initiative to find out.

Dr. Manson: What you're talking about, Joe, strikes me as not addressing the primary care sector issue. The Health and Behavior volume states the following:

The primary care sector is likely to retain a major role in delivering mental health care for the following reasons: better insurance coverage for treatment of physical illnesses than for care of mental disorders; reluctance of many persons to seek care from officially labeled mental health providers; and current and likely future inability of mental health practitioners to accommodate all the patients who are in need of services. (p. 280)

Do these arguments hold with respect to the way in which primary medical care is delivered in Indian country? And if they do, then what becomes the potential role for those providers in the primary care sector with respect to mental health? Forget for a moment mental health counselors. We're now talking specifically about the potential for the role of primary care providers. Is there a role for them? Are there examples from the various areas in which they are providing mental health care, whether it be early case identification and subsequent referral or triage?

Dr. Neligh: I think that's the problem also from the patient's perspective in our area. You've seen from our data that the patients tend to seek psychiatric and mental health care from primary care providers, as opposed to mental health providers.
It's less stigmatizing to go to a primary care provider than it is to come to the mental health trailer or to the mental health program that is in a specific location in the building. Everyone that knows you and is related to you sees you go in there.

My guess is that probably four fifths of the people in our area come to see a primary care provider instead of mental health for their initial contact. We have not yet addressed how effective the triage is between physicians and mental health. How effective is their ability to diagnose major mental illness? We've had some problems in that area. On the other hand, if we have a model where we consult to an Indian Health Service facility and train physicians in alcoholism, mental health, and psychiatric technologies, we improve people's ability to pick up on diagnostic categories related to mental health problems. We've seen that change take place in certain programs over a few years.

**Dr. Mohatt:** I think if you're going to do that, you're going to have to deal with what Joe was talking about in terms of psychiatric social work and medical education, so these doctors come out trained to deal with both the physical and the psychological.

**Dr. Neligh:** We assume that everybody has to almost be trained from scratch. We do a couple of different things to accomplish this goal. We bring them in for a week-long orientation provided by tribal members and experienced clinicians jointly. Then instead of having our area office consultants go out and see patients, we have them go out and consult with providers in the field. So we have an incentive system in place that makes people pick up the skills that we find are lacking. Just as you say, they come out of medical school and we find them ill-prepared for a lot of it.

**Dr. Mohatt:** We also can't ignore the cultural aspects. I really agree with what Gordon said about people choosing and wanting to choose primary care providers. In Rosebud we saw it all the time. It really was analogous to the situation in terms of their indigenous choice of medical practitioners. Lakota medicine does not refer, at least in terms of the Sioux, to somebody to take care of the body. There is not that mind-body separation, or a real analogue at least on the plains, to wanting to go to the physician and expecting that the physician can deal with the whole pantheon of ills.

**Dr. Walker:** Those of us in mental health have to stop and think about the incidence of the problems we see, deal with what is seen in primary care settings, and make that relationship work in an effective way. If it just includes helping them with the process of a referral of a patient, it would be a great deal. For instance, in the Seattle experience, when you realize your chances are one out of two that the patient is going to be an alcoholic, it might be worthwhile to spend a little time helping them with how to make that decision. But more important is to help make a referral that they won't be disappointed by when it doesn't work. It
seems to me that we’re always so apologetic, and the reality is that mental health always goes to the trailers. We really need to be more up-front about how we feel, and quit being apologetic, because most of the patients that are treated out there are patients that we have a feel for, and also must be treating.