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ABSTRACT

The sixth volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Navajo (Window Rock) Area Office. Included in this document are: (1) The Context (geography and description of the Dine, a tribe and a people); (2) Early Development (office in a brief case, addition of mental health workers, Navajo professionals, and decentralized operations with an Area Office); (3) Service Unit Programs (Tuba City's setting and staff, development of a mental health clinic, development of direct services in the first year, case summary for 1969-71, school program, aftermath following the introductory years, second professional, direct clinic services, and third change of senior staff in 1973; Gallup's outpatient services and Gallup Ward; Shiprock; Chinle; Fort Defiance; Winslow; and Crown Point); (4) Special Area Programs (Toyei BIA School's model dormitory and the Medicine Man Training Program); (5) The Change of Command (first Indian Chief of Area Mental Health Programs, 1972-73 overview, 1973-74 overview, and Navajo Health Advisory Board); (6) Summary (problems in 1973 and progress to date). (JC)

NAVAJO (WINDOW ROCK) AREA

MENTAL HEALTH PROGRAMS
OF THE
INDIAN HEALTH SERVICE
1966 - 1974

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Services

Prepared by

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This material was prepared in connection with an initial evaluation [illegible] of Mental Health Programs seven years after their formal introduction into the system in 1963. (NIMH Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: one outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1975.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems, and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.

NAVAJO AREA INDIAN HEALTH SERVICES MENTAL HEALTH PROGRAMS

NAVAJO AREA PERSONNEL LIST*

AREA OFFICE

Dr. Robert Bergman	Chief, Navajo Area Mental Health Chief, Mental Health Programs IHS	June 66-March 73 Oct. 70--
Mrs. Ellouise De Groat	Chief, Navajo Area Mental Health	March 73--
Ronald Lechner, DSW	Deputy Chief Area Mental Health	March 73-July 74
Ms. Ann Rainer	Research Assistant	Summer 66, 3 mos.
Ms. Vivian Eckstein	Research Assistant	Summer 66, 3 mos.
Mrs. Annette Johnson	Secretary	June 66-Sept. 67
Ms. Roberta Schwartz	Secretary	July 68-June 69
Mrs. Laura Lincoln	Secretary (clerk-typist)	July 69-fall 69
Mrs. Sadie A. Tolino	Secretary (clerk-typist)	fall 69-?
Mrs. Rose Mary Foley	Secretary	fall 69-Feb. 70
Mrs. Kathryn A. Westby	Secretary	Feb. 70-72
Susan Gail Powers		spring 71--
Frances Bentzen	Model Dormitory Director	?--74
Dr. John Adair	Anthropologist	fall 71-72
Dr. George Goldstein	Psychologist	Nov. 71--

WINDOW ROCK

Dr. Marian Zonnis	Psychiatrist (consulting w. other SU)	Oct. 72--
Dr. Sheldon Miller	Psychiatrist	July 68-June 70
Dr. William Matchett	Psychiatrist	July 70-July 71
Dr. Kenneth House	Psychiatrist	July 71-July 72
Dr. Rosalie D. Howard	Psychologist	Sept. 69-Sept. 71
Ms. Jeannine Lyerly	Mental Health Nurse	Sept. 67-July 71
Mrs. Katherine Hillis	Mental Health Worker	July 67--
Mrs. Sadie Tolino	Secretary (clerk-typist)	fall 69-now at WR
Mrs. Helena T. Yazhe	Clerk - DMT	July 71-? - now Chinle

TUBA CITY

Dr. Lawrence Schoenfeld	Psychologist	Dec. 67-Sept. 69
Dr. Norbert Mintz	Psychologist	Sept. 69-July 71
Dr. Sophie Mintz	Psychologist (temporary)	July 70-July 71
Ms. Mary Ann Montgomery	Psychologist (temporary)	July 71-June 72
Dr. George Meyer	Psychiatrist	Summer 71, 3 mos.
Dr. Stephen Proskauer	Psychiatrist	July 71-July 72

TUBA CITY (continued)

Mr. Harry Bilagody, Jr.	Mental Health Worker	July 67-Aug. 72
Mr. Dennis Parker	Mental Health Worker	fall 71--
Ms. Lucita Johnson	Mental Health Worker	71--
Jackie Curtis	Mental Health Technician	Sept. 74--
Ms. Eleanor Jae	Secretary	summer 74--

SHIPROCK

Ms. Lucille Harris	Mental Health Technician	73--
Mr. Leroy S. Dick	Mental Health Worker	72--
Ms. Freda Garnaney	Secretary MH	73--
Ms. Margaret Cape	Secretary	72-73

CHINLE

Dr. Marian Zonnis	Psychiatrist (consult w. other SU)	Oct. 72--
Ms. Betty Bitsue	Psychiatric Social Worker	74--
Mr. Robert L. Martin	Mental Health Worker	spring 71-fall 71
Mr. Nemore Bizahaloni	Mental Health Worker	fall 71-73
Mr. James Lee	Therapy Assistant	70-now at Chinle
Ms. Rosalyn Kleinsinger	Social Worker (temporary)	July 71-June 72
Mrs. Helena Yazhe	Clerk-DMT	July 71-now at Chinle

FORT DEFIANCE

Ms. Gloria Davis	Therapy Assistant	70-- now at Alb.
Mrs. Genevieve Cayedito	Secretary MH	Oct. 74--

WINSLOW

Mr. Samuel Tsosie	Mental Health Worker	spring 73--

CROWN POINT

Mr. Frank Willeto, Jr.	Mental Health Worker	July 67-Aug. 73
Ms. Marie McCray	Mental Health Worker	spring 71--
Mr. Albert R. Talino	Mental Health Technician	74--

KAYENTA

Mr. Frank Donald		74--

GALLUP INDIAN MEDICAL CENTER

Jack Ellis, M.D.	Chief, Mental Health	70-July 74
Ronald Lechnyr, DSW	Staff	70-71
Frederick Snyder, M.D.	Deputy Chief, Mental Health	July 74--
Dorothy Jackson, RN	Head Nurse	70--
Dr. Carol Wolman		70-70
Dr. Dave Phillips	GMO	July 71-74
Dr. Don Grubb	GMO	spring 74--
Tom Brod, M.D.		July 70-June 71
Mr. Fred Raje, RN	Mental Health Nurse	spring 71--
Mr. Charles Crysler, RN	Mental Health Nurse	summer 71-72
Ms. Karen Logan, RN	Mental Health Nurse	?-July 74
Jean Lukens	Mental Health Nurse	?--
Ms. Marge Parker	Mental Health Nurse	Aug. 74--
Ms. Ann Ramond	Mental Health Nurse	Jan. 75--
Ms. Cara Wilson, RN	Mental Health Nurse	Nov. 72--
Mr. Chris Harner, RN	Mental Health Nurse	summer 71--
Mr. Marc Rose	Psychiatric Social Worker	summer 71--
Mr. Tom Ney	Mental Health Worker	70--
Julius Bake	Mental Health Technician	Oct. 73--
Richard Hardy	Mental Health Technician	Dec. 73--
Sampson Jim	Mental Health Technician	Dec. 73--
Doris Morgan	Mental Health Technician	June 71--
Ned Pablo	Mental Health Technician	Dec. 73--
Tony Earl Scott	Mental Health Technician	Sept. 73--
Alberta Wilson	Mental Health Technician	Dec. 72--
Ms. Mariam Woods	Therapy Assistant	72--
Elsie Arniso	Therapy Assistant	72--
Lorraine Laughing	Therapy Assistant	spring 70-72
James Lee	Therapy Assistant	70--
Tom Williams	Therapy Assistant	spring 71--
Phillip Savilla	Therapy Assistant	spring 71--
Letha Haskie	Ward Clerk	72--
Flora Garcia	Ward Clerk	Sept. 74--
Loyolla Hubbard	Secretary MH	Oct. 72--
Evelyn J. Hampton	Secretary, GIMC	Oct. 70-Sept. 72 now Alb.
Helena T. Yazhe	Clerk-DMT	? now Chinle
Marge Cleveland	Janitor	2 wks.
Louise Billie	(temporary)	Feb. 75--

* Due to lack of documentation and intra-agency transfers, IHS Area staff lists must be assumed to be reasonably accurate but not the last word. Note cross references.

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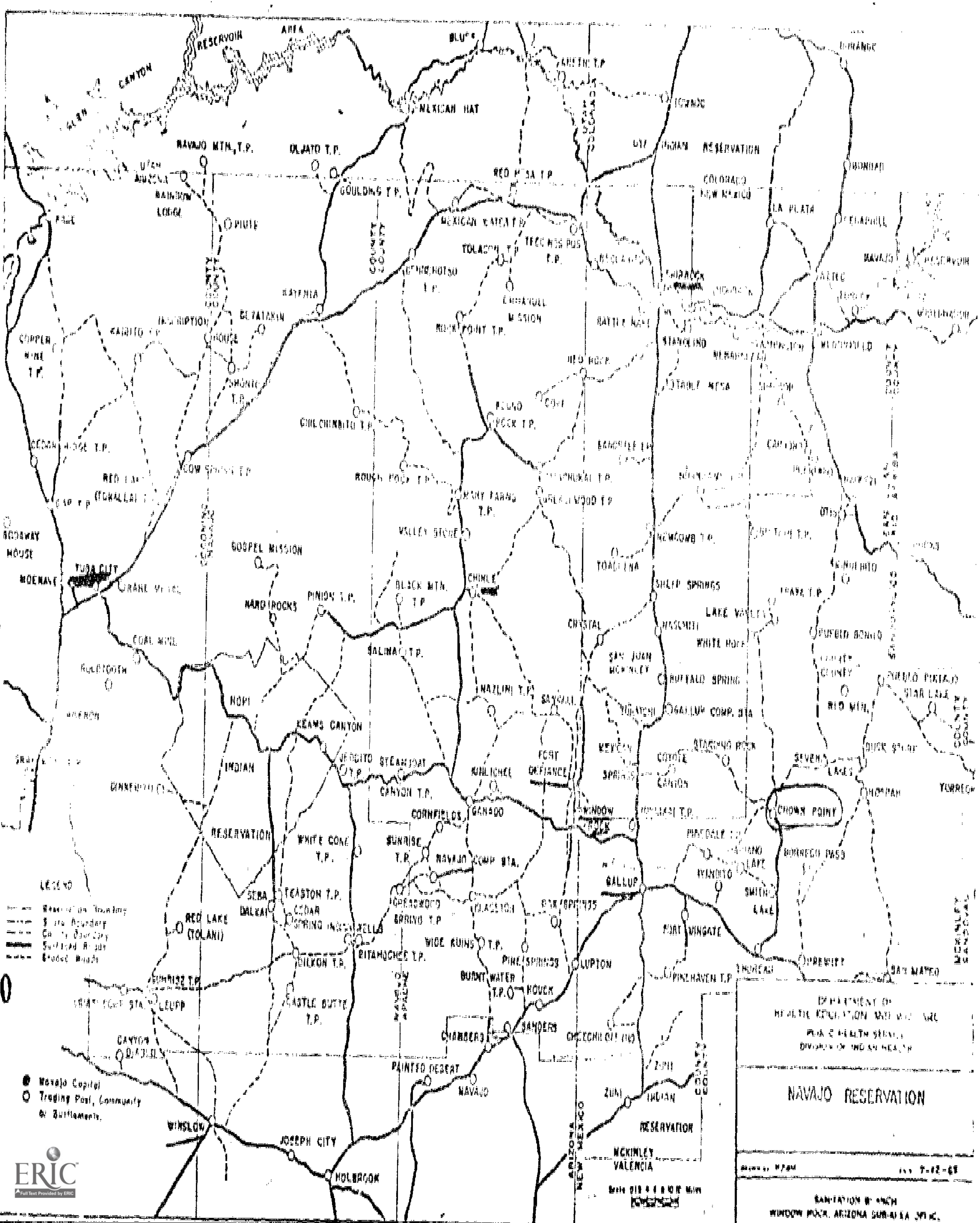

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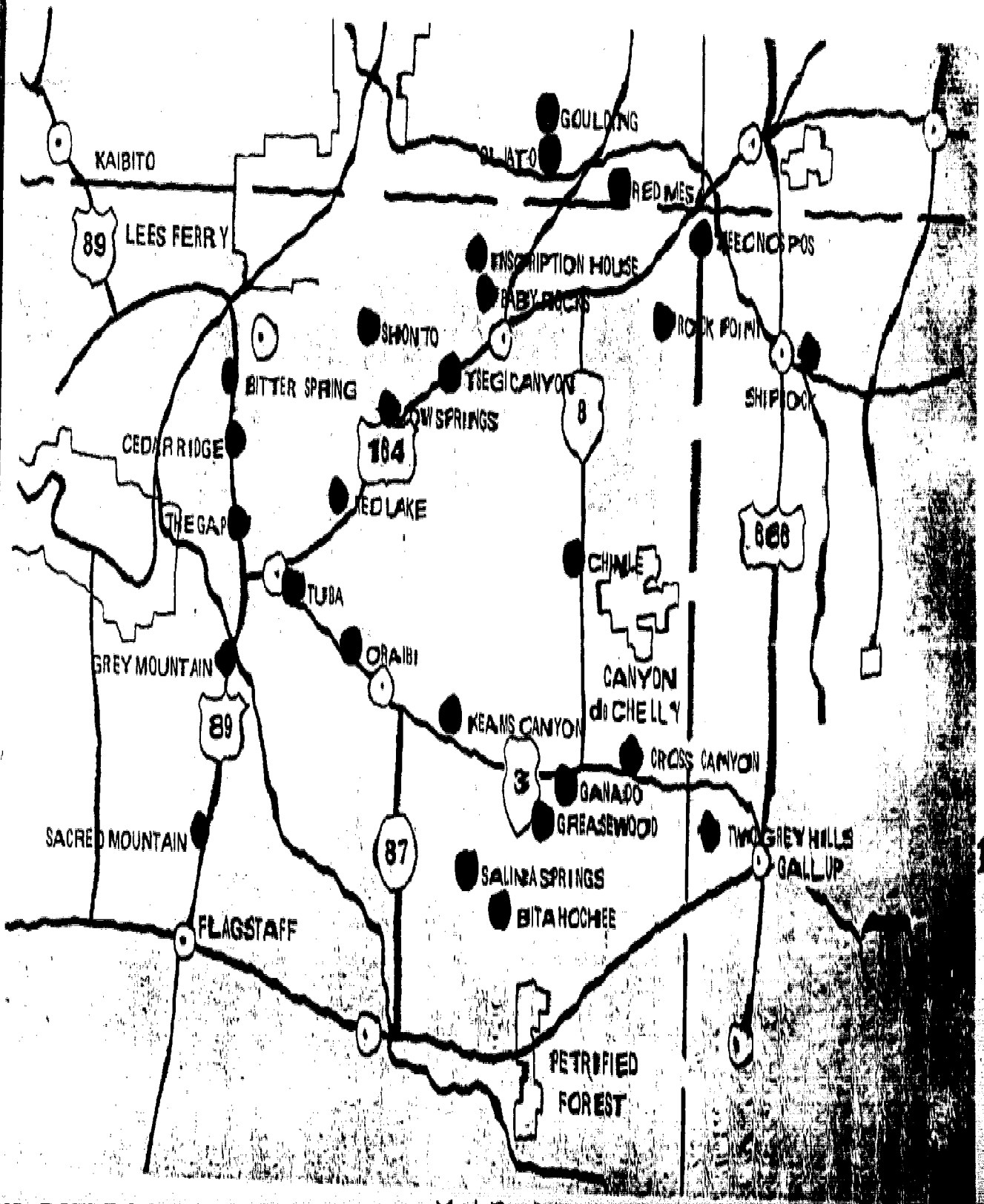
The Doctors' TRADING POST GUIDE



NAVAJO-WINDOW ROCK AREA IHS MENTAL HEALTH SERVICES

I. THE CONTEXT

A. Geography

The Navajo Area serves the Navajo Indian Reservation, with headquarter offices on the Arizona-New Mexico border at Window Rock, just northwest of Gallup, New Mexico. It occupies land in the three states of Arizona, New Mexico and Utah, and in size is the largest single reservation within the United States -- 25,000 square miles. According to a recent count, the Navajo Tribe is also the largest single tribe in this country: 135,000 of its people live on the reservation and an additional 60,000 live elsewhere.

To describe the geography and geology of this vast reservation, one needs not only maps and a compendium of technical terms, but also an entire thesaurus of adjectives. However, a quick tour of the major features may orient the person unfamiliar with the tourist literature and the many published accounts. Albuquerque, a major city 150 miles east of the reservation affords the best point of departure for visitors who can travel west into and around the reservation on major cross country highways.

On Interstate 40, formerly U.S. 66, going westerly past the Pueblos and Grants, one begins to encounter Navajo land interspersed with non-Indian owned land. This checkerboard resulted largely because as part of its Right of Way benefits, the railroad claimed that every other mile in a strip of land 40 miles wide was theirs to sell and utilize. While

the Navajo residents of the Checkerboard Region are not technically living on the main body of the reservation, they do relate to it culturally and politically. They are served by the IHS hospital at Crown Point, New Mexico.

The boundary of totally Navajo-owned land begins about 45 miles east of the New Mexico-Arizona border and roughly 100 miles south of its northern border. This southeastern corner of the reservation is the focal point for administrative and travel orientation to Navajo country. Just below the southeastern edge of the reservation is the town of Gallup, New Mexico, in which a large IHS hospital is located. Located on I 40, Gallup has long been a major railroad and highway center for cross country travel, and its airport is busy with charter flights as well as commercial air connections to major cities. Like most frontier towns in New Mexico, it has a sizable Indian population (2,000 of its 14,000 census). The Navajo population is mainly visible to the town as residents of the shanty-like "fringe." There is also a fair-sized "Spanish population" (though not so large as in many other areas of the Southwest), and a dominant "Anglo" society of merchants, technical experts, and government employees. Each of these groups is stratified in terms of economic and social levels, and both non-Anglo groups tend to be known only in terms of their special problems and exploitable tourist attractions and artistic products. The "drunken Indian" stereotype is well reinforced. Traders in turquoise, silver, rugs, and "sand paintings" are omnipresent as part of the local economy. The sober, the hardworking, the dependable go unnoticed or are taken for granted, and until lately were very much ignored in the commercial and political activities of the city.

Between the Navajo and the Spanish speaking groups there are friendships in the adult generation, and sometimes open, sometimes smouldering gang warfare and rivalry among the adolescents. The local branch of the University of New Mexico does teach Navajo language courses, both to Navajos who have a desire to become literate in their own spoken tongue and to non-Navajo who wish to work at acquiring this complex language to aid them in their work. This is a slow response to the needs of the Navajo population, and most of the Indians seem to look to more distant campuses or to Indian institutions for training and education.

Just north of Gallup, 10 minutes by plane, three times as long by car, is Window Rock, Arizona, the seat of the Area IHS offices, the Tribal Offices and the Bureau of Indian Affairs (BIA) Superintendency. Just why this southwestern corner of the reservation was chosen in 1934 when the BIA consolidated its six or seven Agencies serving the Navajo is not clear. IHS has followed their lead, even though there are no hospitals in Window Rock itself. This spot, like many on the reservation has strong traditional associations with the dominating geological feature: A tall sandstone cliff with a "window" or hole through which those on the valley floor can look at the sky and mountain tops. From the back and top, looking down through the "Window," one sees the valley and its community as though through a lens, with a perspective of both time and space that relates to more eternal and enduring elements rather than the grubby day to day pressures. It is interesting to move from office to office, bustling with daily affairs of administering the affairs of the tribe and its programs, and speculate how often one of the decision makers

unobtrusively makes use of this opportunity. It speaks to the sense of privacy that pervades much of Navajo relationships that to ask such a question seems intrusive to the non-Navajo observer, and is perhaps self consciously dismissed by non-Navajo staff as sentimental. Yet there is a powerful pull to put Navajo affairs into this perspective because of the constant reminder of the sandstone cliffs.

The nearest IHS hospital, and the first one encountered that is located on the reservation itself, is at Fort Defiance, 10 or 12 miles north of Window Rock. Fort Defiance, as can be understood from its name, was an early army outpost, and has many historic associations with Navajo history. One of the pleasanter remnants of the past is the Sawmill, located a little ways out of town in the rising hills. This, the first attempt at Navajo industrial development, harvested timber from the Ponderosa forests of the mountain slopes. The project has now been relocated at a new town, "Navajo."

Fort Defiance itself, sits on the boundary between the woods and the arid mesa, overlooking stark buttes smaller in scale than those of Shiprock or Monument valley. There are deep cool canyons, such as Blue Canyon, near enough to tempt one for an evening drive or weekend picnic, and a number of extended families maintain sheep camps and farms along the bottoms. Members of some of these families commute to Window Rock and Gallup, as well as find employment locally in Fort Defiance. Housing for newcomers is not always easy to find, but HUD and a local developer have begun to build a number of rowhouses and town house apartments. Paradoxically, Fort Defiance appears to have a larger Navajo proportion to non-Navajo population than in most of the border communities,

even while it is taking on the character of a suburban small town. However, the centers of commercial transactions are still more often found at Window Rock and Gallup than in Fort Defiance itself.

Route 264 continues from Gallup across the Reservation in a generally westerly direction. About 40 miles along is the town of Ganado, which is not served directly by IHS but deserves mention. It has the only hospital that is available to non-Indians within the Reservation, including IHS personnel who are neither Indians nor commissioned officers in the Public Health Service. Staff of the BIA who are non-Indian must also use it or go off the Reservation for health care. At one time this installation was expected to become an inland "Project HOPE" similar to the Hospital Ship HOPE serving the Orient in a voluntary program. At the present time there seem to be financial and staffing difficulties, but a health center is maintained and IHS staff consult and work cooperatively with the Ganado staff sponsored mainly by the Presbyterian Church.

Ganado is about halfway between Window Rock and Keams Canyon, an IHS hospital serving the Hopi. The Hopi Reservation lies entirely within the boundaries of the Navajo Reservation, and some ambiguities about its boundaries are a source of tension between the tribes. Since it seemed best not to compound the problems by joint usege of its facilities, the Hopi health and mental health programs are administratively under the Phoenix Area Office, and will therefore be described in that chapter.

Just beyond Ganado, State Road 63 leads north to Chinle and the famous Canyon De Chelley National Monument. Chinle has an IHS health center and serves the valley between the Chuska Mountains to the east and the Black Mesa to the west, both of which have peaks over 9,000 feet

high. The valley, formed by the Chinle and other "Washes" is fertile farmland but it adjoins an arid mesa cut by 800 foot canyons, in whose walls are found a number of cliff dwellings antedating any European contact with people in the Area. The most accessible of these, the "White House," can be viewed from its opposite bank at lookout points developed by the National Park Service. At the same time one can watch horses being herded by jeep on the valley floor, and if the season is dry enough tour the marshy bottom where there are still farms and seasonal dwellings being maintained.

Except for this paved road that funnels tourists into the Canyon de Chelley National Monument, the roads through this valley are dirt roads scraped a-periodically. There are many places where one can be flooded, mired, or trapped in sand if unwary and unused to desert travel. North of Chinle the Rough Rock and Many Farms communities on the opposite slopes of the valley walls have each been cited as experiments in education since they are the first communities to develop all Navajo schools. Together these systems provide classes at all levels from kindergarten through community college levels, with Navajo school boards and staff providing bilingual instruction. Health centers which serve their immediate needs are staffed from the Chinle Service Unit.

Since the roads across the mountain pass are not paved, it is easier to reach Shiprock, New Mexico in the northeast corner of the Reservation directly from the Gallup, Window Rock corner, taking Route 666 which is a north-south artery to Colorado. It runs parallel to Route 63, but lies east of the Chuska Mountains. At Shiprock, there is a 65 bed IHS hospital, and plans are being developed to expand to a size sufficient to

support a medical school which will specialize in training Indian health personnel. The town of Shiprock, named for its proximity to a group of large volcanic formations that rise from the valley floor, is a nearly all Navajo community which has grown rapidly with the development of the San Juan Irrigation Project. This project brings water more efficiently to the farmlands and orchards along the mountain slopes to the north and east. There is a nick cut out of the Reservation outline at this point, representing the earlier purchases by non-Indians of some of the farm land between Shiprock and Farmington, New Mexico. Farmington, like Gallup and other reservation border towns is very much Anglo dominated. It does have active groups interested in knitting together the social and health services. Since Farmington is a County Seat, this activity concerns Navajo use of off reservation resources for San Juan County which runs the depth of the Reservation north and south.

The low rising Hogback, which divides the two communities about mid point of the 30 mile distance between them, makes an easily visible demarcation point along the road and river. A few miles to the north the Reservation widens out to its original dimensions until it reaches the New Mexico Colorado border. This portion of the Reservation often is labeled on maps as belonging to the Mountain Ute Tribe, whose main reservation lies in Colorado. This has been long disputed territory, but Navajo names and residents scattered about its thinly populated surface point to traditional tribal usage which has been upheld in recent court decisions.

A two lane black top road connects Shiprock to Teec Nos Pos on Route 160, another main artery linking Durango and Cortez, Colorado with the Grand Canyon. This route skirts the long Monument Valley, and lies

along the southern edge of the basin of the San Juan River which, with the newly developing recreation, irrigation, and power resource of Lake Powell form the northern boundaries of the Reservation. This Utah portion of the Reservation is not thickly settled. Although there is some intermingling of Indian and Mormon agriculture, there are no major communities of any size.

The dramatic quality of the rocky lava plugs that form the "Monuments" at the southern end of the valley is a frequent pictorial subject, familiar to most persons as a trademark of the Southwestern Desert. The southwestern entrance to exploring this valley is found at the junction with Route 163 at Kayenta, where an IHS Health Center is staffed by personnel from the Tuba City Hospital 75 miles away.

Tuba City, just beyond the western edges of the Hopi mesas, is the only town of any size in the western reaches of the Reservation. It occupies the junction with Route 264, which connects with Window Rock to the southeast and the Grand Canyon and Flagstaff off the Reservation to the west. Its general environment is that of the Painted Desert, and it tends to be a dusty, unimpressive southwestern crossroads community in appearance. There are a few nearby oasis-like spots where water can be found, but life depends upon water pumped from great depths below the desert floor. To most of the IHS personnel, the first months of assignment to Tuba City must seem dreary and isolated. This remoteness is accentuated by the flow of tourists and vacationers between Flagstaff and the Grand Canyon to the west and the Lake Powell recreation area to the north, which diverts most persons at the junction 10 miles west of town. A few tourists detour to Tuba City, only stopping there for a meal, gasoline, a cool drink

or to purchase souveniers. The 75 bed IHS hospital is generally busy and its staff feel stretched rather thin to cover the western reaches of the Reservation, including the Monument Valley, adequately.

Route 89 crosses the Painted Desert and connects with the main East West Highway I 40 (formerly the TV acclaimed Route 66) near Flagstaff. This road lies entirely off the Reservation, except for one ten mile short cut near Gallup. About a third of the distance back to Gallup is the city of Winslow, which like Gallup and Crownpoint is the location of an IHS hospital even though off the Reservation proper. From Winslow east, Route 40 follows canyons and river channels, where some of the scenery is almost obscured by signs promising opportunities to see live Indians or buy artifacts and craftwork at stops for refreshment and refueling. Many travelers are probably unaware of the commercial nature of these establishments, and think they have seen a real Indian reservation, or glimpses of Indian life when what they see is either exploitative or "made in Japan." However, except for a paved road leading to the Hopi country from Holbrook, there is little choice offered for anyone with casual interest to "tour the reservation." Even the State roads tend to have signs reading "Watch for Pedestrians" (meaning Indians) which are designed to remind one of deer and cattle warnings, rather than familiar street crossings of urban settings.

Other than these major highways there are only two other ways of getting about the Reservation that have any practicality. One is to find a well sprung pick-up truck, load it with food, water, a shovel, an axe, plenty of gasoline, and set out on the unpaved unimproved roads that connect to the "camps," farms and small communities. One then gets to know the country intimately, following canyons and waterways, and learning to

anticipate being held up by flash floods, sandholes, mud, and occasional bits of hospitable visiting. This is the way most Navajo people travel, and is part of the daily routine of the Mental Health Workers who serve as outreach and resource persons to the communities away from the main hospitals. The closeness to the countryside and its people makes the distances comfortable, but it sometimes plays havoc with scientifically organized schedules, which seem like impositions from another world -- as perhaps they are.

The other alternative is to fly. Like Alaska, this region has come into rapid acceptance of the small plane and supports many charter pilots. Flying shrinks distance, so that towns and hospitals do not seem nearly so remote. Almost any IHS installation can be reached from any other in an hour flying time or less. This is lifesaving on occasion, when, with seats removed, a four or six seat small plane turns into an ambulance carrying a stretcher and one or more medical attendants. It also means that many professionals and administrators think in quite a different time frame than their clientele who are normally earthbound.

Viewed from the air the geographic and geologic features of the Reservation are more easily grasped. One becomes very conscious that pine woods grow above 7,000 feet elevation, along the slopes and tops of peaks and mesas, in contrast with the sagebrush and pinyon of the mesas and the sandiness of the deserts that are perhaps only 5,000 or 6,000 feet above sea level. The greenness of watered farmland is often dramatic.

Looking down on the pine woods or the mesas one can identify the dwelling places of extended family units, which are colloquially called "camps" even though they are permanent. Focal will be the Hogan, identified from

the air by its rounded shape roof. Connected to it by well-beaten paths and vehicle tracks are a number of other dwellings, which may be of traditional or four-square anglo construction, as well as corals and barns. Some dirt tracks leading off to the next "camp" or small village make a network or spiderweb across the land.

Although the population density is not great, about 5.5 persons per square mile, the distribution is not even. The "camps" cluster about the habitable portions, while other areas are vast and seem not only unexplored but unexplorable. Particularly, there are eroded canyons of dramatic colors and depths which are not to be found on any map, and which are simply not named or nameable in daily conversation, as well as desert stretches created by natural forces and the absence of water. Almost as vivid but hardly as aesthetic as the natural volcanic and erosion products are the man-made scars from strip mining and other efforts to wrest minerals from some portions of the Reservations. The problem of developing resources to support the population, which has outgrown its agricultural base, is not one for easy solution. The price of economic development in devastation and even smog, has been and continues to be a high one. Much Navajo energy is engaged in trying to solve this equation and much emotion is invested in protecting the basic land which has religious as well as material value to the people.

Nearer the paved roads one sometimes has the illusion of flying over a small town, only to learn that below is a BIA boarding school. These appear to be small communities, with housing for staff and dormitories for students. They must be self sufficient with laundries, cafeterias, water resources and power generators, as well as close enough to paved routes

used by trucks in order to be able to secure food stuffs, school supplies, and other necessities from major cities. Several hundred children as young as five or six years of age are gathered up and sent to each of these schools. One reason given for this practice is that the local roads are not dependable enough, and the dwelling places too scattered to make daily bussing as practical as it is in rural parts of more settled states. Other reasons advanced in the past were rooted in attempts to substitute Anglo-European cultural influences for tribal traditions and reasons based on poverty and health. However, the philosophy of separating children from parents in order to "civilize" them is more and more being challenged. Along the borders of the Reservation children attend public schools in towns such as Gallup, Shiprock, Winslow and Holbrook. In the larger towns within the Reservation such as Window Rock, Fort Defiance and Tuba City, community based schools provide for Indian youngsters along with the children of the non-Indian personnel who live and work on the Reservation. But the real problem of providing education to a widely scattered Navajo population is dramatized by the boarding school smokestacks and water towers and airstrip windsocks rising like towns from the desert but still miles from any visible community.

The blending of cultures and the incongruities of modes of transportation are dramatically illustrated at Window Rock. Here the Tribal Police have acquired a fleet of six large helicopters for ambulance duty, yet farm wagons using bald automobile tires and pulled by tired horses can be seen on the streets. There are also probably more pick-up trucks than any other single type of car in the parking lots around the offices and pulled up to the homes of those who live there. The higher grades of

government personnel can utilize airplanes to keep their appointments on and off the reservation, but the majority of the staffs and Navajo clientele count on the pick-up truck and many hitch-hike long distances. In many ways these disjunctive modes of transportation and time relationships are parallel to those in Alaska. However, the individual Navajo family, remote though it may be, can be in closer contact with the outside world if it chooses to make use of the opportunity. In the Arctic, the choice, however difficult, is much less available, and often means a complete severing of ties, while the Navajo can return home more often, and can maintain contact by mail and telephones more easily.

B. Dine

One needs to make some careful observations about the concept of 'tribe' especially since in this instance one is dealing with a single tribal people. The word is somewhat indiscriminately used in general speaking and writing, and often carries connotations of a political organizational unit that is coherently organized and hierarchically structured like Angle-European political units. It is a mystery why even the experts of one culture, fully aware of the difficulties of generalizing about thier own cultural-political units, should expect another group of people to be a single entity. However, the trait seems humanly pervasive, and has especially plagued Indian-U.S. relationships because of the assumptions it involves. To a certain extent the stubborn expectancy of the government agencies that some form

of parliamentary democracy and hierarchial organization will exist has modified the original social and political structure of all tribes. All Indians have had to go through this painful process, and to a certain extent the Navajo have been one of the most successful at turning their adaptive skills to good use in organizing and administering their own affairs while interfacing with the outside majority culture.

Nevertheless, one needs to begin with realizing that there are many Navajo -- the most obvious facts are that no group of 135,000 people will exist without social and economic stratifications, and this people is no exception. There are millionaires and those in abject poverty; scholars and those illiterate even in their own language; simple craftsmen and artists; the philosopher and the shrewd; the honest trader and the bunco trickster. What is less obvious is that there was no common unifying political organization 100 years ago that knit together what the US and the Spanish settlers referred to as a single tribe.

Kluckhon and Leighton suggest that one of the first effective centripetal forces was the experience of the "Long Walk" in the late 19th Century, when about 8,000 Navajo were herded by the Army into Fort Sumner across the state 350 miles from the present edge of the reservation, and held together for a number of years within its stockades. Certainly before that time each of the geographically separated valleys and parts of the Reservation supported its

own band of people who had clan-kinship ties and close associations with its mountains and valleys, and mixed with rather different neighbors, either Pueblo, Zuni, Hopi, Ute or Apache. These six or seven groups shared a common language, common myths and rituals, and did visit one another on occasion, but were distinct bands, rather than a single unit. Because of their language and habits they also shared the common ascriptive designation "Navajo" which seems obscurely but probably simultaneously derived from phonetically similar derogatory appelations in use by the Apache, Pueblo and Spanish speaking populations. However, they referred to themselves then, and now still use the word "Dine" to mean what outsiders mean by Navajo. Translated literally as "The People", Dine carries with it the body of their traditional relationships in continuity between past and present.

The various groups or bands of Dine were not a single political unit, and have only on the last 25 or at most 50 years begun to learn how to organize and think as if they were. In its earliest dealings, the US through the BIA and the Army tended to reinforce the separateness by having six or seven "Agencies" corresponding to the centers of population. In 1934 the re-organizations of the BIA and the development of roads enabled governmental consolidation, and these were subsumed under a single Navajo Agency Superintendent, who was located at Window Rock.

Until this time the Dine did not share the premise that central unified polititical organization was necessary, since their way of life was based on relationships to the universe as a whole, and to other human beings, in quite a different system of thought. When group decisions were needed, all those involved met face to face until differences of opinion were resolved and a consensus was reached. The form of government was more nearly like the model for Quaker meetings or some of the forms being attempted by counter culture contemporary youth groups than anything familiar to the Army or the 19th Century government officials. It must have been a matter of great puzzlement to the Dine why the Americans never learned that if a band from the interior raided a border settlement, that the Navajo living nearer the community could not assume responsibility for them or their damages. Even though they did bear the brunt of the reprisals, this did not motivate them to try to control another band.

Since the consolidation of Agencies at Window Rock, the Dine and the outsider alike are learning to work together, and the reality of a single tribal government is becoming more possible. However, in spite of shared traditions and historic events, there are still differences of dialect and style, as well as details of life between residents of different parts of the Reservation. Such differences are especially pronounced between Tuba City or Kayenta and Gallup or Window Rock, and make for subtleties of

relationships and a need for checking out one's assumptions when moving around the reservation. On the whole, however, pride in the unity of the Navajo people has now become a reality, and the differences within the group are less signigicant than those between any of them and other Indians or non-Indians.

One important remnant of the earlier multiple group identities within the tribe is found in the "Chapters". These originated as a government attempt to formalize the subgroups into a viable structure during the 1920's. While the imposition of parliamentary forms slowed down the process, the basic concept was familiar enough to take root. There are still Chapter Houses throughout the Reservation, serving a purpose somewhere between a local council government and a community center.

In addition to government officials, the bulk of the effort by outsiders trying to understand the Dine has been done by anthropologists. One of their difficulties is that they can often explain the past, where the distance provided by time blurs details and gives outlines a shape. It is much more difficult to explain how that past interacts in the present, and almost impossible for their discipline to project accurately into the future. The Dine are particularly puzzling because while on the one hand they are among the most conservative in their retention of language and social customs, they are among the most progressive in their ability to adopt and adapt technical culture from their neighbors, conquerors, and rivals. Most other 'conservative' tribes make great efforts to keep the technology out along with the social customs, but not the Dine. One has only to look about the households and towns to realize that clothing, tools, jewelry, rugs, enamel ware and plastic, foods, pickup trucks and jalopies or Cadillacs,

television, radio are all adapted and adopted whenever they can be handily incorporated. Yet socially the Dine retain their language, their pride, their ability to fast long periods and to feast to the point of gorging, and perhaps as significantly the values and traditions of their elders as equally visible characteristics that set them apart as "The People".

These, of course, are generalities. There are Navajo who have adopted completely the mainstream ethics and even its Christian religion. Yet at times of crisis one must always be prepared for the majority to turn to the old ways, often in parallel with the new. To be sure it is harder for youth raised in the vacuums of boarding schools to do this, and many of today's adults are caught in the crossfires of generation gaps and cultural gaps simultaneously. The stress is most acute when the stark pressure of population on the land exceeds its ability to support people, yet the Anglo scientific and commercial methods seem equally destructive. But among the kinship ties will almost always be found some who can utilize the spiritual resources of the sacred mountains and the ceremonies of traditional observance to find the strengths to solve the modern crises.

To deliver mental health services adequately, requires that not only the patterns of delivery, but the substance of the help offered take into account the needs and lives of the people. Amongst the Dine the first step is the one taken here, to recognize that a different frame of reference exists. The detailed absorption and adaptation of the skills of the helpers into the strengths of the Dine is far from a simple process. But with mutual respect, the content is not incomprehensible, and indeed,

since many of the People are bi-lingual, can be learned more quickly than can the language. A few may learn to think in Navajo; all may need to learn to think like a Navajo. It is probably fortunate that such a complex task is imposed in the Area in terms of the single tribal group, and not, as in the other Areas, forcing the staff to relate to several at once.

II. EARLY DEVELOPMENT: 1966-69

A. Office in a Brief Case

It is against this complex land and people that one must view the introduction of Mental Health services on the Navajo Reservation. Up to 1966 local problems of emotional disturbance, including relationships between the medicine men and the white physicians were handled by the social workers, the nursing staff, and insightful physicians. Perhaps only the social workers really considered this as part of their day to day job, although PHN's also gained much expertise around practical day to day tensions in families within their home visiting activities.

The seriously disturbed who could not be taken care of locally were sent either to New Mesico State Hospital in Las Vegas or to the Arizona State Hospital near Phoenix, a journey in either case of about 400 miles. It is interesting to note, that although such services were often without charge to residents of the states involved, Indian patients were not considered state citizens, since they lived on federal land and had federal services. Therefore, the IHS was charged the full cost, often $80.00 per day or more, for such patients. This is still true today to some extent, although more mutually equitable arrangements are being negotiated. With such a cost for public care the usefulness of private facilities could also be explored,

and when they seemed more appropriate, they have been and should be utilized.

It is not very clear who was primarily responsible for the request for assignment of someone to develop Mental Health Services on the Navajo Reservation. A strong influence within IHS was Dr. McKammon, Area Director in 1966, and another was Dr. Gerald Levy of the University of Arizona, Department of Anthropology. Certainly there were a number of people who had recognized the needs, among the Dine, in government service, and in the Legislature. However, initially no appropriation was made for the Navajo Mental Health Program as it had been in the case of Alaska and Pine Ridge, South Dakota.

Dr. Robert Bergman, who during his psychiatric residency had been appointed by IHS staff to represent Mental Health Services in their planning, and was therefore the senior of the three psychiatrists available in 1966, accepted the assignment to Window Rock. The local Area Director and his deputies found funds not yet allocated for other projects that could cover the necessities of a minimum essential nature until a budget could be developed in succeeding years. However, Dr. Bergman had no team, no staff, and no proposed program, and recalls that he was not even sure himself what were the expectations for Mental Health Services on the Navajo Reservation.

However, he found himself with plenty to do, and what might be an enviable freedom to work out ways of doing it. He seems to have thrived on ambiguities that sometimes stifle others, and in this way his temperament matched that of The People who have their own informal arrangements far less rigid than following the usual American schemas. Dr. Bergman's approach to therapy and to organizing services was based on high respect for individuals and their context of living, and this too is very much in tune with the Navajo basic orientation toward life and people. It also won the mutual respect of

the physicians and IHS staffs, since their problems, as well as those of the patients, were taken into account.

In his first year Dr. Bergman managed to visit extensively with all the Service Units, and to offer his professional services wherever there was interest in them, without overselling his potential as a solver of all problems. As a sharer of expertise in developing solutions to problems, he accrued experience and also demonstrated a model which is still being followed. Each encounter with a patient became an opportunity for immersion in the life of the People, and a learning experience as well as having therapeutic goals. Since he was unfamiliar with the language, interpreters became a necessity. Dr. Bergman set about to learn to use them well, while at the same time learning Navajo for himself. lThere are skills in using interpreters, especially when the linguistic patterns and thought forms are greatly different than those to which one is accustomed, and he also began teaching as many others as could be interested in these skills. He also felt that the skills of psychotherapy and human relationships could be taught, and began working with his interpreters to explain in exchange what he was doing and hoping to accomplish in his interviews. This process became a selective one, in which the interpreters who worked most often and most well with him were those who had a basic interest in human behavior and skill in developing and maintaining relationships. They became members of a therapeutic team, bringing their own expertise in Navajo culture and their own backgrounds of understanding the context in which people were living. This relationship stands in dramatic contrast to that often encountered when professional therapists find themselves needing to use an interpreter. Frequently within IHS in other places one hears the comment:

"The patients always talk to the interpreter and look toward the interpreter, which makes me feel superfluous."

In selecting his core of interpreters in each location, Dr. Bergman naturally attracted people who were interested in learning, but he also looked for those who were adept at passing on their knowledge. These qualities of concern for people, an interest in human behaviour, a secure knowledge of their own culture and language, and an interest not only in learning but in transmitting their knowledge to others were the characteristics of his working team, rather than any formal educational or disciplinary standards. The persons who became involved were from all levels of the IHS service: a nurse, a social worker, a couple of drivers, a nursing aide, a secretary, all of whom could meet him and one another as equals and who were stable enough not to be thrown off balance easily by the anxiety and turmoil of the disturbed people with whom they had to work.

These interpreters, and many other people about the Navajo Reservation became Dr. Bergman's teachers as he learned the language, learned the customs, learned the ways Navajo people thought, and learned the practical geography of the countryside. He also learned to fly a small plane so that he could get from one part of the Reservation to another without having to require a charter pilot to wait for him, chalking up expensive hours. All of this activity did not require a large office space, and it was frequently observed that the Mental Health Services Office was really in his brief case as he traveled about from one Service Unit to another.

Whether planned or not, during these two years of initiating services, he was acting out a role model familiar to the Navajo. Within their own culture there is high regard for the traditional healer who cares deeply about people, who works very hard developing his skills, but who never loses sight of the important little details of living and relationships based upon proper respect. Confidence and expertise sit easily on the shoulders of the 'medicine man' because he knows his work well, but mixed with this is a personal humility and an openness to the unknown which is a far cry from the defensiveness and what to Indian people appears to be the arrogance of many American professionals.

Also in keeping with the traditional ways of The People is the individual and collective pride in self, and a very real sense of interdependence amongst the family, clan, and social group. Intuitive and purposeful support of these characteristics tended to continue to attract and hold a high caliber of person among the interpreters, and to win respect of the Reservation Communities for them. Through them, and through his own interests Dr. Bergman became very much a part of the traditional and religious life of the Navajo Pepple, becoming known in their language as "Dagaix' Izhun" or "Dr. Black Moustache."

B. Addition of Mental Health Workers

As funds eventually were budgetted for the Navajo Mental Health Programs, Dr. Bergman was able to build upon the base already established and legitimize the role his interpreters had been developing by hiring them as Mental Health Workers or Mental Health Technicians. This was a new classification for civil service, and it took much negotiating to establish the

paraprofessional role at a level which reflected the respect and status they should have in the light of the importance of their work. To a certain extent this is still going on in all Areas, but the Navajo use of talented local people in this role was a model for the career ladder which is being established and the variations which were developed in the other Areas.

One essential feature of the establishment of this cadre of skilled Mental Health Workers was a continuous in-service training program, and through it a continuous interchange of ideas, skills, problems and solutions. The vehicle for this was the establishment of regularly scheduled meetings at which the group comes together from all parts of the Reservation, usually twice a month. This is possible since travel budgets for Mental Health are separate from Area budgets and the amounts needed could be established without competing with other service branches. These meetings, which usually take one whole day, are divided into a consideration of administrative matters and the exchanges of learning and teaching. A continuous topic has been study of Navajo Culture by the Navajo people themselves, as well as in sessions shared with the non-Navajo staff as they were added to the program. Techniques of group, family and indiviual psychotherapy, as well as problems of community organization and consultation are all topics that receive concentrated and recurring attention. In some instances academic credit, leading toward degrees at established colleges and universities has been made possible, and a number of the staff have utilized opportunities for adding general education courses to round out their development.

From time to time one of the staff has taken a leave of absence to secure professional training, and these individuals returning to the Navajo Mental Health Program contribute a return in the way of status and recognition of Navajo people as well as providing role models for other who share in this aspiration. The emphasis on competence and on continued personal growth and development has been characteristic of the Navajo Mental Health Program from the beginning, and has led to the retention of a corps of highly individual Mental Health Workers, who are able to command respect, and to function well in a complex role.

C. Navajo Professional Personnel

In addition to the Mental Health Worker, there has been from the outset an effort to identify and include Navajo personnel at the professional level in building the Mental Health Services Programs. Native American physicians and psychologists are in short supply, and none were available. However, two key positions in the Area are held by Navajo social workers who participate in the same reciprocal exchanges of intercultural and interdisciplinary learning and teaching as their paraprofessional and non-Navajo colleagues. They also stand out as models for aspirants to a strong and integrated intercultural role within Navajo tribal affairs.

Mrs. Ellouise De Groat, MSW was a key person in finding space, developing interest and encouraging involvement in the mental health services Dr. Bergman wished to introduce at Gallup Indian Hospital while a member of the Social Services staff. She shared his convictions that disciplinary titles were not as important as solving problems, and is earnestly convinced that all persons involved in mental health work are students of human behavior.

As a contact person first at Gallup and later at Fort Defiance she was able to arrange many elements of the service delivery so that the Mental Health Programs reached the nursing staff, the physicians, and the field health personnel. Initially, she shared in the interpreting activities, and found others who were interested in this task. When the budget was available to add professional staff, she joined the Mental Health Programs as Deputy Chief for the Navajo Area.

Also at Gallup is Betty Bitsue, who was a registered nurse and has also acquired a Masters in social work. She too is a Navajo, and her development of outpatient services, as well as her experience in hospital settings makes her role a central one for the Mental Health Program in that setting.

Both of these women represent a newer generation of Navajo, who have taken advantage of the mainstream educational opportunities, and then with great courage returned to apply their understandings to work within their own people. In many instances the price paid by persons who leave the Reservation for education has been to become neither fish, flesh nor fowl when they returned. Many share the feelings expressed by Thomas Wolfe in "you can't go home again." However, both Mrs. Bitsue and Mrs. De Groat recognized their need to sort out their own cultural patterns and to come to terms with the traditions of The People, as well as the contemporary dilemmas that they face. In undertaking this task they have been able to share their expertise with the older traditional paraprofessionals, as well as with the younger ones who have experienced uprooting in boarding schools and army experiences.

D. Decentralized Operations with an Area Office

As can be deduced, the regularization of the paraprofessional roles for Mental Health Workers, and the recruitment of Navajo professional staff indicates that eventually a budget for the Navajo Mental Health Programs was established. At first this was $75,000.00, later it increased bo be more nearly proportionate to that of other Areas. These funds were utilized in adding the Navajo staff, and also significant non-Navajo professionals. In general, the oppration of the Program remained de-centralized, with professional staff recruited for and assigned to the Service Units, rather than located centrally in Window Rock. The gradually enlarging staff was kept in touch with one another through the vehicle of the Area-wide training and administrative meetings, and by regular visits from Dr. Bergman as a consultant and as someone with expertise for continuing clinical services supervision and 'back-up' on difficult cases.

Space was definitely assigned to the Mental Health Programs in the Area Offices at Window Rock, and clerical staff added who could handle both the Navajo Area correspondence and telephone calls, but also the obligations that went with Dr. Bergman's second responsibility to the national development of IHS Mental Health Programs. The national headquarters activities and roles are described elsewhere, as they emerged from the initial period when they were inter-twined with development of the Navajo Area programs. However, it is a matter of some pride that the Navajo program staff can feel that they were in many ways pace setters and trend establishers for national program models. It also from time to time diverted attention of the Area Office from local tasks and problems, making

doubly important the ability of Navajo Area Mental Health Staffs to function autonomously.

This was a period of rapid growth of staff and expansion of activities. By 1968, there were two psychiatrists, a clinical psychologist, a Mental Health nurse consultant and three Mental Health workers.

Although the attempt seems to have been relatively short-lived, it is commendable that the workers in the Mental Health Program paused in their busy schedules long enough to collect descriptive data about patient flow during this phase. Data collection began in October 1968 and ran for eleven months. Some of the results were subsequently reported in a publication authored by Dr. Schoenfeld, who was the clinical psychologist operating out of Window Rock from October 1967 to October 1969. (Schoenfeld, C. S., Miller, S. I.: "The Navajo Indian: A Descriptive Study of the Psychiatric Population." International Journal of Social Psychiatry, Spring, 1973, pp. 31-37).

Some of the results of this study are reproduced for the purposes of this report as base line data. During the period from October 1968 to September 1969, 348 new cases came to the attention of the Mental Health team. Characteristics of this patient population were reported by tribal affiliation, sex, age, marital status, referral service and disposition, and primary diagnosis.

I. Tribal Affiliation (n = 348

Tribe	%
Navajo	90
Hopi	4
Zuni	<1
Other	6
Non-Indian	<1

II. Sex (n = 348)

	%
a) Male	42
b) Female	58

III. Marital Status (n = 348)

a) Married	34
b) Single	52
c) Widow	5
d) Divorced and separated	9
e) Unknown	<1

IV. Age (n=348)

a) 0 - 10	9
b) 11 - 15	15
c) 16 - 20	12
d) 21 - 30	21
e) 31 - 40	22
f) 41 - 50	10
g) 51 - 60	6
h) 61 - 70	4
i) 71 +	0

V. Referral Source and Disposition (n= 348)*

	Referral Source		Disposition	
	Number	%	Number	%
United State Public Health Service	233	67	334	96
Bureau of Indian Affairs	208	60	33	10
Tribal Agencies	52	15	17	5
Self	52	15	0	0
State Welfare Programs	49	14	6	2
State Mental Hospitals	21	6	17	5

*A patient may have been referred from more than one source. A disposition may also have involved more than one agency.

VI. Primary Diagnosis (n = 348)

		%
a)	Mental Retardation	10
b)	Psychosis Associated with Organic Brain Syndrome	2
c)	Non-psychotic organic brain Syndrome	4
d)	Psychoses, other	16
e)	Neurosis	30
f)	Personality Disorder	8
g)	Psychophysiological Disorder	4
h)	Special Sympton Reaction	3
i)	Transient Situation Disturbance	10
j)	Behavior Disturbances of Childhood/Adolescence	6
k)	Conditions Without Manifest Psychiatric Disorder	8

In a later chapter, we shall re-examine these trends and compare them with data coming from other areas. Among things worthy of some note at this point, however, are the relative youthfulness of this patient population and the preponderance of women.

Over two thirds of the referrals were initiated from within the USPHS itself, with the BIA a close second in terms of sheer numbers. The Disposition figures indicate a tendency to retain patients and clinical responsibility; a trend which may be characteristic of new programs which have not had time to cultivate and utilize local resources. (Schoenfeld et al suggest elsewhere, that this trend may be due to the attitudes and perceptions of the mental health team--very positive towards themselves and relatively negative to other agencies, particularly the BIA. See Schoenfeld LS, Lyerly RJ, Miller SI: "We Like Us", Mental Hygiene, vol. 55 no. 2, April 1971, pp.171-173,

With regard to diagnostic characteristics, the lack of alcoholism looks somewhat startling until it is realized that the major alcoholism

treatment program on Reservation during this time was an OEO, rather than Mental Health project.

The emphasis on consultation with other agencies throughout the Reservation and its adjoining territory, and in the two states Arizona and New Mexico is easily overlooked if one attends only to clinical records. In the section on Special Projects later in this chapter are two examples of extensive consultation and development of interlocking networks of services, one based in the BIA Schools, and one within the Navajo traditional institutions. Other examples are reported as each of the major Service Unit programs are described in the sections that follow.

During the next four years, 1969-73, the programs and staff developed through the acquisition of four psychiatrists (2 at Gallup, 1 at Tuba City, and 1 traveling between Fort Defiance, Chinle, and the Hopi Reservation) at least one psychologist and sometimes two, an educational specialist, and a number of social workers. A position for a Deputy Area Chief of Mental Health Programs was created, and a number of other supporting personnel were intermittently used in the fields of counseling, nursing, and administration.

III. SERVICE UNIT PROGRAMS

A. Tuba City

1. The Setting and the Staff

Among the earliest of the supporting personnel added to the Navajo Mental Health programs were Norbert Mintz, Ph.D. and his wife Sophie Mintz. Norbert Mintz was the recipient of an NIMH Career Development Fellowship and chose to serve some of the period with IHS, and par-

ticularly selected Tuba City IHS Hospital as a location where he could function usefully in expanding the services. He arrived in 1969, as the first full-time professional on the staff, and assumed leadership in developing both services and establishing some parameters of research. Dr. Mintz provided the following description of the setting at Tuba City:

> The Tuba City Indian Hospital was opened in 1919 as a permanent clinic-dispensary-hospital of seven beds. The second hospital of 35 beds, which replaced the first hospital, opened in 1927. The current hospital of 75 beds was opened in 1954, and community services reaching out from the hospital were begun at the end of the 1950's. In the summer of 1969 (which was when the on-location mental health program was begun), the hospital was staffed by six general medical officers, one internist, one obstetrician-gynecologist, one opthalmologist, two pediatricians, one public health physician, one surgeon, and one medical social worker. The hospital ran medical, surgical and pediatric in-patient wards, and a variety of outpatient clinics (general, pediatric, opthalmology, etc.). Medical support staff consisted of a dietitian, environmental program specialists, nurses, an anesthetist, nursing aides, pharmacists, a health education aide, and a mental health worker.
>
> The mental health capability, as of the summer of 1969, consisted of work done by the medical social worker, by the mental health worker, and by the psychological or psychiatric consultant who would come for part of a day, twice a month, from the eastern end of the reservation. The medical social worker had as his primary responsibility the problems of economic rehabilitation of patients, pre-discharge planning for patients, alcoholism, and child welfare. However, mental health work, sometimes separate from and other times in conjunction with these other duties, also was undertaken by social service. As of 1969, it was estimated that 10% of the social worker's case load consisted of mental health patients.

Prior to the summer of 1969, Dr. Bergman had flown to Tuba City for twice-monthly consultations, and a mental health worker/interpreter, Mr. Belagody, spent full time within the catchment Area.

Dennis Parker, the Navajo Mental Health Worker was trained by Jerold Levy as an anthropological interviewer to secure family and cul-

tural information prior to the establishment of mental health services. He was added to the staff very soon after Dr. Mintz' arrival. Mr. Parker began to assume responsibility for casework (with supervision provided by both Dr. Mintz and Dr. Bergman), and to participate in Navajo Area-wide case conferences and training sessions. He became skillful in monitoring the effects of various psycho-active drugs, and in developing working relationships with General Medical Officers and Mental Health Consultants. His work involved not only being available to hospital staff, but also making home and field visits to follow patients in their more remote locations after clinic visits, providing some initial screening and casefinding, and generally linking patients with their families, camps and clans.

The rationale for field work is given vividly by Dr. Mintz in a personal communication:

> As already mentioned, the medical social worker could only devote about 10% of his case load to seeing patients in the mental health categories. The mental health worker's prime responsibility was defined as outreach into the community and follow-up of patients who had been seen either by the out-patient department physicians or by the mental health consultant. Because of the topography and geography of the land, as well as the social system of the Navajo people, a field visit to a patient usually was an all day affair. The land in the eastern end of the Navajo reservation is a semi-arid desert which is punctuated by deep canyons and steep, high, sandstone bluffs. Erosion is widespread, rendering vast areas unavailable to modern transportation, and much of it is extremely difficult to traverse even by horse or foot. The western half of the reservation in 1969 had approximately 350 miles of paved road and perhaps another 300 miles of unpaved (but maintained)-dirt road. It is estimated that only three out of ten families owned a pick-up truck at the time, so that the other seven out of ten families were dependent on foot, horse transportation, hitchhiking, or transportation in pick-up trucks provided by their neighbors for a fee. A survey done at the Tuba City hospital showed that during a two-day period almost 60% of people arriving to the out-patient department and to the hospital

wards had to pay for their transportation. This payment ranged from one dollar to $18, with a median of $5 per person. Under these circumstances, it is not surprising that the twice-monthly mental health clinic, held by the traveling mental health consultant, was not always regularly attended by the population.

The lack of roads also hampered the mental health worker from easily traveling out into the field to see patients. However, a second factor that made home visits to patients a lengthy affair is the social structure of the Navajo people. As with many rural and agricultural populations, the culture of these people dictates that business is not transacted in a hurry. Many social formalities and obligations must take place before a person can get to the point of his visit. Thus, it would be a rare and unusually productive day when the mental health worker would manage to see three patients in one field visit.

2. Establishing the Mental Health Clinic

Dr. Mintz continues to describe his situation as he entered into the IHS activities at Tuba City in the summer of 1969 as follows:

After gaining some understanding of the conditions in the western end of the Navajo Reservation, it became obvious that in order to do mental health research as well as to provide a mental health program for the Navajo (and Hopi) people, it was necessary to alter the pattern of mental health care that existed at Tuba City in 1969. While keeping the same structure that previously existed (consultation with various community agencies and specific "mental health clinic" days for which appointments were made for patients), I initiated a walk-in mental health clinic running virtually seven days a week, which also offered the possibility of immediate referral (day or night) from the out-patient department medical clinics or the in-patient wards of the hospital. . . At the beginning, in so far as it was possible, patients who walked in or were referred from the medical departments were seen within an hour or two. Since at first I was working predominantly by myself (it was decided to allow the mental health worker to continue for this first year to do the same job as he had been doing in the past, which mostly was home visits and follow-up), my ability to see people immediately was of course determined by how many people were referred on the same day.

As the case load increased, it became necessary to see people very briefly for evaluation and support, and then to reschedule them for anywhere from a day to a week later. By the time of the second year of the mental health program, expanded staff and further training of the mental health workers made it once again possible to run the clinic with a minimum of waiting time. When treatment was started

and further visits were necessary, a patient would be given an appointment for a specific day and a specific time. However, he would be seen whenever he came, regardless of whether it was on the wrong day or at the wrong time. The only penalty, if the patient did not get there at his scheduled time or correct day, was that he would have to wait his turn until all those who were there at their scheduled time and correct day were seen.

The physical layout of the mental health clinic also was altered when the new program was started. Previous to the summer of 1969, the mental health worker and twice-monthly consultant would see the patients on the hospital ward (if on a hospital visit), in the patient's home (if a field visit), or in an office trailer that also was used by the opthamology and medical social work services (if a mental health clinic out-patient visit). Since there was no room for expansion in the office trailer used by the opthalmology and medical social service departments, and since when I first arrived I was not part of the Indian Health Service (being funded, instead, by the Career Development program), I arranged the purchase of an office trailer which was parked next to the existing opthalmology and social service trailer, and used it to see patients. This clearly defined this program as a "new" service, related to the medical services of the Tuba City Hospital but at the same time somewhat distinct from the rest of the activity of that hospital. This structure had the advantage of allowing the mental health program to use the facilities of the hospital, but at the same time allowing a certain autonomy which enabled it to develop a different atmosphere for its own services. Arrangements were worked out with the general hospital not only for referral of patients, but also for hospitalization on the pediatric, surgical, or medical wards for up to several days. This procedure was used in the case of patients who required hospitalization for such conditions as suicide attempts or acute psychotic episodes. The pharmacy department of the hospital was the facility used for psychoactive drug therapy that was done with some of the mental health patients.

With the development of the walk-in clinic and the full time availability of professional consultation and supervision, it was possible to add another Mental Health Worker. This complement, of one professional and three paraprofessional staff members seems to be a stable complement for the unit, with replacements being made if one of the paraprofessionals leaves for schooling or for other reasons. A receptionist secretary position was also provided early in Dr. Mintz' tour of duty,

and this position was used in later years as a stepping stone to the greater responsibility of the mental health worker position by one or more Navajo.

3. Direct Services in the First Year

The work of this unit is well described in the formal report submitted at the end of the 1969-70 period by Dr. Mintz to the Area and National headquarters of the IHS Mental Health Programs:

> The clinical program at the Hospital and OPD provides diagnostic consultation and case treatment by the Mental Health team. At first, most Mental Health referrals came through the Out-Patient Department and primarily were for psycho-physiological problems. As the Mental Health Service expanded, cases were referred from the In-Patient units, as well as there being an increasing number of self-referred from adolescent-parent generational conflict, to psychosis. The relationship to the In-Patient Services became two-sided, with the Mental Health Program hospitalizing some patients who are psychotic, suicidal or in alcoholic hallucinosis. In addition to holding regular clinic twice a week, the Mental Health staff is available several more days a week for consultation and emergency treatment. They also use these non-scheduled days for the continued treatment of patients who are identified on scheduled clinics. Besides treatment provided by the team in the Hospital and in the Mental Health and Social Service trailers, many home visits are provided, primarily by the Mental Health workers. These home visits are oriented toward prophylaxis as well as toward treatment.
>
> During the first 12 months of the clinical service, 70 male and 150 female patients were seen by the staff. About 80% of these patients were seen jointly by Dr. N. Mintz and one of the two Mental Health Workers (since most patients do not have sufficient command of English to allow treatment to be in English). About 10% of all patients were carried alone by the Senior Mental Health Worker (Mr. Bilagody), with consultation by N. Mintz. The remaining 10% were seen primarly by N. Mintz, with consultation by Mr. Bilagody or Mr. Parker. As Mr. Parker becomes more experienced, it is expected that he will carry some patients on his own also. Even though most patients were seen for brief intervention (4-6 treatment sessions), the time involved was greater than might be thought, because of two factors: home visits are time-consuming because of distances and poor roads, but yet often are necessary. About 75% of all patients seen were given psycho-active drugs at some point, although only in about 30% was drug therapy a continuous accompaniment of treatment. About 10%

of the patients were being maintained primarily on drugs, with supportive treatment from the staff. These mostly were psychotic patients and patients with entrenched psycho-physiological complaints.

A variety of additional services were provided both inside and outside the service Unit. Consultations have been scheduled at Kayenta Health Clinic, and have been offered (on a request basis) at Keams Canyon, Winslow and Monument Valley Hospitals. Regular visits to Arizona State Mental Hospital and to Gallup Indian Hospital were made by N. Mintz and Mr. Bilagody. Consultation to various shcools (Kaibeto, Shonto, Flagstaff BIA Dormitory, Ramah, Toyei, Rough Rock) have been made by S. Mintz and Mr. Bilagody, and sometimes by N. Mintz. These visits have included recruitment of high school students for special off-reservation high school and college programs. Talks have been given to students and staff at Tuba City Public School by Mr. Bilagody and N. Mintz, and Mental Health personnel have been active in community programs and planning, ranging from Mr. Parker's involvement in community alcohol programs to S. Mintz trying to facilitate and encourage Indian self-employment ventures.

An area that the Mental Health Program virtually has avoided is the problem of alcoholic patients per se. To be sure, there are many Mental Health patients whose problems include alcohol abuse, but they will be seen primarily for depression, suicidal attempts, family problems, anxiety attacks, insomnia, etc. This is a tactical choice, which some may not agree with. However, it seemed to be most fruitful to work with alcohol abuse in the context of some other symptom, one which is subjectively disturbing the patient, using this as leverage to approach the alcohol abuse. However, the Mental Health Staff also have given talks to schools and to other community agencies on alcohol abuse, and have provided consultation to the Tribe's ONEO alcoholism program and to the hospital's antabuse program.

4. Summary of Cases 1969-1971

After completion of his Career Development period in 1971, Dr. Mintz summarized the epidemiologic information that he had observed in Tuba City, as well as a pilot attempt to determine if the effects of psychotherapy were reflected in the medical records. These two brief reports are included in full because they present rare hard data, as well as a discussion of the problems involved in finding appropriate ways to utilize work in research designs. . .

PRELIMINARY AND INCOMPLETE EPIDEMIOLOGICAL SURVEY OF TUBA CITY PROGRAM

The following is a simple tabulation of 345 identified patients seen by me or the mental health staff during the two years I supervised the program. By "identified" I mean that these were the index patients who went through the intake procedure. Family members who were involved in treatment of the index case were not counted in the tabulation, even though many of them were considered by us as patients and received treatment in addition to the usual family interviews or treatment sessions for the identified patient. The only exceptions were when a family member began to consider him or herself as a patient, and requested (directly or indirectly) our services. In such instances, an intake procedure was done, the patient had a folder opened, and this became one of the 345 patients in the sample. Patients who were seen by the mental health staff and by visiting psychiatrists over my summer vacation were not included, unless these patients were continued in treatment after my return (thus either being seen by me, or my being involved in supervising the mental health worker seeing the patient). Also not included are a few persons for whom treatment was on an "informal basis" and on whom no records were kept, neither mental health records nor medical records. These were all out-patients and were in sensitive positions vis-a-vis the hospital, the town, or the tribe. However, several persons are included in the 345 who also fit into the above "sensitive" categories; records had to be kept on them because of the more serious and/or more public nature of their problem and/or the formal nature of the treatment. Also, all patients seen on (or referred through) the in-patient service had intake procedures; they necessarily were considered as falling into the more formal treatment category, even though they may have been in "sensitive" positions. Finally, those few patients from the Tuba City area seen in outside mental wards or hospitals (Gallup Indian Hospital, Arizona State Mental Hospital, Phoenix VA, etc.) were included, but the many patients from outside the area that the mental health workers or I saw in consultation at the Kayenta, Keams Canyon, or Monument Valley out-patient clinics were not included in the 345 patients, unless continued treatment was instituted and patients were followed in the field by the mental health workers; in the latter case, intake procedures were done, a folder opened at Tuba, and they were then included in the 345.

Sex: males, 126 females, 219

Race or Tribe: Navajo, 296; Hopi, 25; Piute and Piute/Navajo, 7; Navajo/Hopi, 3; Navajo/other, 5; Hopi/other, 1; other tribes, 3; Anglo, 5; Black, 0.

Age

Age	Number
5-14	34
15-19	55
20-24	48
25-29	55
30-34	42
35-39	41
40-44	19
45-49	23
50-59	23
60-up	6

First visit of mental health staff member (myself or mental health workers) during my tenure occurred with the patient: on the ward of the Tuba City or other PHS hospital, 132; in the MH clinic or other out-patient clinic or in the field, 209; on the ward of Arizona State Mental Hospital, 4.

Referral source: Out-patient department physician, 79; hospital ward physician, 130; social service (includes several patients "inherited" from social service the first few months after I arrived), 32; school referrals (including school nurses and administrators, etc., as well as guidance staff), 23; self-referred, 33; friend or relative, 29; police, 3; work supervisor, 2; legal aid society, 1; state hospital, 4; on my request (suggested after record review, which I routinely did every few weeks), 9.

Suicide attempt (or in a few cases a threat on verge of being carried out) was reason for first contact during my tenure: attempt, 55, attempt suspected by referral agent but judged by MH not to be an attempt, 7. In addition, three Navajo men were brought in DOA by suicide during my tenure at Tuba City. Families of all three were seen by someone of the MH staff (neither the DOA nor their families are included in the 345 index cases) subsequent to the suicide. None of the men had been in treatment with the MH staff during my tenure. However, two of them had

records of psychological disfunctions (including suicidal ideation and behavior) several years prior to my arrival at Tuba City. In a record review, I had requested that the out-patient department give one of these three men an appointment to see us when he next came into OPD, but he never was given it or else never came; and the second man had been seen by a social worker for a single consultation at Tuba City several years before I arrived, but had never been involved in continued treatment then or later. Methods used by these three successful suicides were gun, drugs plus alcohol, hanging.

Psychoactive drugs prescribed by medical staff within two years prior to the patient first being seen by the MH staff (during my tenure). These were prescriptions for psychic conditions, or for psychophysiological conditions, or for psychic "overlay" or "exaggeration" of physiological conditions, which were prescribed by physicians prior to any consult by the MH staff. Patients given psychoactive drugs for acute alcohol reactions, but not given maintenance prescriptions after the acute stage (e.g. Librium given until the actue phase ended, but patient not prescribed the drug thereafter), were coded as "none" in this count, as were other "single shot" prescriptions for acute insomnia treated with Chloral Hydrate or Thorazine for a few nights). Likewise, patients with "physiological" epilepsy receiving Dilantin and/or Phenobarbitol were coded as "none" in the count (unless other psychoactive drugs for other problems were prescribed), as were patients on Antabuse for alcohol abuse (unless other psychoactive drugs were prescribed), and children given drugs for minimal brain damage syndromes and the patients given Darvon for pain (although the latter was clearly used by some patients as a psychoactive drug). Included in the count were patients for whom Phenobarbitol was used as a sedative for a week or more. Forty-seven patients out of the 345 cases did not get tallied because the prior two years were spent in whole or in significant part away from the Tuba service unit, and so the information would not be comparable to other cases ("away" does not include the frequent migratory visits taken by many Navajos to relatives, unless evidence appeared to show that this was in fact a significant move out of the area of our health care). Thirteen additional cases were not tallied because complete prescription records were not found at the time of this recording.

Thus, in the remaining 285 cases: patients having no record of psychoactive drugs within two years of first visit to MH staff, 157; patients given only a single type of drug (Librium & Valium counted as a single type, as was Imiprimine and Desiprimine, while Thorazine and Mellaril were counted as two types), 66; patients given more than one type of drug, 61; patients given drugs, but number of types unknown, 1.

Psychoactive drugs prescribed for patients longer than two years before their first visit to the MH clinic during my tenure. Using the same coding scheme as directly above, there were 44 cases for whom complete prescription records for this time period were not available. In addition, 39 patients spent a significant part of their recent life out of the area of the Tuba City health care facilities. Thus, of the remaining 262 cases included in this count: patients having no record of psychoactive drugs prescribed longer than the two years prior to first MH visit, 186; patients given a single type drug, 39; patients given more than one type drug, 37.

Combining the above two results on psychoactive drugs. There were 56 patients who were not counted in both counts (no available records, or out of the area for two years and longer prior to first visit). Of the remaining 289, patients having no record of prescription for psychoactive drugs anytime prior to first visit, 126; patients having one or more psychoactive drugs sometime prior to first visit, 163.

Patients prescribed psychoactive drugs on recommendation of the MH staff. Regardless of whether or not the patient was on drugs when first seen by the MH staff during my tenure, the following tally shows how many patients were recommended to be on psychoactive drugs, and for how long, following the MH staff's evaluation. Some patients were continued on the same drug that they had been on when we saw them, some were continued on drugs but the type was changed, some were started on drugs who had not been on drugs when we first saw them, and some patients on drugs when we saw them were recommended to discontinue these drugs. Finally, the length of time a patient was on drugs refers to the actual number of months during which a psychoactive drug recommended by the MH program was taken anytime in that month. In many cases this was not consecutive but intermittent: a patient who was on a prescription for two months, then off for a month, then on for two months, then off for the remainder of my duration, would be counted as having been on drugs for 4 months. Also, patients taking a prescription for a few days in the month would be counted as having been on drugs for a month. A fair proportion of anxious patients who were started on a regular drug regime at first and then were later switched to an intermittent take-when-needed regime, were counted for each month during which they took pills, even if this were only for one or two days. In other words, the count represents any month during which a drug was taken, no matter how much or how little. Finally, some patients are "open-ended" for number of months, because when I left they were still being maintained (either continuously or intermittently) on drugs. Some of them undoubtedly would have been discontinued soon, while others would have been

maintained for a long time. To get some breakdown on this, patients still being maintained were categorized into three groups: first visit to MH staff was 1-3 months prior to my leaving (therefore there was a good likelihood of discontinuance soon); first visit 4-7 months prior (still a fair chance of discontinuance); first visit 8-12 months prior (probable long-term maintenance); more than 12 months prior (long-term drug maintenance). Since copies of these records were complete at time of counting, the data are based on all 345 cases. However, 20 cases were inappropriate to include because they were seen for diagnosis only and were referred outside the area (hence not treated by the MH staff). Thus the breakdown is for 325 patients:
Patients that MH recommended to be on no psychoactive drugs for the entire time during my tenure, 182; patients recommended by mental health to be on psychoactive drugs some period of time but were not receiving drugs when I left, 82; for one month only, 46; for two months, 18; for 3 months, 7; for 4-7 months, 9; 8-12 months, 2. All of these 264 patients (those receiving some drugs and those never receiving drugs) were on no drugs when I left. In addition, there were 61 patients that were still on drugs when I left, and these break down as follows: on drugs for 1-3 months, 11; for 4-7 months, 6; for 8-12 months, 6; for over 12 months, 38. Combining the two breakdowns, we can state that approximately 55% of MH patients had no psychoactive drugs recommended for them by the MH staff for the entire period of possible contact during my tenure. In addition, we can estimate that 15% would have had drugs recommended for only 1 month, 8% for 2-3 months, 4% for 4-7 months, 1% for 8-12 months, and 15% for over twelve months.

Alcohol related medical problems. These refer to medical problems that were precipitated by alcohol abuse (accidents, fights, pneumonia), rather than being problems of DT's or hallucinations. This percentage is based on eliminating patients with incomplete records or children for whom the analysis would be inappropriate. Of the remaining 245 patients who were seen the first two years of the mental health program, 20% were seen in the out-patient department for alcohol related medical problems within two years prior to their visit to the mental health service.

Any psychiatric or psychological contact or diagnosis within 2 years prior to first visit at the Tuba City Mental Health Program. For 271 of the 345 patients we were able to get appropriate information. Of the 271 cases, 126 patients had never received a psychological diagnosis of any kind in the two years prior to our seeing them, nor had they had any mental health treatment. This is just a little under 50%. Of the remaining 50%, about half were patients who had been seen in the medical out-patient department and had been given a psychological or psycho-physiological diagnosis, or (in a few instances) they had been seen by the mental consultant or by social service as out-patients and had been given a psychological diagnosis. The other half (25% of all patients)

had not only been seen in the out-patient department, but also had been hospitalized in the medical ward of Tuba City with a psychological diagnosis or (in a few instances) had been sent to a contract psychiatric hospital, within two years prior to our first contact with them.

Translator needed. For the year 1969-1970, the hospital found that in the medical out-patient department they needed translators part of the time. In my own work, our statistics for translators differed somewhat from those of the medical out-patient department. 41% of the patients that I saw needed no translation, 42% of the cases needed a translator all the time, either for language translation or cultural translation. This analysis includes non-Navajo patients. However, the Hopis or the other Indians (except Piute) generally would not need linguistic translation; thus, if one would just do an analysis of Navajo patients seen, the percentages of patients needing translators would be much higher. One reason why the mental health program needed somewhat less translation than the medical out-patient department is because we did not have a large percentage of old patients (who always need translation), and we did not have a large percentage of very young children (whose mothers would be the ones for whom translation was required).

Mental health worker visits (out-patient). 40% of the mental health program's patients were never seen by a mental health worker without my also being there. The remaining 60% of the patients were seen as an out-patient at least for one visit by one of the three mental health workers, without my presence. The median number of patient visits that the mental health workers had by themselves with these out-patients was 1.2 visits. In 60% of these cases, the most experienced of the three mental health workers saw the patient.

A Pilot Study to Determine if Psychotherapy Effects are Reflected in Medical Records

Norbert L. Mintz

Thirty-two patients were randomly chosen from the 345 case folders compiled on patients seen at the Tuba City Mental Health Program. Of these 32 cases, 29 (89%) were Navajo, 2 were Hopi, and 1 was Navajo-Hopi; this percentage of Navajo patients in the pilot sample compares favorably with the percentage of Navajo patients among the entire 345 cases (87%). Twenty of the 32 patients are female (63%), which again compares favorably with the percentage of female patients in the entire sample (64%).

For these 32 cases, we examined the medical records for out-patient department visits as well as for in-patient hospitalizations. For the pre-psychotheraphy measure discrete illness visits to the medical out-patient departments were counted for a period of two years prior to the first visit of the patient to the mental health program, and the same was done for hospitalizations. By "discrete" is meant that short-term re-visits or follow-up visits for the same problem were not counted, but a later recurrence of the same illness was counted. Thus, if a patient came with an earache, and three days later returned with the same complaint, that was not considered a new visit; but if the same patient returned two months later with a recurrence of the earache, that was counted as a new visit. Likewise, if a patient was hospitalized with a broken leg from an auto accident, and was re-hospitalized a week later because it unaccountably did not seem to be healing correctly, that was not considered as a new hospitalization; but if the same patient was hospitalized a month later because he tried to ride a horse and thereby disturbed the bone alignment, that would be counted as a new hospitalization.

After this count was done for the two years prior to the first mental health visit, a post-psychotherapy count was done following that first mental health visit. The length of time covered by this second tabulation varied with each patient. Since the tally was done one month before I left Tuba City, the maximum span between the patient's first mental health visit and the time of medical record tabulation could be two years, whereas the minimum span could be one month. This non-comparability of time span between the pre and post records was adjusted by pro-rating the post-therapy tabulations to a base of two years. Furthermore, 5 of the 32 patients for whom the post-psychotherapy medical records spanned only a three month period prior to the tabulation were dropped from data analysis, on the premise that 3 months was too short a time for a reliable count. Other patients also had to be eliminated from the data analysis: 8 because they were not consistently residing within the western end of the

reservation during the total period of time covered in our record tally; 1 because the medical records were unable to be located during the several weeks of record abstract; and 1 because it was the record of a mentally defective child who was seen for diagnosis and placement recommendations, not for psychotherapy. Thus, 17 records of the original 32 were able to be used in data analysis (53%).

The 17 patients whose medical records could be used were segregated into two categories: those who were judged undoubtedly to have benefited from their contact with the mental health program, and those who could not be judged in as unequivocal manner. The judgment was strict and conservative; a more flexible evaluation would have placed some of the "no benefit" patients in the category of having received some benefit from their contact, if one were to include such a category. The reason for not having such a category is that I was both the therapist and the clinical evaluator, and so wished to use a very simple and strict categorization. With this basis for segregation, 10 patients were judged as undoubtedly having benefited, and 7 patients were not able to be so judged.

The "benefit" and "no benefit" groups were then compared for difference in number of out-patient medical visits and in number of hospitalizations for pre-therapy and post-therapy time periods. For post-therapy out-patient visits, the 10 patients judged as undoubtedly improved had a mean reduction in medical out-patient visits of 7.9 visits per two years, while the 7 "no benefit" patients had a mean reduction of only 1.3 visits per two years. A t-test for this difference was statistically significant beyond the .01 level for a two-tallied test. Turning to hospitalizations, the patients judged undoubtedly improved had a post-therapy mean reduction of .8 hospitalizations per two years. A t-test for this difference was not significant. The t-test was computed only to allow comparison to the results of the out-patient visits. Actually (as discussed below) the data were not distributed in a manner appropriate for a t-test. A Mann-Whitney U-test, which was an appropriate test for the hospitalizations data, also showed no significant difference.

The results of analyzing out-patient visits clearly supported the prediction that when psychotherapy was judged obviously to have been effective, it would be reflected in a reduction in the number of subsequent visits for medical treatment. Those patients judged to have gotten "no benefit" also had some reduction in cut-patient visits after contact with the mental health program; this either was due to random variation or else to the fact that this categorization had at least three types of patients: those who probably gained some benefit, those who gained no benefit, and those who got worse despite our efforts. If the number of patients who gained some benefit were larger than the number who got worse, then the reduction in medical out-patient visits even for the "no benefit" group is understandable.

Results of the hospitalization analysis were in the predicted direction, but short of statistical significance. It is not difficult to see the reason for this if one understands several facts about this data. Hospitalizations are not as frequent an occurrence in an individual's life as are out-patient visits. Therefore, a large sample would be required before reliable patterns could be assumed. Our pilot sample of 17 cases was sufficiently large for the out-patient comparison, but not for the hospitalization comparison. In addition, there is a difficulty in deciding what to do about 7 of the 17 patients who had no hospitalizations before therapy, and likewise had no hospitalization after therapy. This result is favorable in the sense that those patients remained free of serious illness after therapy, and in this respect in some way should be counted as a positive result. On the other hand, having had no hospitalizations before therapy makes such an interpretation at least open to argument. But a problem arises statistically when one includes these patients in the pre-to-post analysis, because although they contribute zero to the sum of pre-to-post changes they are counted with the number of patients on which the statistical analysis is based. In a larger sample of cases, one will be able to analyze the data in several ways, so as to get a better estimate of whether or not there is no difference on the hospitalizations measure.

5. The School Program

A second component of the mental health program in Tuba City was the school program. This got early attention and was more rapidly explored than it might have been otherwise by the fortuitous presence of Dr. Sophie Mintz, wife of Dr. Norbert Mintz. Dr. Sophie Mintz has much experience in child and school program development and consultation, and as a professional in an area where such personnel is scarce, first began volunteering her services as a consultant to the BIA boarding schools. This supplemented the direct clinical services to individual school children by focusing on the potential preventive work that could be done through a school counselling program which was already a part of the BIA plan for the school. After the first year when her

services were contributed, Dr. Sophie Mintz was provided a salary by IHS and she continued this work with the boarding schools at Tuba City, Kayenta, and Kaibeto located within the area served by the Tuba City IHS hospital and its satellite field clinics and health stations. Dr. Mintz also made some contact with the public schools attended by both Navajo, Hopi, and non-Indian children in the more thickly settled sections of the catchment area.

Although her services were ostensibly welcomed, the bureaucratic structure of the BIA and the boarding schools is such that effective implementation of many recommendations was impossible. One of the problems was a confusion about meaning of such terms as "counselling" which to Dr. Sophie Mintz and other mental health professionals implied a structured, professional and therapeutic relationship between a staff member and a child or group of children. However, the term is also used within the BIA to refer to the dormitory staff who function as housemothers and assistants to the dormitory staff--and who have quite different functions in this residential setting than school-oriented counselors. There was also a deep gulf between the view and committment of mental health staff and programs which would be both preventive and alleviate milder forms of emotional distress and the BIA school staff's interpretation of their functions. One can realize the depth of this gulf when it is realized that the Tuba City Boarding School is responsible for its pupils 24 hours a day during the school year, and provides their total social and physical environment. Consequently, small changes in ways of relating or performing one's duties were apt to cause ripple

effects throughout a closed system, and a very tight control in innovation and change was excercised both formally and through informal social controls on staff and pupils alike.

Nevertheless, a formal counselling department was established, and eventually subdivided between elementary and junior high divisions within the school. It was a source of frustration to the consultant that administrative authority did not ensure that actual 'counselling' was carried out. However, the two years of consultation experience paved the way for many constructive actions that were taken at a later time. The frustrations experienced in attempting to deliver mental health services to boarding schools are similar in all Areas of IHS, and Dr. Sophie Mintz' pioneering work in the Tuba City portion of the Navajo Reservation is a well documented expression of this problem. By establishing this dimension of community consultation early in the history of the Tuba City Mental Health Program as a foundation for later work, they have made a real contribution.

6. Aftermath of the Introductory Years

The contributions of the Drs. Mintz to the Tuba City program generally tend to be glossed over by later staff for a number of reasons. One lies in the differing expectations of staff of the hospital and of the mental health staff. The medically oriented staff had hoped for a psychiatrist who could share the medical O.D. responsibilities and assume full care of psychiatric and disturbed patients. As a psychologist Dr. Norbert Mintz was not available for this responsibility. He earnestly devoted himself to assisting as a consultant to the medical and nursing

staff whenever they found it appropriate, particularly when there were emotional symptoms co-existing with medical problems; as well as facilitating the referrals to psychiatric institutions when they were truly needed. However, his behavioristic approaches to human deviant behavior were more psychoanalytic (as they might have expected) but did have the medical flavor to which they were accustomed, and occasionally dissonant notes were heard. Pediatric and surgical staff were more receptive to his consultations than were some of the other general and special personnel.

The second problem that arose around the psychologists was their involvement in research without it being clearly understood by local staff or patients. Not only were the patients being analysed and having their unconscious motives interpreted to them from a very different world view than they had previously experienced, but others, not identified as patients, discovered that they too were being observed and categorized. As this was discovered there was a feeling of being deceived, as well as a loss of mutual respect. As one person expressed it, many felt that "we were like somebody's beetle collection, all labeled and stuck on pins. . . not people with feelings." The resentment was doubled because it was done without the understanding, the consent, or the collaboration of the Navajo people which had otherwise characterized the Mental Health Program.

Without access to the study itself, or to the conculsions drawn from this data, it is difficult to tell whether or not the Navajo fear of distortion is justified. Certainly the anger at being fooled or tricked is understandable. However, it should be pointed out that as

recently as 1968 the discussions of the "Human Use of Human Subjects" and the guidelines for protection of people who participate in research had not come to the forefront of professional attention. The use of misdirection, and of attempting to be objective by not sharing research goals with participating groups was very standard practice for many psychologists. In all fairness the behavior of these professionals cannot be retroactively judged by standards that are now being developed. Whatever the rights and wrongs of the matter, the distrust has continued, and certainly made the development of Mental Health Services in Tuba City that much more difficult than it might have been.

7. The Second Professional: Stephen Proskaeur, M.D.

The professional assigned to Tuba City in 1971 to replace the Drs. Mintz was Stephen Proskauer, M.D., a child psychiatrist who was fulfilling his armed forces draft obligations as a USPHS officer. He managed to eradicate most of the distrust of non-Navajo professionals and to establish respect within the medical staff. His youthful earnestness and well-developed skills offset the cultural gaps between his energetic desire to create change and the slower pace of the people. His ability to be open, enthusiastic, and genuinely respectful of his patients was probably the best antidote that could have been prescribed for any residual bitterness of the previous experience.

The team of three Navajo paraprofessionals in Tuba City developed some sense of specialization, with one attending particularly to the problems of children and another to liaison work with alcoholism programs. The third mental health worker, one of the older men in the

program, studied the properties of drugs used in psychiatric situations, and developed an in depth knowledge of their properties, side effects, and the indications for favorable results. In his role he is often able not only to clarify the confusions of family and community about the medication schedules and anticipated effects, but is also invaluable at providing linkage to the non-Navajo staff of the hospital and providing them with concise information about cultural and familial factors affecting treatment.

8. Direct Clinic Services

The number of patient visits in the Tuba City Mental Health Program outpatient service is summarized for fiscal year 1973 in the accompanying table

July 72	116
August	271
September	137
October	197
November	186
December	174
January	200
February	282
March	260
April	285
May	255
June	197
TOTAL for year	2,560

	Male	Female	Total
Total no. patient visits	1,229	1,331	2,560
Number of scheduled appointments not kept	286	370	656
Number with appointments who came but were not seen at the time	4	10	14
Number of 'drop-in' patients seen without an appointment	254	289	543

This represents a busy outpatient program, but it only describes one area of activities of the staff, school and community consultations, and regular clinics at Kayenta averaging at least six patient visits per week, are not included in the above statistics of community and school consultations. Some idea of the scope of the full range of the Tuba City programs can be appreciated from these excerpts from a report prepared by Dr. Proskauer in 1971.

Current Activities:

1) Clinical services at Tuba City Hospital. Average out-patient census is about twelve patient visits per day. Average in-patient load, 3 or 4 patients. After-hour emergencies occur about three times a week with great variation from week to week.

2) Kayenta Clinic. Dennis Parker and I go one day a week and see an average of 6 patients each visit. We eat lunch with the doctors when time permits and do some informal consultation that way.

3) Kaibeto Upper School consultation project (see attached memo)

4) Tuba City Public School consultation. I meet every other week with a group including the guidance counselors, the school psychologist, and the juvenile officer from the Tribal Court to discuss cases and keep lines of communication open. This is shaping up into an in-service training program similar to Kaibeto in some ways.

5) Other schools. Shonto is interested on a children's group making movies but not in mental health consultation. At Leupp Boarding School, I have made one visit so far with some possibility that a small consultation program may develop. At Tuba City Boarding School various teachers and even one guidance counselor are cooperating and asking for our help. Without having any formal program, I plan to exploit each referral as much as possible for in-service education by arranging conferences of involved school staff with us after eacy psychiatric evaluation. Mary Ann is doing some testing at some of the smaller schools, e.g. Red Lake, to help them set up 89-10 programs for special classes.

6) Staff Meetings. The entire staff meets weekly on Monday mornings for two or three hours over coffee and cookies or such. I felt from the beginning the need for us to trade experiences, ventilate feelings, and educate each other on this very busy service. Although it had been suggested the staff would resist this, there has been only one person difficult to involve. The discussions have stimulated us as I had hoped and now are a part of the routine here with increasing openness from the more reticent staff members.

7) Reciprocal service program with Northern Arizona Comprehensive Community Mental Health. You'll soon be getting a copy of the letter of agreement between the Coconino Community Guidance Center and the Tuba City Mental Health Unit which provides in essence that CCGC will cover Flagstaff Dorm and Page Public School System in exchange for monthly psychiatric consultation from me and some cooperative training arrangements for staff interested in working with Indians. There are already smooth cross-referrals going on between us.

8) Of immediate concern is the opening of Gray Hill School in September, 1972. Present BIA plans allow for 300 ninth graders only to be housed in the 600-bed dormitory during the first year. BIA has assurance of completing only nine new housing units for staff at the school! Therefore all instruction will be provided by Tuba City Public Schools. Mr. Jackson seems quite hospitable to the idea of a joint proposal to set up a specially staffed dorm for adolescents with emotional problems. If there were some way to pay for housing through the proposed project, we could be certain of enthusastic BIA support. I'll send you a possible proposal based on the actual lay-out of the dorms so you can begin thinking about how much it would cost and where we could get the money. Mr. Jackson is already checking on possible funding through 89-10 special education. But maybe we would do better to call it a "delinquency prevention program" and get L.E.A.A. plus alcoholism money.

9) Alcoholism Prevention Programs. We are working on three possible proposals to submit to you for constructive use of your contract money for the Western Navajo.

A. Contract to the Flagstaff Indian Center for (1) setting up a cultural center to provide Indians in the Flagstaff area with a positive alternative to socializing in bars, and (2) hiring a Navajo mental health worker to work at Coconino Community Guidance Center and at the cultural center.

B. Contract to the Tuba City O.N.E.O. Office through the Navajo Tribe to obtain anthropological and psychiatric consultation and in-service training in group and individual psychotherapy for alcoholism counselors, as well as some vehicles so that the O.N.E.O. workers can reach outlying camps in order to work with families.

C. Contract to the Tuba City School Board or the Tuba City Chapter to (1) equip a teen-age drop-in center and hire a counselor for it, (2) sponsor in the regular school curriculum a series of discussion groups covering medical aspects of alcohol and other drugs, positive role models for young Navajo males, and various ways young men can adapt to the tensions of living caught between traditional and Anglo cultures.

MEMORANDUM

To: Kirby Jackson, BIA School Superintendent, Tuba City Agency;
Robert Bergman, M.D., Chief, Navajo Area Mental Health Program;
John Porvaznik, M.D., Service Unit Director, Tuba City Hospital;
All involved staff at Kaibeto Upper School

From: Glover Rawls, Principal, Kaibeto Upper School;
Stephen Proskauer, M.D., Psychiatrist, Tuba City Mental Health Unit

Re: Mental Health Consultation at Kaibeto Upper School, Academic Year 1971-72

Date: October 18, 1971

This is to clarify the extent and purpose of the Mental Health consultation program in effect at Kaibeto Upper School for the present academic year.

Dr. Proskauer, a fully trained child psychiatrist, has agreed to spend each Wednesday afternoon at Kaibeto to meet with two groups of staff.

The first group, meeting from 2:30 to 4:00 p.m., includes counseling staff and dormitory supervisors. The activities of this group worked out with Dean Goodman, Head of Counseling, include: (1) discussion of individual children manifesting emotional problems in dormitory or classroom in order to reach a better understanding of the child's difficulties and then to plan for utilizing the school's human resources in an optimal way to help the child; (2) in-depth supervision of selected cases being seen in counseling; (3) discussion of pertinent readings from the psychological literature as the opportunity arises. From time to time, other academic and dormitory staff will be invited to these meetings when the discussion is to focus on a child under their care. Also, Dr. Proskauer will on occasion make classroom observations or interview a child himself when necessary.

The second group, meeting from 4:00 to 5:30 p.m., includes certain interested teachers and teacher's aides who wish to develop their skills in helping individual children outside the classroom setting during overtime hours. All staff participating in this group will receive compensatory time for every hour they devote to work with selected children and for every hour of weekly group supervision with Dr. Proskauer. The goals of the group include enhancing members' capacity to develop rapport with troubled children and to make optimal use of the ensuing positive relationships for the children's

psychological benefit. Each participant will discuss at least two on-going cases in detail during the first term. To increase the comfort and effectiveness of the group, no changes will be made in membership until the end of the first term, at which time old members may drop out and new ones may join.

This intensive inservice training program in basic counseling for interested teachers not only should develop new skills outside the classroom but also should enchance the participants' abilities to relate to children in the more familiar classroom setting. Times for supervision and interviewing children will be chosen so as not to interfere with the teachers' academic responsibilities.

We hope that from these beginnings other programs of collaboration between Kaibeto Upper School and the Tuba City Mental Health Unit will evolve as the need arises and new resources become available.

9. Third Change of Senior Staff: Joseph Wakefield, M.D., 1973-

In the summer of 1973 two of the Mental Health Workers from the Tuba City program entered academic programs for degrees, leaving the unit at least temporarily. This together with the assignment of a psychiatrist to replace Dr. Proskauer, Dr. Joseph Wakefield, has temporarily changed some of the pattern of activity. However, Dr. Wakefield, with some experience in the Aberdeen Area program, appeared to be adapting to the South West and the continuous development of staff is well provided for in the overall program design. The SUD and physicians are deeply involved in maintaining Mental Health Services.

Recruiting new staff will be even more important as the treatment center modeled on a Half Way house comes closer to becoming a reality. Present planning is for this program to be housed, together with the outpatient program and regular Mental Health Program offices, in the old Tuba City Indian Hospital, probably utilizing the pediatrics wing, as a new 125 bed hospital is completed and occupied by the Service Unit staff. A memo describing this plan was forwarded in the winter of 1971, and gives much of the rationale and an outline of the proposed physical plant. Therefore it is quoted here.

SUBJECT: Re: Facilities for Tuba City Mental Health Unit after completion of planned new hospital building and proposals for staffing and utilization of these facilities.

As you know, the finishing touches are now being put upon the detailed floor plans for a new hospital building to be erected adjacent to the present Tuba City Hospital facilities. Since only a single small office is allocated to the Mental Health in the new hospital, space outside that structure will be required to house our expanding mental health services.

In my opinion, the available space best suited to this purpose would be the West Wing of the present hospital, the current Pediatrics Ward.... Minor structural alterations [are all that would be] required to house all the projected mental health services in this one space...The only major changes required would be partitioning of two rooms, installation of kitchen appliances, refurnishing the rooms, and retiling the floors.

The resulting unit would house both our out-patient offices and a live-in milieu therapy area capable of accommodating sixteen adult patients or four family groups at capacity including kitchen, craftshop, dining room, and meeting rooms as well as bedrooms.

Anticipated staff would include: psychiatrist, psychologist, five mental health workers, recreational and crafts therapist, out-patient secretary, and clerk-typist (total: 10 staff members). Note that no nurses or nurses' aides would be required, since the live-in unit would be set up on the model of a half-way house therapeutic community, rather than on a hospital ward model. Psychiatrist, psychologist and mental health workers would be active participants in both the live-in unit and the out-patient clinic.

The Mental Health Unit would continue to provide consultation services to the wards of the new hospital. Psychiatric patients with acute medical, surgical or management problems would be admitted to these wards and treated by Mental Health in collaboration with the other services. Those requiring milieu therapy would be discharged to the live-in unit as soon as they were well enough. It would be important that the live-in unit be administratively separate from the hospital proper, so that patients could be responsible for their own medications, etc. With psychiatric admissions to the new hospital ward limited to patients requiring medical care and/or close observation, the number and duration of these admissions could be curtailed considerably by the availability of thelive-in unit, freeing up beds for acute medical and surgical needs.

The treatment center plans are a reflection of the Mental Health Services attending to developing relationships within the hospital and also throughout the western Navajo Reservation community itself. As a result of experiences over the past few years of utilizing the beds in the general hospital for psychiatric patients, the need for inservice training of the staff had been recognized. Dr. Proskauer had developed excellent consulting relationships with the physicians but observed that the nursing staff were often uneasy with such patients. To a certain extent this can be understood in terms of their understaffing and need to keep ahead of the routine and technical care of their patients, who range in age from newborn infants to the elderly. It did not seem that nurses were so much afraid of the emotionally disturbed who might be admitted to their wards, as in a quandary about how to deal with these patients' unpredictable behavior and how to meet their need for special understanding. Seminars have been established utilizing the services of Ronald Lechnyr, DSW, who consults on a weekly basis, and Dr. Wakefield the new psychiatrist. The potential impact of this program is indicated by the fact that not only was time arranged for these meetings during the working day, but that many nurses who work other shifts, and were thus on their own time, attended the first few that had been held.

The support of the physicians for Mental Health Services also embraces the Mental Health staff's concern about keeping relationships open with the traditional and family elements of the patient's own social groups. Both physicians and Mental Health personnel feel free to bring up the question of utilizing traditional healers, and there is ample opportunity for medicine men to visit the patient within the hospital setting, and to

provide their support and parallel ministrations. Interestingly enough, with the growth of some Mission congregations, this same courtesy is extended to those patients who prefer Christian prayer services.

The Tuba City Indian Medical Center Mental Health Program has been described in some detail to show the complexity of interwoven activities that are developed, and because it has all the elements that are reflected in various ways in the other Service Units, with the exception of an inpatient ward at Gallup. The other Service Units will be treated much more briefly because of the similarities of many of their activities with those described here.

B. Gallup

1. Outpatient Services.

The Gallup hospital is a five floor major medical center with a number of specialty services. It has a well-developed Mental Health outpatient program for both drop-in and referral clients, staffed by two social workers, Elizabeth Bitsue, ACSW, who has already been mentioned and Marc Rose, ACSW. It also counts among its staff two well seasoned Navajo paraprofessionals, and has the clinical participation and consultation of the psychiatrist who also heads the Gallup Ward. A great deal of effort has been expended by this staff to stimulate the community of Gallup to take an interest in the needs of its total population, and to assume a role in dealing with the problems of alcoholism and special needs of school children. Consulting relationships to the OEO, community and tribal programs in the region, especially those in Gallup itself, are a focal concern to the whole staff.

Since the Gallup program is also one of the two in IHS which has

successfully developed an inpatient mental health ward, this program is described in more detail below. What should be noted here is that there is no sharp separation of inpatient and outpatient services, so that a total program with continuity of care is maintained.

2. The Gallup Ward

In Gallup, beginning in 1972, funds were appropriated for establishing services in the IHS hospital to be operated by the Mental Health Programs branch. There was unused space on the top (5th) floor, opposite the pediatrics wing, with a day room, kitchen, nurses' station and a series of rooms suitable for single and multiple occupancy, and with adjacent office spaces for several staff. Jack Ellis, M.D., initiated the program together with Ronald Lechnyr, MSW, who left to secure a DSW. After returning to the Area office as Depty Chief of Mental Health Programs for a year, he assumed directorship in 1974 from Dr. Ellis. The inpatient staff includes a head nurse, Dorothy Jackson, also recruited at the start of the program and five RNs to cover the three shifts.

Originally the program opened as a five day a week Day Hospital program. The space within the hospital was utilized as a meeting place for staff and patients, first from 8-5 and later extending into the evening until around a 9 or 10 p.m. bedtime. Staff provided supervised activities of a recreational and occupational therapy nature, as well as some pre-vocational craft work. Patients either returned to their homes if they lived near by, or to arranged rooms within the community.

Under this program there were plenty of staff to provide an active therapeutic milieu, and to keep alive the links with home and community through regular programs of home visits, family sessions and community consultations. The Mental Health program had its own assigned vehicle(s)

to take the entire group, patients and staff alike, on picnics, fishing trips, and to participate in ball games and community activities such as a county fair or Indian ceremonials. There was no rigid division of activities between inpatient and outpatient staff responsibilites, at least for the Mental Health technicians, all of whom maintained continuity with their former roles in the community at large.

As the length of day for the program extended, some division into shifts was evolved, but there was an overlapping period during the day when all staff could and often were present to compare ideas and share experiences and treatment goals. Morale during this period was high. Although individuals from time to time had problems, the records for this period reflect a frankness and an ability to retain cohesiveness as a unit while working out interpersonal difficulties.

From time to time a patient was admitted who was sufficiently disturbed that his use of local community facilities was not possible. These more disturbed persons were fed and housed in the regular Gallup Indian Hospital facilites, usually being given a bed on a general medical ward. However, as may be inevitable with such arrangements, complaints began to be heard with increasing frequency about this small group of patients. Their language was not always socially acceptable, and their restlessness often presented problems to the night medical nurses. In addition, general nursing staff and other patients were often fearful when it was learned that the occupant of the bed at night was "mental."

Not all the complaints came from the medical side of the hospital. The Mental Health staff felt strongly that the demand for drugs to keep

their patients sedated while out of the Day Hospital was directly counter to their own efforts to move toward greater self-control and toward developing a sense of responsibility and reality testing in their patients. The after effects of the drugs used to promote sleep and sedation also tended to dampen the patients' abilities to tune into the world around them, and to induce a certain amount of dependency that was considered undesirable.

After about a year as a day hospital only, the decision was made to extend the ward to 24 hours a day. This involved a number of major shifts in personnel, to provide coverage. Those patients who were able to profit from it were enrolled in a sheltered workshop established by the Voactional Rehabilitation service, and for many this meant that their contact with the hospital staff was limited to a couple of hours in the morning during breakfast and the group meeting, and several hours in the evening from supper time until a cab called to take them to the boarding home for the night. More distrubed patients, and those newly admitted to the ward spend the whole day within the ward, and gradually work up to this arrangement as they can tolerate it, and profit from it.

In order to survey the technical aspects of the ward functioning, a report originally written for the Area Chief of Mental Health Programs has been expanded, and occasionally quoted directly.

a. Staff

The staff of the Mental Health Services program at Gallup Indian Hospital, as of February 1973, includes the Psychiatrist-Administrator (Dr. Ellis) and a Head Nurse (Ms. Dorothy Jackson). The supporting staff

can be divided into two groups according to supervisory responsibilities.

1. Supervised by the Psychiatrist	Number
Staff Physician	1
Psychiatric Social Workers	2
Mental Health Technicians (field workers)	2
Secretary	1

2. Supervised by the Head Psychiatric Nurse	Number
Psychiatric Nurses	6
Mental Health Technicians (inpatient workers)	11
Ward Clerk	1
Volunteer Mental Health Technician (supported by Southwest Indian Foundation)	1

Each of the roles represented above require some comment and description.

1. The Psychiatrist: As Chief of the Mental Health Services in the Gallup Indian Mental Health Center, the Psychiatrist is limited in his supervisory role to the group shown, although informally he is looked upon as Chief of the entire Mental Health Service, to whom everyone reports. Since he is also serving as Chief of Staff for the Hospital, he has extensive involvement in overall administration of the Gallup Indian Medical Center. As a result, his chief scheduled activity with other members of the Mental Health Service is during the daily one hour staff meetings held for patient review, and for in-service training and administrative discussion. He also leads an additional seminar on Tuesday evening open to the general medical community.

Dr. Ellis comments:

> I find my days extremely crowded as a rule, with Mental Health administrative matters, general hospital adminstrative matters, interminable meetings, seeing patients, consulting, and going to the Crownpoint Mental Health clinic every two weeks. I probably see a more selected group of patients than the other members of the Mental Health Service: forensic evaluations, therapeutic abortion evaluations, employees and

Commissioned Officer dependents, for evaluation, crisis and long term therapy. In addition, I meet weekly with several key members of the Mental Health Service and also with other staff members who need to talk for personal or professional reasons.

2. Staff Physician: He is in charge of the inpatient service from the psychiatric point of view, with the psychiatrist as a consultant. He is perhaps the most central figure in the Mental Health Service for direct, daily patient care (inpatient).

3. Psychiatric Social Workers: Mrs. Elizabeth Bitsue and Mr. Marc Rose, MSW, carry the main burden of outpatient work and consultation to other services. In addition, Mrs. Bitsue is essentially the child specialist, and Mr. Rose is very heavily involved in maintaining the flow of inpatient work in many ways hard to specify. Both are available for intake and emergencies on a 24 hour call, 7 days a week, according to a schedule shared with the Psychiatrist and Staff Physician. Mrs. Bitsue, who speaks Navajo, is invaluable in this role.

4. Mental Health Technicians (field workers): Mrs. Catherine McCray more nearly functions like other mental health technicians in outlying service units, while Mr. Thomas Nez has gradually built up a role here that is difficult to define. Mr. Nez spends a good deal of his time with the inpatient service as a free-floating therapist frequently consulted for dealing with traditional Navajo problems. He is probably the main focus of attempts to combine Anglo and Navajo psychotherapy. For these reasons, he carries a considerably smaller load of patients for home visiting than does Mrs. McCray. He is also the liaison person with New Mexico State Hospital, visiting there regularly and charged with

the responsibility of maintaining pressure on the Gallup staff to bring patients back from the State Hospital whenever possible.

5. Head Psychiatric Nurse: Mrs. Dorothy Jackson, R.N., spends a good deal of time in dealing with the general hospital problems. She is not involved in general hospital administration, but she has to take care of relationships with other departments. Assisted by the Secretary, she maintains liaison and does trouble shooting. She is responsible for management of the ward, for supervision of the nursing and mental health technician staff and for provision of mental health care to inpatients, under the supervision of the Director of Nursing, and in collaboration with the Psychiatrist and Staff Physician.

Mrs. Jackson is an experienced nurse with a keen interest in developing therapeutic skills and a therapeutic community. She comes from the northern middle west and is more brusque, and more quick in her movements than the usual southwestern person. Her almost compulsive attention to detail and administrative requirements counterbalance the psychiatrist's tendency to use intuition and to improvise, so that they make an excellent team when they both participate equally in the program.

6. The Psychiatric Nurses: However desireable it may be to make ward administration a shared responsibility, the Inpatient Ward Nurses have certain inflexible and inescapable legal responsibilities such as Ward Management and Medications. In matters involving psychotherapy, however, they join with the physicians, social workers, and Mental Health technicians in free-for-all staff discussions about patient management. Some nurses prefer to avoid primary therapist's responsibilities. Some become therapists for a number of patients. If a nurse is fearful of

her ability to manage the ward with a given patient not on medication, especially at night, her decision overrules until other techniques have brought the patient into better ability to conform and stay within bounds. This is one of the topics of staff discussion and discussion in general meetings of staff and patients, so that it provides a reality check and a learning experience for everyone in working through such situations.

It has become the custom for only nurses to make daily chart entries, although all staff leave notes and report critical incidents to the Nurse on Duty, particularly when significant developments take place out of her range of vision and awareness. To some extent this produces more stilted official patient records than might otherwise be the case, but it also frees the Navajo staff from self-consciousness about their written English. When a patient is being followed off the ward, whoever is responsible makes chart entries.

All six of the Registered Nurses are non-Navajo. Five of them are women, and three are relatively new to the Gallup program. The one male nurse has entered into the therapeutic community spirit by making his home and neighborhood, adjoining the hospital grounds, a source of odd jobs such as kitchen work and housecleaning for women, yard work and digging cellars, etc., for men. Patients can thus earn competitive wages for such jobs as they graduate from the sheltered workshop programs and test their work tolerance and ability to earn a day's pay for a day's work. These activities are in addition to his regular hospital shifts, and are not given extra compensation by IHS.

7. Mental Health Technicians (inpatient workers): All but one of the twelve Mental Health Technicians are Navajo individuals recruited and trained by IHS. Some have had extensive experience with other agencies, but others are relatively young. The age range is from 20 to about 50. Not all are equally fluent in English, but since the Anglo staff cannot use Navajo without some embarassment, things even themselves out. The veteran non-Navajo staff have developed some ear for Navajo, so that when it is appropriate for the Mental Health Technicians to fall into this language with their patients, it is not a completely exclusionary process.

The Mental Health Technicians are highly individual persons, and represent a wide variety of backgrounds. There are those who have raised their own families, and those who are products of the Boarding Schools from elementary school age, who are just learning about family life as adults. Several have had [illegible] experience, Court experience, and have close relatives who have needed special services for the retarded, physically handicapped or disturbed. These experiences enable them to relate in an immediate and first hand way to the clientele, both patients and families.

Much of the direct interaction that takes place between staff and patients falls to the Navajo staff, who are creative in sharing opportunities with the patients to make fry bread, listen to and practice Navajo songs, and otherwise involve them in familiar group activities as a part of their therapeutic relationships. The Navajo staff also model for the patients a way of interacting with the non-Navajo power

structure that is based on mutual respect and takes many risks of openness that is not typical of the patients' prior experience. This can be reciprocated when a nurse awkwardly allows a patient to help her learn the art of patting out fry bread, or laughs at a Navajo pun which may be overheard or inadvertently result from an attempt to speak in that tongue.

This ability to learn from one another, and to trust one another, especially across language and cultural barriers, takes the craziness out of the cross cultural confusions and allows it to be dealt with for what it is -- aberrant or unrealistic thinking and action. Experience with this exchange has greatly facilitated the staff's ability to trust one another's individual styles of therapy, and to value these differences as well similarities in points of view. The Mental Health Technicians probably have as much impact on the staff in their development, as the whole staff does upon the patients.

b. Staff Requirements

To operate a safe therapeutic environment on this inpatient service is not easy with the number of staff available. For simple security and custodial care, there needs to be at least three people on the ward at all times. The minimal staffing pattern should be one nurse, one male, and one Navajo-speaking person. Minimal therapeutic care begins when there are at least four staff on the ward, allowing for variations in activity and relationships. To have four persons available as a minimum 24 hours a day, there needs to be a total of 24 nurses and Mental Health Technicians. There are only 18. (This is based on a formula that produces

24 hour coverage 7 days a week, allowing for leaves and so forth, of the number of positions required times 6.)

The average number of staff members on direct patient care duty per 24 hour shift is 9 to 9 and 1/2. The shortage is compensated for at this time by means of overtime, by the blessing(!) that the staff seldom take their full annual leave, by occasional volunteers (usually for the summer months), and by daytime and occasional nighttime fill-in from the outpatient staff (referred to locally as 'outside staff'). These include the psychiatrist and staff physician who all pledge one day a week ward coverage as needed, in whatever role is appropriate for them to assume.

c. Patient Census

The average daily patient census for the last few months of 1973 has been about 28. The average number of patients per staff member per 24 hour period has been about 3. These figures include patients who may not have been actually on the ward, but may be home visiting, going to sheltered workshops, biding their time in jail, or on a temporary suspension because of infractions of ward rules, etc. It might be noted that not all staff carry equal case loads, since some nurses do not participate in individual therapy, and some mental health technicians work most successfully with one kind of patient and others with quite different ones. When a patient is admitted, all community consultation with agencies families, and liaison with other IHS Service Units becomes a ward responsibility.

d. Inpatient Ward Goals and Functions

To quote Dr. Ellis,

The purpose of the Inpatient ward at Gallup Indian Medical Centers is to maintain an ongoing social system of staff and patients that, in spite of alarms and confusions, offers the patients the following:

a. A relatively safe place of asylum, retreat and restitution.

b. Restraint when necessary, for the sake of both the patient and the society, including our staff, both physical restraint and the restraint of chemotherapy.

c. Psychotherapy: individual, family, and group.

d. Perhaps most important, a psychotherapeutic community experience, possibly of more importance than chemotherapy or psychotherapy. This is a resocialization experience, or a corrective social experience, which we hope offers a number of positive values to patients:

(1) Involvement with others in contrast to previous isolation and alienation, in an interactive group in which in the long run warmth and care predominate over anger and conflict.

(2) Relatively open communication and self-expression, at least as an ideal, in which there is a constant attempt to promote clear communications, clear as to meaning but without interferring with the interruptions and diversions of spontaneous social interaction.

(3) Role models, staff members and possibly other patients with whom patients can identify, for the sake of learning to act more responsibly, resolve or endure conflicts and problems more effectively.

(4) Problem-solving techniques used early and effectively in response to individual and group problems; for example, community meetings, crisis meetings, gripe sessions.

(5) A general tendency within the group in the direction of personal responsibility and autonomy for each group member.

e. Daily Inpatient Direct Care Activities

Activities which come under this heading are:

1. Community meetings, small group therapy meetings, individual family psychotherapy meetings, plus crisis meetings when necessary.

2. Group activities, occupational, diversional, or recreational, of whatever kind can be devised to promote interaction between patients and the staff.

3. Housekeeping. (The hospital provides no housekeeping services, so work is divided up among patients and staff.)

4. Assistance with personal hygiene and grooming.

5. Accompanying patients to the cafeteria, lab, and other sections of the hospital.

6. Management of ward crises, medication administration, restraint, assistance with medical examination and treatment.

7. Charting.

8. Patient reviews at group meetings in which all therapy plans are reviewed at least once weekly.

9. Telephoning to agencies, individuals, outlying mental health workers, etc.

f. The Role of Psychotherapy

It is nearly impossible to estimate the amount of individual psychotherapy that takes place, since so much of it occurs in a relatively unplanned and unstructured fashion. Family therapy meetings average at least eight hours weekly. Informal drop-in visits by ex-patients and out-patients occur

at the rate of several daily, taking about fifteen hours of staff time weekly. One Mental Health Technician spends about three or four hours a week with the alcohol problems clinic in Medical Social Sciences. In addition, consultations to patients on other wards and services, probably most often for alcohol-related problems, averages about one a day, managed usually by the ward physician or a psychiatric social worker but often by a Mental Health Technician.

Dr. Ellis comments:

> "To maintain such a social system, it takes more inter-action work than most of us anticipated before we got into it. Ours is a complex group and it's a wonder that we have been able to continue working together. The staff is about half Navajo and half non-Navajo, half professional and half para-professional, etc. We are forced to work closely together, thus becoming aware of a multitude of conflicts of values, life styles, cultures, training, moods, abilities, whatever. We have found that we are often not sure what is good for our patients but we have become reasonably sure that it is bad for our patients, as well as for ourselves, when our conflicts remain covert and thus potentially sabotaging. We have had to devise a number of techniques to get our conflicts into the open so that we can deal with them. This takes much time and, at least initially, it goes against the grain of most of us; it is uncomfortable and emotionally fatiguing."

g. Evaluation and Follow-up

Follow-up of individual patients is done as part of the continuity of care. Where the patient lives within the region served by the Gallup Indian Medical Center, this is no problem. When he or she comes from one of the other Service Units, a summary and requests for information must be exchanged with the Mental Health workers and staff at the distant unit. Informal transmission of this information is easiest when the staff can meet with the local staff at regular training sessions during the month, and a formal written system is being devised.

Formal evaluation of this program is difficult for many reasons. Perhaps it takes both time and energy the staff do not have left over from its direct service demands. Perhaps it takes an outside perspective, as well as an adequate bi-lingual record-keeping system. One bit of data is available, however based on comparison of admissions during the first two years of operation.

Admissions	Fiscal year 71	Fiscal year 72
Total # of individuals	245	234
1st admissions		63%
2nd admissions		21%
3rd admissions		8%
Average daily patient load	28.9	28.5

There is also available an analysis of a series of consecutive admissions totalling 297 (dates not specified). The diagnostic categories and percentage of patients in each suggest that 71% of the caseload of the inpatient services during that time consisted of persons with problems in three major diagnostic categories: Alcoholism (26%), Transient Situational Disorders (24.5%), and Personality Disorders (20.8%). Since opening the 24 hour coverage facility, this situation is changing, and the number of long term chronic patients is increasing. This changes the kinds of therapeutic activities needed, and has also affected staff morale. Working with chronic patients is frustrating, irritating, and disheartening. Much of it is work in the dark, since there are few useful guidelines for this type of program applicable to this population and in this theoretical frame of reference. Training programs for the inpatient staff are shifting away

from community-based and preventive intervensions, toward re-evaluating treatment methods for chronic patients -- the "Untreatables". Seminars on a twice weekly basis deal with both theoretical and practical problems of chronic patient management.

above covers the description of the Gallup Ward activities and staffing. However, it barely suggests the atmosphere and energetic activity that prevails there. In order to make this part of the program come alive for someone who has not visited the ward, the best source material seems to be a memo written in January 1974 by Dr. Jack Ellis to Dr. Donald Swetter of the IHS, as an informal description. With the permission of both, it is reproduced here.

> We had 234 admissions in fiscal year 1972, of which 63% were first admissions, 21% second admissions, and 8% third admissions. This was the best indication I had at that time of the extent to which our mental health services was actually successful in treating the kinds of mental illness referred to us. As you know, we have minimal ability within our facility for research and evaluation and the types of people recruited to provide mental health services at our facility generally lack research and evaluation interests or abilities. We, therefore, have no better information available at this time as to our success or lack of it. We have plenty of clinical impressions, however, both of discrete successes or failures and of trends and perspectives. What I will attempt to do in this memo is supply some of these.
>
> [illegible] trends and perspectives, a recent event may be of interest. [illegible] negotiating with the University Without Walls Group from Denver [illegible]nt attempting to set up an educational program for our staff, when [illegible]ed to a psychiatric nurse from a prominent psychiatric facility in Colorado and told her of some of our activities. She was quite impressed as I told her of our attempts to combine radically diverse treatment modalities in our facilities. We take all comers, acute and chronic, hopeful and hopeless, whatever age (except children under about 12), whatever diagnosis. Though our staff-to-patient ratio is probably more appropriate for a custodial mental hospital rather than a therapeutic mental hospital, we are more or less fanatically interested in being a therapeutic hospital and therefore, attempt to provide an appropriate

treatment modality for each type of patient. This means that at any given time we may be providing tender loving care to an acute psychotic, hard-boiled behavior modification experiences to a chronic schizophrenic or alcoholic, family therapy to an adolescent, marital therapy to a suicidally depressed married person, vocational rehabilitation, and security lock-up for dangerous patients. I mean this literally; we may be doing all these things at once plus the usual chemotherapy, group therapy and individual therapy. Probably the greatest exteme is on one hand the treatment method we prefer for certain types of acute psychotics which consists in allowing the patient to undergo his psychosis with mimimal interference and maximal understanding and sympathy with his problems and needs. We thus attempt to utilize his psychotic state of mind as a growth experience. all of which requires that the staff deal with the patient in as non-threatening, non-critical, non-interfering a manner as possible. On the other hand, there are the treatment methods we have developed for chronic schizophrenics and personality disorders such as alcoholics, in which instances the staff is coercive, critical, definitely interfering, enforcing rules, setting limits and punishing infractions by suspension, voluntary lock-up for discharge. In order to provide such radically different modalities simultaneously, an enormous amount of staff discussion is necessary to bring to the surface intra-staff conflicts and resolve them sufficiently, so that neither treatment method will be sabotaged.

Our psychiatric nurse visitor from Colorado was greatly surprised at our having learned to accomplish this, stating that at her facility they had been unable to resolve this dilemma and, therefore, had to limit their treatment methods to those that were similar enough to each other to minimize conflict. I am not widely enough acquainted with what goes on in other mental hospitals to know whether our accomplishment is as effective, but I suspect that it is indeed unusual and is a result of the fact that I have a strong position within the Gallup IHC, that our staff has considerable diversity, as well as being half para-professional and half Indian and that no influential member of our staff is identified with any one treatment modality enough so that he finds it too stressful.

We are able, I think, to minimize the hot-house aspect of our services and stay in touch with the diversity of the community and provide our patients with whatever individualized treatment program seems most appropriate to their needs.

We must be realistic. We want to provide quality mental health treatment in a therapeutic rather than a custodial mental hospital setting. We would like to know that we are at least as successful as other mental hospitals in providing treatment such that patients could leave the hospital with improved functioning, never having to return. But the pressure we feel from the surrounding society is not so much to provide good treatment, but to ensure the safety of the surrounding society from the real or perceived threat from persons thought to be mentally ill.

Unless we take action adequate to relieve the anxieties of the surrounding society, we will not be seen as useful and will receive no support in our attempts to provide any forms of therapy other than protective custody. Ever if we are unsuccessful in our attempts to provide better than average therapy, we are still seen as serving the necessary and desirable purpose if we simply provide adequate custody. And this we do, although with our minimal staff it is often necessary to utilize males such as myself and other physicians and social workers as custodians. The rest is gravy, but it is the gravy which makes it all worthwhile. By gravy, I mean all the ways we have found to beat the heat and remain primarily a therapeutic mental hospital.

Anecdotes may help. Among the patients brought to us by their families for custody, one young woman in late adolescence was among the most hopeless looking. She was shapelessly obese, unattractive, and unable or unwilling to enter into any kind of relationship with anyone in any other way than as a helpless-seeming mess of unpleasantness. We first saw her a couple of years ago and were unable to accomplish much more than stabilize the grosser aspects of her psychosis with drugs enough that her family was willing to take her home again. She returned several times. In such cases, the method we have evolved is to wait until some member of our staff can gain the trust of the patient at which time increasingly hard-boiled expectations are communicated to the patient that he act responsibly and actively to change his behavior and take better care of himself. In this case, as I said, it took a couple of years, but finally it happened. A mental health technician is working closely now with this patient, who is now working in another hospital, dressing attractively, taking the initiative in conversation, and even displaying a sense of humor. If we were really an acute treatment hospital, as we originally intended to be, we would have sent her to the state hospital by now. If we were really a custodial hospital, as our staffing pattern would indicate, she would have been accepted as a chronic patient with little hope of ever leaving the hospital. Being neither fish nor fowl, we were able to adopt the luxurious stance that when at first we did not succeed, we could try, try again.

Another anecdote is that of a man who showed up one afternoon, referred from another Indian reservation with a history of having been in and out of the state hospital about 20 times and being nearly a complete outcast in his community, especially after having killed a man. He didn't want to stay with us, and we didn't want him to stay, with such recommendations, but felt that we had to try since there was nowhere else for him to go. He was rather threatening in appearance, so a decision was made to gather all our male staff around him and tell him bluntly how we would subdue him if he acted in a threatening way, while at the same time offering him every possible freedom as we attempted to gain his interest in our activities. Our show of force was so convincing that he made no threatening gestures after that, and though he spent every day talking

of wanting to leave, he did not leave for several weeks, during which time he talked to many of our staff who treated him with considerable respect. When he did leave, he had apparently regained enough respect for himself that he was able to reintegrate himself into his community. On last report, he is again a functioning member of his community.

Another anecdote concerns a patient we brought back from the state hospital where there are no Navajo-speaking staff. She stood in a corner for over 2 years, resisting every attempt to get her involved in our program, until one of our younger female mental health technicians finally got interested enough and impatient enough to begin almost bullying the patient enough to elicit any kind of response. The "bullying" escalated such that it was necessary to hold one or two staff meetings to discuss the possibility that this young mental health technician was overdoing it and actually being cruel to the patient. It was decided at these meetings to monitor but not interfere with this work, and things progressed to the point where, at present, the patient is home with her family, being visited occasionally by the young mental health technician at home.

Another patient who had been in the state hospital a number of times was most psychotic when he came to us, believing among other things that he was an air controller. During meetings he would hold his hand to his mouth, like a microphone, and guide the various airplanes that flew over the hospital towards the air field. He had numerous disturbing behaviors which irritated staff and other patients alike, and an attempt was made at suppressive drug therapy. This was only partially successful, and in any case it did little to modify his underlying eccentricities and there was considerable staff dissention as to what to do next. One mental health technician thought that even though he was chronically, rather than acutely, psychotic he should be taken off drugs and allowed to remain psychotic and receive the tender loving care type of treatment mentioned above. Other staff members disagreed because of the disruptiveness of his behavior at meetings. A compromise was reached wherein the patient was allowed to be as flagrantly psychotic as he wished while in his room (with the mental health technician favoring this mode of treatment present), while he was also required to follow the usual rules while he was in the public areas and at meetings. The compromise appeared to work and the patient acted crazy in his room for over a month, air controlling, writing incoherently, making bizarre noises and movements and so on, while at the same time "behaving" in public. Eventually, apparently, he was able to give up his psychotic state of mind willingly and return to a relatively normal state of mind, somewhat eccentric by ordinary standards, leave the hospital and find work. When last heard from he was doing well.

I am even proud of some of our failures. We worked with one man for over two years before we gave up and returned him to the state hospital. He had been in a state hospital in Illinois for 10 years before he came to us and we could not easily admit failure. Eventually, however, our

staff became so discouraged that we began to resent his presence and thought that he would be less resented at a custodial mental hospital. With regret therefore, we transferred him to the New Mexico State Hospital. Another sort of failure is that of a young man with whom we worked for over 4 years while he made one suicide attempt or gesture after another and threatened violence to members of our staff as well as of the community until he finally died of an overdose, either accidentally or on purpose, in the local jail. We have the privilege as well as the burden of being in close enough touch with our community that we cannot give up except through transferring to the state hospital, so long as our patients continue to come to us or be brought to us. There is no other facility to pass the buck to. It's a burden when we can't figure out something to do, but a privilege when the pressure to do something forces us to learn something new. If there was ever a program that is constantly improving and providing greater output with no increase of input, it is ours, in my biased, unhumble opinion.

The kinds of cases I have mentioned may seem to represent a small fraction of our work, and they do indeed in numbers; but, in terms of staff effort, it is hard to describe the quantity of work involved in managing such patients, while at the same time maintaining the continuous flow, in and out, of the more routine admissions and out-patients typical for a mental health service. It is often difficult to justify such an expenditure of effort for such a few patients who will never be very highly functioning members of any community, except on humanitarian or idealistic grounds. Gains are very slow and very limited, and though we learn something about human behavior, we may not learn much that is useful in other occupations or walks of life. It is discouraging work and morale is hard to maintain, especially in the face of the incessant threats of reduced resources.

If only for this reason, we turn eagerly to educational efforts or community involvement to escape the discouragement of the daily work. We have attempted in a number of ways to maintain an ongoing in-service educational program and this year are negotiating with the University Without Walls at Loretto Heights College in Denver to evolve an educational program for our staff that will enable interested individuals to work towards bachelor's degrees. This is very stimulating to those involved, although to many of us it is quite an additional work load.

A few of us are still involved in community mental health projects, although our lack of resources forces us to concentrate our energies upon our in-patient, out-patient and emergency services to the neglect of a really active community program. I am still involved in the Gallup Interagency Alcoholism Coordinating Committee (GIACC) and its high in the sky $11 million proposal for a comprehensive alcoholism rehabilitation project. I am chiefly interested in attitudinal change in Gallup rather than in the proposal itself, which I really don't expect to see

funded. In my opinion, my efforts will be reasonably successful if I can get the community, especially its elected officials such as city councilmen and county commissioners, to affirm community responsibility to take the initiative in confronting the alcoholism problem in Gallup. The buck was passed to IHS. Since that time, however, in part through the efforts of our mental health service, the relationship between the Gallup IMC and the community, including the local police and sheriff's department, has improved so much that there is no more buck-passing and, in fact, only recently both city council and the county commission vigorously asserted their desire to do something, including, if necessary, taking over sponsorship of the alcoholism proposal.

Another member of my staff, Mr. Mark Rose, Psychiatric Social Worker, is involved in negotiations with other community agencies toward the evolution of an overall mental health planning body. We expect to get more involved in this direction as it becomes apparent that the state hospital in New Mexico, as in other states, will no longer be willing to accept any and all referrals, but will place the burden more heavily upon the local communities. While it is tempting for us to take the lead in such planning, we increasingly tend to drag our feet and give the local community time to take more initiative, using us as resources.

One last thing that it occurs to me to tell you is that we consider that a mental health service has a useful role to play in a comprehensive health service to the extent that we can develop techniques for helping other health professionals in their interpersonal relationships both with patients and with each other. Toward that end I, as you know, remain involved in overall hospital administration and other members of my staff either take the initiative or make themselves available for consultation with other departments, not only for patient care, but for smoother overall staff functioning. A presumptuous aim, perhaps, but one we would hesitate to relinquish, especially since, whether we succeed or fail, it helps us maintain an involvement with the whole hospital and overcome the tendency to be seen as a foreign body.

h. Summarizing Comments:

The development of a general hospital-based psychiatric service is often recommended to community planners as an alternative to providing more space in state institutions and separate private facilities. The Gallup experience reflects the viability, and the strains, of attempting to do this in a creative and innovative fashion.

Several problems seem to be associated with the program that are not yet solved.

The first of these problems is the differentiation of an adequate day hospital model from a 24 hour facility. As this program emerged, it was first a very successful day hospital, treating mostly acute and transient problems within a well-defined milieu. However, as pressure to be responsible to the community's need for some resource for chronic patients and for more violently disturbed patients arose, the program shifted from its successful limited base to accomodate 24 hour care.

There seems to have been two results, neither of which were anticipated.

The staff found itself stretched thin by the need to cover 24 hour, 7 day week with a crew that had been adequate for at most 40 hours, 5 days a week. This may have been slightly offset by the addition of one or two RN's, but it rendered impossible the staff cohesiveness and inter-staff contact that marked the successful maintenance of morale and effectiveness

of the day hospital.

The shift to 24 hour coverage was also a covert invitation to admit more chronic patients, both returnees from the state hospital and those whom the community had exhausted itself caring for. It should be noted that the staff of the Gallup Ward has begun differentiating effective treatment models for the chronic versus the acute patient, but it has not had an opportunity to keep a balanced degree of satisfaction. The initial therapeutic gains which provided immediate gratification to the staff were based on the effectiveness of early case finding and appropriate intervention that short-circuited the process of inducting people into the patient role. Part of the local morale problem involves shifting from expectation of these gratifications to the ability to derive satisfaction from more miniscule steps toward self-sufficiency on the part of severely retarded adults and others whom even the staff recognizes, albeit in quotation marks, as "[illegible]tables." To expect this shift in the face of the other changes in staff cohesiveness has been a real strain. That the shift in accomodation is taking place without the loss of viability in the original program, is worthy of commendation. Perhaps the task will be easier if the differentiation between the two programs can be made more explicit, and adequate staff for each can be funded, recruited, and inducted into the continuous training and service delivery program.

A second problem that appears obvious to an outside observer is the degree to which the program depends upon the balance of personalities and the free interchange of responsibility amongst the various staff components. This program is indeed rooted in a world view more compatible with the

Indian sense of values and relationships than are most programs in or out of the Indian Health Service. Although all but one of the professional positions are held by non-Navajo personnel, the prefix 'para' is seldom heard. The responsibilities assumed by the Navajo Mental Health Technicians are great and as well carried out as those of the more arbitrarily classified professions of nurse, social worker or physician. There seems to be mutual respect at all levels, except for a few new nurses, who have not been fully inducted into the system. Even this can be accepted, provided that there is opportunity for full participation in the therapeutic program, since respect for individual differences and development of individual potential seem to be the themes of the program.

However, this is a team operation, and if one member leaves, or is depressed in functioning for any length of time, the team work begins to falter. To what extent the program is reproducible with another set of personalities, or with shifts over time in the roles of the present members, remains to be seen. The probabilities are that it has been unique in specific ways each year of its existence, and will change over time as it has in the past. However, a solid base of open interaction can be a self-correcting part of the system that will maintain its integrity in spite of change.

Finally, it is hoped that efforts will be made to develop more adequate data upon which to base an evaluation of the program and to provide methods for incorporating its salient features into similar programs in other parts of IHS. In principle, even if not in detail, this program should be one of keen interest to many community mental health specialists throughout the country.

C. Shiprock

Dr. Ronald Lechnyr, who has returned to the Navajo Area after earning a D.S.W. degree, provides the active consultation from the Area office not only to Tuba City, but also to Shiprock and Winslow. He too is learning to fly, but at the present time utilizes charter flights to get to these distant points on the reservation. The programs at Shiprock and Winslow are linked closely with the social services offices at those two hospitals, and depend for day to day services on the Navajo Mental Health Workers and Social Work associates to supplement the work of the Social Workers. The Mental Health Workers divide their time between being available to the hospital staff and work in the field, which may mean a 'camp' 75 miles away or an agency or family within the town itself.

In Shiprock there was a realistic sense that the hospital staff at all levels felt free to call on any member of the Social Service or Mental Health Worker teams for a wide variety of assistance. Some problems are those of arranging for family care for a patient, or for discussing after care of a surgical incision. Others involve complex interactions of family and patient in planning to meet the needs of a teenager who has made a suicide gesture or of a parent in middle life who faces a need for care for an elderly member of the extended family. The Navajo staff are very much in demand as interpreters for nursing, medical and field health staff.

A social work assistant assigned to this office is a young Navajo woman who is combining her experience and inservice training with active pursuit of an academic course at the Farmington branch of the University of New Mexico. Her ability to engage the non-Navajo agencies in Farmington is a potential breakthrough. Over long years of barriers, the distances between Indian and non-Indian are being dismantled slowly but effectively. The staff as a whole found it difficult to be explicit about specialized roles and responsibilities, and eventually concluded that perhaps this is why their Mental Health program avoids the 'hassles' that sometimes characterize combined offices with a number of levels of background and disciplinary expertise.

D. Chinle

1. Early Years

Chinle Arizona is known as the gateway to the Canyon de Chelley National Monument. These deep canyons, with a river bed at the bottom, were the last refuge and hiding places of the Navajo before the long, forced march to Fort Summner, and therefore have a special significance in Navajo history. There are additional reasons for respecting these sites found in the cliff dwellings set in caves of the 800-foot walls, which form a tourist attraction as well. As a national monument, paved roads along the top of the canyon walls make such vistas easily available, while some guided tours by jeep or horseback are also available. Farming -- including orchards and horse herds -- mostly carried

out by non-Navajo, is an activity of the canyon floor.

The IHS Health Center at Chinle serves a wide swath of the eastern reaches of the Reservation, including some of the interior reaching toward Rough Rock and Black Mesa.

ental Health Services began with periodic visits by Robert Bergman in 1967-68 as he initiated the Navajo Mental Health programs. Dr. Bergman utilized the services of Kathrine Hillis as an interpreter, and she became one of the first and most valuable of the Mental Health Workers when this staff position was created. Arrangements were made in 1967 for a contract with the University of New Mexico Department of Psychiatry, for the services of William Douglas, Ph.D., an anthropologist with clinical skills and experience. Dr. Douglas made regular monthly trips to Chinle, working with Mrs. Hillis and t n with later persons recruited as additional Mental Health Workers, consulted with the IHS staff and with other agencies in the Area.

When in 1970 Dr. Douglas became a full-time IHS staff person in the Albuquerque Area coverage for Chinle was shared by Navajo Area Office staff for a time with Dr. Bergman's aid in back-up. But more and more responsibility kept falling on the paraprofessional staff. A trailer was secured for offices, and in 1973 Dr. Marian Zonnis, a psychiatrist began making weekly consulting trips to Chinle.

2. Dr. Marian Zonnis

After serving in a temporary capacity during summer vacations, Dr. Marian Zonnis, a southern California psychiatrist, has joined the IHS Mental Health Program in the Navajo Area. She has taken over the clinical consultation and back up duties at Fort Defiance and Chinle on the Navajo Reservation and the Keams Canyon Service Unit on the Hopi Reservation. Her method of working with patients almost always includes family sessions, in which she and one of the Navajo Mental Workers work as co-therapists. On the days when she makes the trip to Chinle the Mental Health Workers are both present, although they otherwise prefer to spend a major portion of their time in the field. With the provision of a trailer at one of the satellite Health Centers, as well as one on the grounds of the thirty-bed hospital at Chinle, they are able to stay relatively easily within call for emergency situations arising in the medical service inpatient and outpatient clinics.

Dr. Zonnis has found it helpful to circularize the medical staffs and Service Unit Directors with a listing of the characteristics of appropriate referrals, as well as announcements of the schedules established for 'clinic' or office hours when she and/or one of the

Mental Health Workers can always be found. Since no Mental Health professional is available full time, in her absence one of the General Medical Officers attached to the hospital serves as basic medical consultant and back-up for the Mental Health Workers. The list of types of patients that Dr. Zonnia felt nurses and physicians, as well as Field Health personnel might consider referring to the Mental Health Program is given below:

A. All persons who have made threats, gestures, and suicidal attempts.

B. All patients whose problems are attributed to alcoholism and drug abuse.

C. Patients who are obviously emotionally or mentally disturbed.

D. Persons with serious depression and grief reactions.

E. Persons with illnesses or deviant behavior which are largely determined by emotional factors.

F. Suspected cases of mental retardation not previously evaluated.

G. Persons with convulsive disorders.

H. Infants and children who are showing emotional and behavioral disorders.

I. Teenagers showing emotional and behavioral disturbances including adolescent pregnancy.

J. Persons with serious marital and family conflict or family disruption.

K. Patients and families with special problems related to aging and chronic illness.

E. Fort Defiance

At Fort Defiance, as at Chinle, there is no full time professional Mental Health staff. Like Shiprock, Fort Defiance bases Mental Health Workers in the Social Services Branch office, and as at Chinle, Dr. Zonnis consults regularly.

At both Chinle and Fort Defiance, as the value of the services Mental Health Staff can provide has been experienced, the Service Unit Director tends to express a continuous desire that a Mental Health Worker be available to the medical staff at all times. This sometimes causes conflicting demands to be placed on the staff who feel drawn by the values they have found in their outreach and home based interventions. To a certain extent this strain is a growing pain, as the Mental Health Services have succeeded in establishing their usefulness to the clientele and to the regular IHS staff. It may be first indications that an additional growth of staff is necssary. Until then schedules and priorities are negotiated periodically to adjust to the shifting needs and best deployment of resources; without sacrificing either role completely.

F. Winslow

The Winslow Indian Medical Center, as was noted in the geographic description, is located off the Reservation opposite the southwest corner of the Reservation. It has a patient care load like that of Gallup that includes Indians living in or near the city as well as those who travel from the remote, unmarked camps and small communities in that section of the Reservation. A full time Social Worker and a

Navajo Mental Health Worker have only recently been assigned, compared to the longer period of development described in other Service Units. In many ways the program there is very like those at other units of the program in their earlier stages. Development of both community links and clinical services takes much the same form, although the distance from the main reservation provides a slightly different bias.

G. Crown Point Indian Hospital

Crown Point IHS Hospital is located slightly east and south of the main boundaries of the Navajo Reservation, in central western New Mexico. It serves not only the adjacent Reservation population, but also the Navajo populations in the rest of New Mexico known as the "checkerboard" and the Ramah Reservation, near Zuni, and the Cañoncito Reservation, a small pocket further east toward Albuquerque. There is a Social Worker there who works with these dispersed populations. In addition there is consultation provided by the Albuquerque Area Office to Cañoncito by the Mental Health program staff, especially the psychiatric nurse Irene Zinciewica.

The consultation involves working with both the Field Health staff at Cañoncito, especially the Public Health Nurse and with the CHR and Headstart programs' staff. Since this is the only Navajo population served by this consultant, there is less ease and familiarity with the culture and customs of the resident population than in many other Service Units and Field Stations of the Area.

Otherwise, the general activities do not differ in any marked sense from those of other Service Units in the Area.

IV. SPECIAL AREA PROGRAMS

A. Model Dormitory, Toyei BIA School

In addition to developing services at each of the Service Units, Dr. Bergman worked collaboratively on two special projects during his six years as Chief of Mental Health Programs. One of these was designed to demonstrate the applications of mental health prevention techniques to the complex situation created by the BIA boarding schools. In establishing these schools the BIA was meeting a need for providing a means of education, and the number of schools now located on the Navajo Reservation contrasts with the situation in the 1930's when almost all Navajo children had to be taken to Oklahoma or other states to acquire an education. However, even though closer to home, the Reservation boarding schools do not provide for daily contact with parents and other family members that is an essential ingredient for developing well rounded, healthy personalities. The staff to pupil ratios of 30 or 40 children to one adult may be suitable for classroom situations, but are hardly adequate to the needs for personal interaction in the dormitories. Actual adult to child ratios of from 1:60 to 1:120 are fairly common in BIA boarding facilities. After school hours, and on weekends, this ratio is often stretched to the utmost. Ironically it is during these times when access to adults may be the most required and most helpful to children away from home.

The Toyei Model Dormitory was organized for primary school children around the premise that a ratio of about 12 to 15 children per adult, as a round the clock ratio, would provide more interaction, and would stimulate the healthy aspects of personal development that would reduce the problems within the school and into the future years of these children's development. Furthermore, an effort was made to introduce Navajo staff and culture into

day to day functioning in the dormitory, and Susan Gail Powers, M.A., specialist in education, together with Frances Bentzen, Ed.D., were special staff added under the grant to develop the model dormitory project. An objective evaluation was made by an outside team of psychologists headed by Dr. William Oetting of Colorado State College at Fort Collins. The evaluation team compared the physical, academic and social growth of the children in the Toyei Model Dormitory with the growth of children in similar school settings without the additional staff and consultation. The results are very dramatic, one of the most noteworthy being the finding that while the percentage of children developing chronic enuresis increases in most BIA boarding schools for primary children between September and June, at the Model Dormitory it steadily decreased and was a negligible occurrence by December. In sports, 4-H projects, and academic achievement these children seemed not only to do as well as normal expectancy, but often better. The Model Dormitory project has been reported elsewhere (see section IV.A), and therefore will not be further discussed here except to note that it was one of the creative and cooperative solutions to a persistent problem developed under the auspices of the Navajo Mental Health Programs. At the end of the grant a number of its staff joined IHS either at the national or Navajo Area level.

B. Medicine Man Training Program

This program, too, has received national attention, and is shown in "Navajo: the Fight for Survival," a BBC film available through TIME-Life films, New York. The respect and collaboration that was established with the traditional leaders brought to the attention of the Mental Health Programs staff the serious problem of the need for Medicine Men, particularly those who had

mastered the intricate arts of the "Sing" or ceremonies often referred to as "the Ways" which are utilized as curative, and which have both individual and group therapeutic effects. Because the shift from a barter exchange economy to a wage economy made taking time to become trained difficult, there were not enough persons learning the ceremonies to replace the older men. In the late 1960's it became apparent that there was real danger that some of these unwritten liturgies might be lost. An application for training was made to the National Institute of Mental Health and funded under the title "Navajo Mental Health Program". For four years this program supported stipends for apprentices and salaries for medicine men . The students and teachers in this program met regularly to learn their difficult craft. 45 Navajo men and women were participants in this program, headed by Mr. John Dick of the Rough Rock community. Twice monthly Dr. Bergman met with the trainees and faculty to share instruction in general medicine and psychiatry, while himself learning traditions and gaining insight into the Navajo Ceremonials and their underlying dynamics. A renewal application has been made, and if approved and funded there will be additional shared instruction and participation with IHS Navajo Mental Health staff, especially those in the Area office.

V. THE CHANGE OF COMMAND

A. First Indian Chief of Area Mental Health Programs

It has already been noted that Navajo personnel are involved in the Area Mental Health Programs at both the professional and paraprofessional levels. With the shift in 1973 of the national programs headquarters to Albuquerque, Ellouise De Groat has assumed the role of Chief of the Navajo Area Mental Health Programs. She has thus become the first American Indian to head a Mental Health Program within the IHS Area system. Her active

participation in tribal and community affairs, as well as her committment to the basic principles of the program in mental health from the beginning, assures a continuity and flowering of a truly Navajo program.

B. Overview 1972-73

Mrs. De Grout's annual report for 1972 is included here as a summary description of the overall program, at the point at which she took over the full responsibility as Deputy Chief.

MENTAL HEALTH BRANCH
NAVAJO AREA
1972-1973

A. BASE PROGRAM

The Mental Health program consists of providing psychiatric, psychological, consultative and Social Service activities for the Navajo Area on an in-patient, out-patient and home visit basis. The program also provides referrals to both state and local governments. In addition, regular direct patient care is provided at several clinics throughout the reservation, including a psychiatric day ward at Gallup, New Mexico. Consultative services are provided to BIA boarding schools on and off reservation, public schools, mission schools, as well as BIA Social Services. Public Health Nurses, and hospital inter-disciplinary staff. Our consulting activities with the tribe includes: Tribal police and courts, Tribal Education Branch, and the Tribal Council's Health, Alcoholism and Welfare Committee. Other agencies such as the ONEO Community Action Programs, which include an Alcoholism Program, a Community Development Program and a Pre-School Center, also utilize our consulting services.

Trends - Progress - Position Changes

Currently the staff consists of 1 Chief of Mental Health Branch, 1 Deputy Chief, 3 full-time psychiatrists, 2 psychologists, 3 social workers, 1 staff physician, 7 registered nurses, 9 mental health technicians, 9 therapy assistants, 5 secretaries, 1 clerk, 1 ward clerk, 1 Director, Toyei Dormitory, and 1 Assistant Director, Toyei Dormitory and 4 vacancies.

In another report, and repeatedly as a theme, the staff described above has its unique characteristics emphasized. In addressing the Parole and Probation Officers of the 2 states, Mrs. De Groat described her staff's characteristics as follows:

> The majority of the staff are Navajos. The uniqueness of the program is that learning experiences work both ways: The non-Indian staff learn from the Indian staff about Navajo traditions and culture, while the Indian staff learn from the Anglo professionals the dynamics of behavior, psychotherapy, drug therapy, etc....

(Annual Report for 1972 continued here)

The work load has been steadily increasing over the past years, especially now that the communities, agencies and beneficiaries have become aware of the Mental Health Program. The Tuba City psychiatric patient load has doubled since July as has the Kayenta clinic. In addition to an increase in patient load, the staff at Tuba City has in the past year made regular visits to Tuba City, Shonto, Leupp and Red Lake boarding schools to assist with students, and to perform in-service staff training and testing. An addition of 1 psychologist and a part-time clerk as been made to the regular staff at Tuba City. The Fort Defiance psychiatric clinic has also shown an increase in out-patient visits as well as a need for regular follow-up of patients through home visits. In the past year a Mental Health technician was added to the staff, and more recently another Mental Health technician was transferred to this facility to assist with the continuing increase of patient load. A significant factor for this increase may be attributed to the growth of this community, and the development of new community programs such as: the Family Service Agency, the Problem Drinker's Clinic at Fort Defiance Hospital, the TB Control Program, and the Twin Lakes Alcoholism Rehabilitation Center. The Fort Defiance staff and the staff at Project Hope Hospital have established a regular weekly psychiatric clinic at Ganado. In addition to clinics at Ganado and Fort Defiance, the psychiatrist also holds clinic at Chinle and Keams Canyon once a week. Until this past year there was no regular staff or full psychiatric coverage at Chinle other than weekly visits by the staff psychiatrist, Mental Health worker and a part-time psychologist, who has since transferred to Tuba City.

A full-time Social worker was staffed at Chinle to take full charge of day to day mental health activities for the Chinle Service Unit. In addition to regular patient care, the Chinle staff also provides consultative services to the communities of Chinle, Many Farms, Rough Rock, Pinon and Nazlini.

The Chinprock Service Unit in the past year has had a signigicant increase in patient load. A full time secretary was recently staffed to assist with the daily activities of the Mental Health and Social Service staff.

The Winslow Service Unit receives weekly consultative services. In the past Winslow was offered the position of a mental health worker, but did not accept. This position is now being advertised and should be filled in the near future.

In the past year Mental Health has been contacted more frequently to do consultative services, at times far beyond what we are able to do. New trends have been in areas of establishing rapport and a closer working relationship with numerous agencies, Tribal organizations, Navajo Area Health Advisory Board, Tribal Health, Alcoholism and Welfare committees, and local school boards. There has also been a great demand for assistance in the areas of alcoholism programs, not only from the ONEO Alcoholism branch, but state and regional agencies as well. Recent trends have been for involvement of Indian and community leadership. For example:

a) Mental Health has participated at the community as well as regional and national level in coordinating planning meetings to establish an American Indian Commission on Alcoholism. The Mental Health Branch was instrumental in developing a Navajo area commission on alcoholism. Mental Health policy is to encourage continual Indian involvement in contractual services at local levels. This has brought together community people such as law enforcement officers, social workers, educators, physicians and others to work more closely in an attempt to find better ways to combat the problem of drinking in the Indian communities. Recently the Mental Health Branch entered into a contract with the Navajo Tribe to establish a center for crisis intervention for problem drinkers. The target population are those individuals who belong neither in jail nor in the hospital, but who would benefit from initial contact with a helping person, who would direct the individual to the proper helping agency.

b)Mental Health has continually been involved in the Medicine Man School at Rough Rock since its inception. Thus far the feedback has been excellent and the results indicate that students are making significant progress. A significant side

result has been a closer cooperation and understanding between the local medicine men and the Indian Health Service. In addition, the Mental Health Branch and the Navajo medicine men, including those at Rough Rock, have continued to consult one another in patient care.

c) Public, mission and boarding schools have this past year made more requests for school consultation with both students and staff members. At this time these schools have no provisions to deal with troubled or problem students. BIA school officials are becoming more aware of the problems in their schools and the help necessary for the problem students. The Mental Health staff has been able to offer services in a few areas such as in-service staff training, testing and consultation with staff. The Mental Health staff also is anticipating future meetings with BIA school officials, Tribal Education leaders and school board members on the increasing problem of anti-social behavior including drinking, and thefts.

d) Mental Health has been actively involved in the Toyei Model Dormitory Project, the first of any such program to evaluate the needs of Indian children in a boarding school. Toyei Project is in its terminal year and is yielding significant results. At the end of this fiscal year a complete evaluation of the program will be available. Currently the Mental Health staff, BIA school officials and Tribal school board members are engaged in negotiations to extend the Toyei Project.

e) The Mental Health staff also has in the past year sponsored a National Organization Development Training program for interdisciplinary staff of the Indian Health Service and BIA staff in Albuquerque. In addition, several such training programs have been conducted in several boarding schools.

f) Another area in which the Mental Health Branch has been actively involved is the Equal Employment Opportunity Program. Several members of the staff have, in addition to their regular duties, devoted time and energy to the EEO Program as counselors and Assistant EEO Officer.

g) Tuba City has been involved in negotiating a contract for a Teen Center as well as a Half-Way House for Problem Drinkers. The Tuba City staff also has been working closely with the BIA school in writing up a proposal for the Gray Hills High School project for Emotional Disturbed Children.

The Mental Health Branch is making attempts to increase professional and para-professional responsibilities as well as staffing Indian administrative personnel. The Mental Health workers and therapy assistants have continued periodic in-service training by the present professional staff in areas of psychiatric patient care, interviewing, human relations and behavior, community resources, consultation, etc. to meet the needs of the patient and his family. Likewise, the Navajo personnel have been teaching non-Navajo staff members in the areas of Navajo kinship system, culture, etc. The para-professional staff has taken advantage of serveral training outside of Indian Health Service such as the Indian Workshop on Suicide and crisis intervention, Group Therapy and Family counseling sessions, the Southwest Group Psycho-therapy and Mental Health Technician Workshop.

B. 1972 INCREASES

The Mental Health Branch was given 11 positions. These positions have been utilized as follows:

A Deputy Chief of the Mental Health Branch, Navajo Area was staffed. A full-time Social Worker was hired for the Chinle Service Unit, where in the past there was no regular psychiatric coverage. An assistant director at Toyei Model Dormitory was staffed, a full-time secretary in Shiprock, and two registered nurses and 1 therapy assistant were hired for the Gallup Ward. Four positions are vacant and plans are to fill these positions. The administrator has been difficult to fill because of housing problems, a selected person turned down the position for that reason. With the 1972 Budget several purchases were made for office equipment and furniture. Three typewriters, an adding machine, rental on Xerox, books, carpet for the Tuba City office, 4 transcribing machines, 4 dictating units, and equipment for Toyei Project.

C. 1973 INCREASES

Headquarters has necessary information. No report required.

D. UNMET NEEDS

At the present time one of the biggest unmet needs is in providing services to school children. As stated previously the schools have no facilities or personnel to deal with emotional disturbed children.

Another area of unmet need is the poor psychiatric coverage in Kayenta, Tohatchi, Greasewood and other various school health centers throughout the reservation. The distances and poor road conditions

contibute to the long man hours and time spent traveling to and from facilities as well as to the homes of the patients.

There is a need for funds to equip a 24 hour in-patient facility at Tuba City. A proposal has been drawn up to utilize a wing of the present hospital for an in-patient Mental Health facility after completion of the new hospital. Anticipated staff includes psychiatrist, psychologist, five Mental Health workers, recreational and crafts therapist, secretary and clerk-typist. No nurses would be required since the live-in unit would be set up on the model of a half way house therapeutic ocmmunity, rather than a hospital ward model.

Arrangements with public and private Mental Health facilities such as county Mental Health Programs in Winslow, Flagstaff, Page, St. Johns, Holbrook and Gallup are being discussed. Thus far the Indian Health Service Mental Health Program has been able to provide a better service for Mental Health patients as well as attempting to meet patient needs by staffing Navajo and/or Hopi personnel. At this time time any long term contractual negotiations would not be feasible, though we do provide consulting services to these agencies.

E. INCREMENTS

In our relationship with the schools, the Mental Health staff will be able to continue serving as consultants assisting teachers, guidance counselors, and instructional aides, as well as providing counseling services to children. Also to continue assistance to BIA school personnel to formulate plans and programs to meet the project needs of the children.

The Mental Health Branch has so far established regular clinics in the major hospitals and will continue to meet these. In order to meet the needs of continued field psychiatric patient care we will need to utilize the Mental Health technicians to a greater degree.

Coordinating services with other existing agencies such as the Community Health Representatives, Social Workers, and alcoholism workers, meet the needs of isolated areas would be desirable, but due to diversity of training, location distances, travel time, patient load of each group and areas of work this would not be feasible.

With regard to county Mental Health programs, the Mental Health Branch is committed to serve in a consultant capacity where Navajo patients are seen, this will be continued.

At present a program is being developed also for Pre-school Mental Health Status Test Battery for Navajo children. In connection with this our staff will be trained to perform the testing. Another standardized test battery is also being developed to test scholastic achievements and intellectual functioning for boarding school students and adolescents.

A committee in Portland with representatives from each Indian Health Service area is currently studying and evaluating the total Mental Health Program.

C. Overview 1973-1974

Some further detailed information may help bring the description of the Navajo Area Mental Health Programs into the time span of this report, Calendar 1973. During the summer of 1973 Dr. Bergman moved to Albuquerque, separating the 2 functions he had been performing, as both Area and IHS overall Chief of Mental Health Programs. At that time George Goldstein, Ph.D. who had originally entered the IHS Mental Health Programs in connection with the Model Dormitory project, and who had been available within the Navajo Area, moved to the national level. Miss Gail Powers, a Master's level psychologist, remained at Window Rock as a school and educational consultant as her work with the Model Dormitory reached the end of that grant. Three secretarial and administrative positions were also transferred to the national office at Albuquerque, placing a strain at the Area level until new budget adjustments can be made.

In the summer of 1973, at one of the Area training meetings, information was collected from the staff about their activities and patient loads. The following tables summarize the highlights of this data. In scrutinizing the tables it should be noted that they are based on total Area staff, with the exclusion of Gallup, since that staff is reported in part III describing IHS inpatient wards, and since their activities are not completely typical.

Table 1
Estimated number of individual patients seen for clinical service in a typical month

Modality of therapy	Professional staff (4)	Mental Health Workers (
Individual therapy	52	187
Couple therapy, (pairs seen)	10	30
Family Therapy (families seen)	14	62
Group therapy (groups led)	1	27

NAVAJO AREA: NUMBER OF STAFF REPORTING CONSULTATION WITH OTHER PROGRAMS*

	Professionals (4)			Paraprofessionals		
	About Patients	About Programs	Formal Contract	About Patients	About Programs	For Cor
IHS Physicians	4	3	2	8	1	
IHS registered nurses	4	2		7	2	
IHS P.H. nurses	3	2		7	1	
IHS staff	3	2		3	4	
Private Drs. clinic	1	1		3	1	
Community health reps.	3	2		4	5	
Public schools	2	1		6	5	
BIA schools	4	2		8	4	
Parochial schools	2	1		1		
Head Start programs	2	1		2	3	
Day care programs		1			1	
BIA Social Services	4	2		7	2	
State and county welfare depts.	2	2		5	1	
Vocational rehabilitation	1	1		5	2	
Family Services couns. agency	1	1				
Community Mental Health	2	2		5	2	
State hospitals	2	1	1	7	2	
Traditional healers	1	1	1	6		
Alcoholism counseling	3	3	2	7	3	
Detoxification programs	1	1	1	3	2	
Halfway houses	1	1		2	2	
Tribal courts	3	1		6	2	
State and local courts				4		
Tribal police	2	1		4	1	
Sheriffs	2	1		4	2	
Jails	3	1		4	2	
Tribal Health Board	1	1	1			
Fort Defiance Chapter					1	

*Estimated for a typical month of 1973

This table should be read as follows: 4 out of 4 professionals and 8 out of 12 Mental Health workers reported consultations with IHS physicians about patients. 3 out of 4 professionals and 1 out of 12 Mental Health workers reported consultations with IHS physicians about their programs. 2 out of 4 professionals and none of the Mental Health workers reported a formal contract arrangement for consultation with IHS physicians. (Formal contract may be written or oral, but involves definite agreement about time, topics, and roles.)

Particularly interesting is the way in which the staff reports its distribution of time on various activities. They were asked to estimate the amount of time spent in each of 6 categories during a typical month, using either the current month (July or April) as a reference. Again, the number reporting, 4 professionals and 12 Mental Health Workers, excludes the Gallup staff, and also does not include those on vacation or educational leave. However, the patterns, seem relatively stable from interview and observation of some of the absent staff during other visits to the Navajo Area.

Table 2

Staff Time Distribution for a Typical Month (NAVAJO AREA)

Activity	Professionals (4)	Mental Health Workers (12)
Direct Clinical Service	25%	22.6%
Consultation re Patients	22.5%	17.5%
Consultation re Programs	17.5%	12.3%
Teaching	10%	9.1%
Learning	--*	25.8%
Administrative Tasks	25%	12.5%

*In interviews professionals revealed that they interpreted this as professional reading, academic study, etc. and that they did not have time during regular working hours, but tried to keep up with their profession in off duty hours. When asked directly about learning from Navajo people about their language, traditions, and views, they universally said that this could not be separated from the entire gamut of activities, since all interactions were opportunities for learning.

Case loads are difficult to estimate. Until well into 1973 no separate uniform records were kept by the Mental Health staff. Various estimates have been made that about 1,500 patients are seen per month, but they are recorded in hospital and outpatient charts, where other staff may also make psychiatric or Mental Health notations as part of the preliminary diagnosis or in recording observations. Therefore, audits of patient records cannot reflect Mental Health Staff activity. The estimates of the 4 professionals totaled 114 patients seen during that portion of their time spent on direct clinical service, but individuals reported a range of from more than 20 patients per week to 2 or 3 per week. 6 paraprofessionals reported seeing more than 20 individual patients per week, and 6 reported working with between 5 and 10 families per week in addition to other patients. When data is available from the new Patient Problem Oriented Reporting Form, introduced in 1973-4, more accurate descriptions of both patient/staff ratios and the kinds of problems that are characteristically seen.

D. Navajo Health Advisory Board

It is important to note that the Navajo Mental Health Programs have been developed with the close collaboration and overview of the Navajo Advisory Board, which functions through representatives from all parts of the Reservation and has taken a lead nationally in its aggressive monitoring and support of IHS programs. In many ways this relationship extends to the Service Unit level, where Chapters have Mental Health Committees, who can work with staff in developing specialized functions in their localities. Establishing liaison between the local and Area wide, as well as National Advisory Boards is facilitated by the central role played by Navajo staff in the total program, particularly at the top administrative level. There is throughout the IHS Mental Health branch an awareness that as qualified Indian persons become available they should take over from non-Indian staff. In the Navajo Area this has been accomplished to a greater degree than in any other Area. The Navajo Area Mental Health Programs are in many ways an example of the model espoused in most Community Mental Health Centers, of community involvement, consumer direction, and development of the potential resources of the population being served.

VI. SUMMARY

A. Problems in 1973

1. The most important problem in 1973 is the tension over growing pains, as the program shifts itself into new alignments, accomodates to the departure of some familiar staff who may have been part of the Navajo Area for 4, 5, or 6 years, and to the addition of new professional and para-professional staff. It is not easy for persons associated with one role to

assume a new one, yet this has been the case as Mrs. De Groat, Dr. Lechner, Dr. Ellis, and others have grown in skill and broadened their experience during the 6 year life of this program. Neither is it easy to lose vital persons who have played a major role in initiating programs and setting the pattern for the roles and relationships that have become the pattern throughout the Area. In many instances the Navajo retention of personnel has been remarkable for its length and for the closeness of interdependent team work that has developed. Only in minor instances has there been real relief that some staff within or outside the Mental Health Program would only be around for the customary 2 years. However, this closeness and esprit d'corps does intensify the separation anxieties and sense of loss when a staff member does leave for any reason. With the separation of the national and Area responsibilities into 2 staffs, in 2 different locations, a mild depression could be felt, only slowly counteracted by pride in having the Area leadership in familiar experienced hands. This is not a major problem, but it should not be ignored.

2. Although there seems to have been intuitive planning that initiated new activities with additional personnel, the results of established programs are now so well known that there is widespread expectation of services from the Navajo people, and from community agencies, as well as from IHS medical staff. Sometimes this exceeds the capacity of available manpower. This means that in some areas, especially in Chinle, Winslow, Crown Point, and to some extent in Fort Defiance and Shiprock, additional staff need to be added to keep up with the simultaneous increase in demand for availability at the Service Unit and for community and outreach

5. Adequate data on case loads, types of patients, and types of problems brought to Mental Health Staff would aid considerably in planning and in justifying requests for changes and additions to programs and staff. This is particularly necessary as the Mental Health Program becomes more integrated into the over-all Area planning, budgetting, and administrative channels.

6. Although it has been minimally verbalized, there are some difficulties in the replacement of a psychiatrist by someone from another discipline, no matter how outstanding and well qualified. When, as in the case of Mrs. DeGroat, this person is also a woman and a Navajo, IHS especially, will have to be alert to its potential, even though unconscious, discriminatory attitudes.

B. Progress to Date

1. One of the most significant achievements of the Navajo Area Program in Mental Health has been its integration of Navajo personnel at all levels from Area Chief to entry level clerk and paraprofessional. It is perhaps easier to do this over an Area that deals with a single tribe, and therefore enables personnel to work flexibly as to geographic location, and also without competitive inter-tribal jealousies. Nevertheless, this is a truly significant element of this program, and illustrates what can be established as precedents for other Areas as well.

2. The interwoven values from the Navajo tradition and the best of a variety of Mental Health and psychiatric ideals has been well

accomplished. The development of mutual respect as part of the atmosphere in which Indian and non-Indian work together, and in which professionals and paraprofessionals learn from one another, has established program traditions which have continuity that bridges the turnover problems involved in staff turnovers better than most IHS Area programs as a whole.

3. The respect for traditional healers and for missionary contributions alike has enabled the broadest spectrum of the total Reservation population to utilize the Mental Health Program without fear of ridicule or reprisal.

4. The development of Inpatient, Outpatient, Partial Hospitalization, Consultation and Educational programs has earned this Area Program the right to claim full Community Mental Health Center status should it choose to do so. The involvement of the Navajo Advisory Board, and local chapters and committees, would put many institutions across the country claiming that status into shadow.

5. Taken as a whole, the Navajo Area program demonstrates how local autonomy can be coordinated into a program of continuous growth and development.