AN ABSTRACT OF THE THESIS OF

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Title: Traditional Medicine and Self-Determination in Resolving Mental Health Problems Among Southwest Oregon Native Americans

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Native Americans in southwest Oregon are a heterogenous group comprising one-quarter of the state's total Indian population. Despite their notable size, Native Americans in this six county area are either ineligible for, or inaccessible to, federally sponsored Indian health facilities available to Native peoples elsewhere. Research was conducted over an eight month period to determine the prevalence of Native American mental health problems, rates of service utilization, and cultural appropriateness of available services. For thesis study, inquiries focused on use of traditional medicine and Indian providers as viable alternatives to the established non-Indian mental health system. Under the supervision of the Southwest Oregon Indian Health Project, interviews were held with service providers, clients, and members of local Indian populations.

Results show that southwest Oregon Native Americans underutilize county mental health facilities due to real and/or perceived barriers to treatment. Among these are cultural

barriers in which non-Indian therapists do not, or are unable to, respond appropriately to tradition-oriented Indian clients. An exception is the alcohol programs which Native Americans use more often. It is clear that participation in these programs is greater due to the higher prevalence of alcohol problems, increased cultural sensitivity among staff, and differing attitudes toward being alcoholic as opposed to "crazy". Three Indian-specific alcohol programs within or adjacent to the service area are particularly attractive to Native American clients.

Native peoples frequently expressed interests in developing their own programs, accessing traditional medicine people, and having more input within the existing county system. Indian alcohol programs have become a rallying place for Indian self-determination in mental health care because they adhere to Native beliefs and values, and are refuges for traditionally-oriented providers and clients. Unfortunately, their existence is tenuously linked to non-Indian funding sources and regulations -- a situation difficult to improve from either side.

Research conclusions indicate that Native American mental health treatment is in a transitional period. A resurgence of interest in the use of traditional medicine has been part of the transition. Improved legislation for Indian health care and religious freedom have contributed to the articulation and organization of Native American concerns. Answers to self-determination in southwest Oregon Native

American mental health care will become more evident as Pan-Indian issues are resolved and communities develop better communications and referral networks with local Indian populations. Infringing economic constraints can be alleviated if community treatment facilities use more sensitive, personalized outreach to Native Americans in their areas, and if they allow them greater control in determining traditional treatment alternatives.

Traditional Medicine and Self-Determination in Resolving Mental Health Problems Among Southwest Oregon Native Americans

by

Alison Taylor Otis

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Director of Special Programs, Student Services

Chairperson of Anthropology Department

Dean of Graduate School

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Typed by Georgia Harrelson-Porter for Alison Taylor Otis

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CHAPTER ONE

INTRODUCTION

Purpose and Objectives

This thesis explores how Native Americans with identified mental health problems respond to treatment programs which utilize medicine persons or traditional Indian values and methods of healing. Specifically, it looks at the Native American population in southwest Oregon and the programs and service providers who address mental helath problems within this group.

In researching this subject, I have attempted to accomplish the following objectives:

1) Investigate the extent to which current mental health services and Indian-specific programs are utilized by Native Americans in a six county area.

2) Investigate the types of services offered by these agencies and programs and how they relate to Native American issues and needs.

3) Learn the number of medicine people and/or individuals sought out for their use of traditional ways by Native Americans with mental health problems and the extent to which they are sought.

4) Learn the nature of traditional ways and practices of Native healers and providers; how these differ from the existing service system in philosophy and orientation.

5) Investigate possibilities for using traditional healers/healing patterns within the state and county service system; the effects this may have on both systems.

6) Investigate utilization of additional support systems (e.g., family, tribal).

7) Investigate Indian client perceptions of services in both systems; client awareness of program objectives and philosophy.

8) Investigate perceptions of ideal services networks as seen by clients and service providers in the Indian community.

Southwest Oregon is a unique region for study in terms of Native American inhabitation. One-quarter (25.6%) of Oregon's 27,309 Indian population (Table 1) resides in the six county area (Bureau of the Census, 1981), yet none are eligible for, or easily accessible to, federal health care benefits. The Indian population in southwest Oregon is a heterogenous one. Composed of over 142 tribal representations (SWOIHP enrollment files, 1981), the population is separated by its cultural diversity, levels of acculturation, adaptation to both urban and rural environments, and differing commitments to traditional values.

Because of this heterogeneity, it is important to learn how mental health problems can best be treated. Increasing

demands for culturally sensitive, Indian-specific programs suggest the current non-Indian mental health system is unsatisfactory (Eugene Indian Center, 1979). Service utilization rates by Native Americans reinforce this theory, as does recent evaluation of the problem (Otis and Katz, 1981). On the other hand, little research has been done to examine the influence, utilization, and effectiveness of traditional medicine or practices in treating Indian mental health problems.

Indeed, not much is known of the medicine beliefs indigenous to Native Americans in southwest Oregon, and organized integration of introduced practices is relatively new. Understandably, this kind of research is challenging to accomplish. In addition to the fulfillment of research objectives, it requires renewed sensitivity and respect for traditions that are now at risk of being lost to history or exploited and standarized under the semblance of holistic health (Bates, 1980).

Table 1
Comparison of 1970-1980 Census Figures
Native Americans vs. General Population
(from U.S. Bureau of the Census, 1975 and 1981)

County	Native Americans 1970	Native Americans 1980	Native Americans % Change	General Population 1970	General Population 1980	General Population % Change
Coos	383	1308	242	56,515	65,047	13
Curry	180	332	84	13,006	16,992	31
Douglas	413	1122	172	71,743	93,748	31
Jackson	433	1189	175	94,533	132,456	40
Josephine	235	597	154	35,746	58,820	65
Lane	764	2471	223	213,358	275,226	29
State Total	13,558	27,309	101%	2,091,345	2,632,663	26%

Review of Literature

Research literature has repeatedly pointed out that mental health indicators specific to Native Americans show a higher percentage suffering from mental health and stress-related problems than is true of the general United States population.[1] Reasons for these problems are complicated, ranging from deeply rooted factors in history to current concerns in their physical, spiritual, and socio-cultural environments. Causal theories abound. While wide variations in problem frequency exist, mental health problems do occur at higher percentages in most Indian groups, as do the conditions which perpetuate them (e.g., see Littman, 1970; Resnick and Dizmang, 1971; Havighurst, 1971; Shore, 1975; Dumore, 1980).

Extensive bibliographic materials were provided by the White Cloud Center in Portland -- a professional, Native American-operated clearinghouse for nearly all research done on Indian mental health. Much of the work regionally pertinent to this study has taken place in the northern Pacific Northwest or has been limited to reservation groups directly under Indian Health Service (IHS) supervision. In fact, in an effort to dissolve the myth that no mental health services exist for Native Americans, Beiser and Attneave (1978) have carefully documented thirteen years of IHS work in this field.

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[1]For summary, see IHS, 1976. Also, Chapter III.

Mental health research among Pacific Northwest Indians has been widely reported by Dr. James Shore, Psychiatrist at the University of Oregon Health Sciences Center in Portland. Shore has made suicide comparisons among several Northwest reservation groups (1975), and affirmed the value of Indian medicinal practices in mental health therapy (1977). In conjunction with Kinzie and Patterson (1972), Shore developed a community mental health consultation program on a Northwest coast reservation. With Borunda (1978), Shore reported on problems faced by Indians in the Portland area and the failure of existing mental health services to treat them adequately.

Gonzales (1979) of the Seattle Indian Health Board has also written on urban Indian needs. She calls for development of mental health treatment modalities that include traditional medicine and cultural training for service providers. Responsiveness of mental health services to Native Americans in the Seattle area has been measured and found lacking by Sue, Allen, and Conaway (1978). Their figures show that Indians seek out service but often fail to continue. Fuchs and Bashshur (1975) have studied the use of traditional Indian medicine among urban Indians in San Francisco. Their study shows that use diminishes as the acculturation process becomes more complete.

Work examining the relationship between Western methods of psychotherapy and Coast Salish medicine practices has

been conducted by Jilek and Todd (1974) and Jilek-Aall (1976). Their conclusions indicate that traditional healers have been successful where psychotherapists have failed. The authors feel both systems can work together. Fritz (1976, 1978) has investigated the incidence of mental disorders among Saskatchewan Indians and initiated a community psychiatry program there. His conclusion is that an unrushed, decentralized program will experience cumulative growth in the Native American community.

Within the southwest Oregon study area, research has focused on minority health needs assessments at county levels (WOHSA, 1978; Douglas County, 1980; Lidman, 1979; Kraiman, 1977; Alexander and Weber, 1980). The evaluations emphasize the invisibility of the Indian population, lack of service utilization, and Indian preference for culturally-specific alcohol treatment programs. More regionally comprehensive works include: Castro (1975) on alcohol and drug abuse among Native Americans at the state level; the Eugene Indian Center's (1979) document on general health needs of Indians in southwest Oregon; Whited's Urban Specific Health Plan (1979) which proposes the means for achieving those health needs; and Otis and Katz's (1981) assessment of mental health services for Indians in southwest Oregon. Western Oregon sweatlodge programs have received some local attention for their Indian-specific treatment (Kutsky, 1978: Krant, 1979) but little else (Worden, 1980 is one exception).

Background

Information contained in this study is based primarily on data collected during eight months of research for the Southwest Oregon Indian Health Project (SWOIHP).[2] Work began in August 1980 and culminated in April 1981; it included two months of preparation and literature search and six months of field work and report writing. The overall purpose of the research project was to assess the extent of mental health problems and rates of service utilization by Native Americans in a six county area of southwest Oregon. In addition, an evaluation of the appropriateness of available services was made. The project was funded by a grant from the National Institute of Mental Health and was under direct contract to the Community Support Project at the Oregon Division of Mental Health.

The study population was composed of adult Native Americans perceived as being "chronically" or emotionally disturbed and residing within the target area. Definition of

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[2]Additional data gathering and background work for this thesis was accomplished during earlier studies with Native Americans in the same region. These studies included: a SWOIHP/OSU/IHS nutrition and dental assessment (1980), a culture history of the Umpqua River Basin (Hogg, 1979), and a three year on-going oral history project with the Coquille Indians (Hall, 1978).

"chronic mental illness" was left largely up to specifications utilized by individual mental health programs and/or state recommendations. General identifiers were suicidal, chronic depressive, manic, schizoid, or any behaviors seriously inhibiting a person's ability to function in the community. Alcohol and drug abuse was considered to be one type of mental health problem.

In its third year of funding under the 1976 Indian Health Care Improvement Act, the Southwest Oregon Indian Health Project is a program of advocacy and referral to the health care delivery system for off-reservation, terminated, and federally unrecognized American Indians. Because there are no reservations in the project area or due to the status of Native Americans there, Indian people within SWOIHP's jurisdiction are inaccessible to, or ineligible for, the federal health benefits offered by the Indian Health Service or related health facilities to Native Americans elsewhere in Oregon or the United States. They belong within the nearly 50% of the general Indian population who reside outside available health networks (American Indian Policy Commission, 1976).[3]

SWOIHP's major objective is to improve the health conditions of Indians in the service area so it is equal to that of the general population. Mental health is considered to be an integral part of the whole Native person's health.

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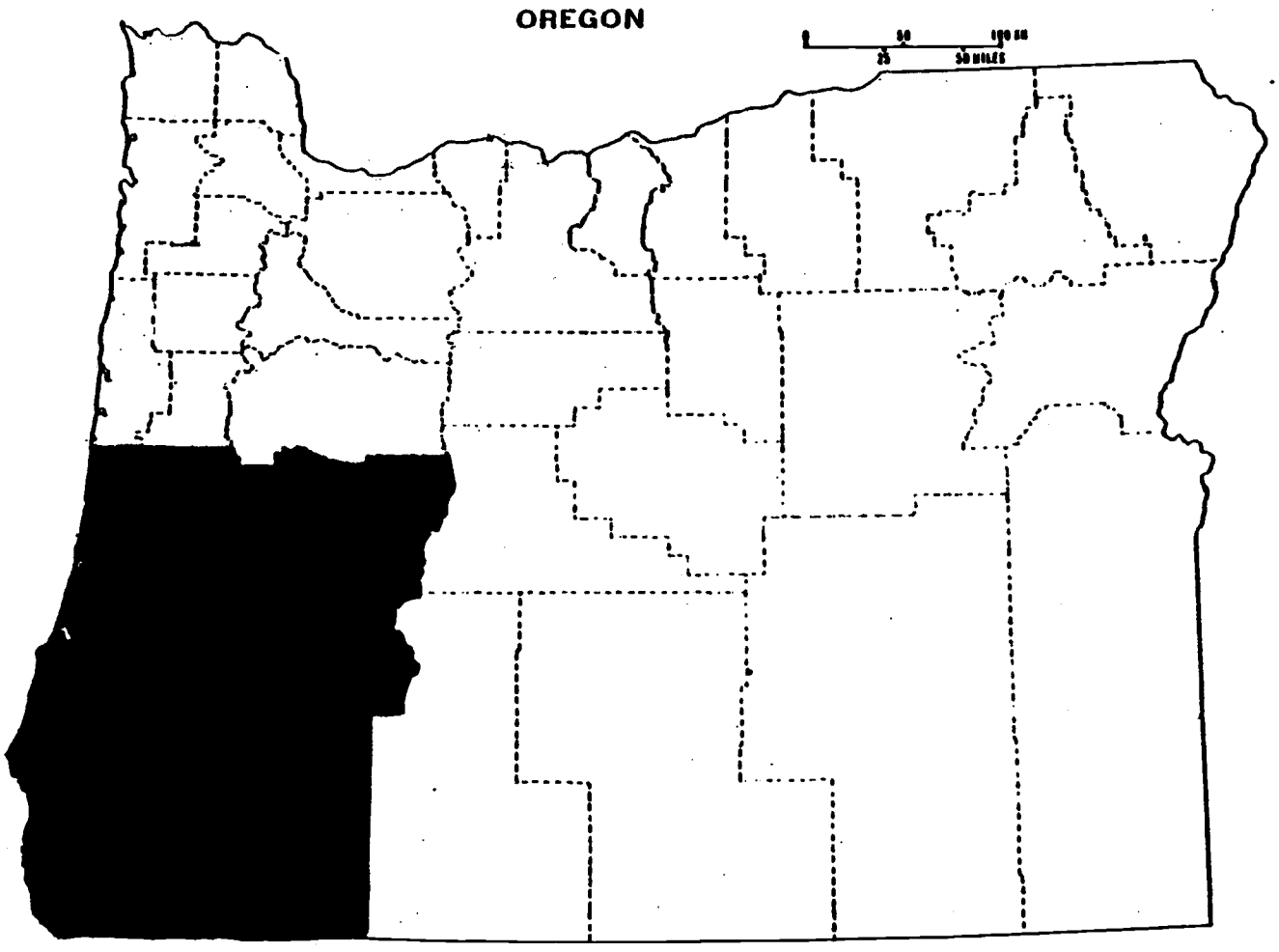
[3]For IHS definition of "Indian" see Appendix A.

SWOIHP is therefore concerned with providing access to beneficial mental health services which fulfill Native American preferences for service delivery. The concern is not simply whether mental health services exist. It is whether they are utilized by Native Americans, and if not, for what reasons. Indeed, previous studies (Borunda and Shore, 1978) indicate that underutilization and appropriateness of services are significant problems to be examined when helping Indians in the urban, off-reservation environment.

SWOIHP's main office is in Eugene and is supported by outlying offices in each of the six counties that it serves: Douglas, Jackson, Josephine, Coos, and Curry (Figure 1). Each county is represented by a Native American Health Outreach Worker (HOW). Under the supervision of the Project Director and the counsel of a geographically representative Board of Directors, HOW's supply the regional efforts which are critical to carrying out SWOIHP's advocacy and referral program. In addition, VISTA volunteers work in several counties helping the HOW's and aiding in community organization activities. The combined energies of the SWOIHP staff and directorship provided services to a total of 3,244 individuals in the 1980 fiscal year; 1,117 people were reached by the "Medicine Bag," SWOIHP's monthly newsletter.



Southwest Oregon Indian Health
Project -- Service Area

Figure 1

CHAPTER TWO

RESEARCH PROCEDURES

Research Design

Previous research in the field of Native American mental health has been helpful in providing basic guidelines for the overall assessment and general goals of the questions focused upon here. Of particular note is the work done by Ryan and Spence (1978) and Ryan (1980). According to Ryan, past research in this field has been poorly constructed methodologically. It has often been irrelevant to program development and unsuited to the culture studied; communication of research efforts and findings has tended to leave out the subject communities. By adapting Ryan's research model and objectives, it is hoped that many of the pitfalls encountered in past work were avoided. Among the objectives taken from his model and incorporated in this study have been:

1) A complete literature search and review, including current programs and needs assessments.

2) Culturally-specific, sensitive methodology and research instruments, designed with input from Native Americans in the local area.

3) Identification of problem areas and collection of pertinent data concentrating on issues in the development of greater responsiveness among mental health programs to cross-cultural concerns.

4) Effective communication between a) the researchers, b) the personnel in the mental health system, and c) members of the Native American population in the target region. Emphasis was placed on establishing better communications at the local level with hopes that improved networking patterns -- particularly between the county programs and established Indian providers -- may lead to the resolution of existing mental health problems.

To satisfy both general and specific research objectives, preliminary negotiations between SWOIHP and the contracting agency at the State Mental Health Division agreed upon a fixed number of interviews to be conducted. These numbers were calculated estimates based on an understanding of the issues involved, the length of research time allotted, previous knowledge of available services, and the size and organization of the Native American population in the area. During the course of the assessment it appeared likely that interview numbers would need to be scaled down -- not because they were unrealistic representations of who should be interviewed or who was available, but primarily because the contract was for a short eight month period. To achieve the most effectiveness the researchers required adequate time for travel and office work, e.g., field note review, scheduling activities, and monthly progress reports. As a two-person team working one half-time position, this essential time often seemed to be lacking or used at the cost of

critical interviews. In anticipation of these limitations, interview numbers were renegotiated in February.

What was not foreseen was a future increase in effectiveness as the researchers became more familiar with key spokespeople and different management procedures from one county to the next. As a result, it became possible to make up time and interviews lost earlier in the fieldwork. In the final analysis the most notable loss was the inability to interview friends and families of Native American clients who had utilized mental health service providers. This forfeiture was largely due to the timing factor, but was also due to difficulties and sensitivities inherent in locating clients for interviews. In addition, several clients were transient or purposefully seeking help at a distance from their homes. While it is thought that input from friend and family interviews would have been a valuable addition to the research, interviews with clients alone were more substantial and revealing than had been previously expected.

Table 2, which follows, illustrates interview numbers as they progressed from initial proposal to final outcome.

Table 2
SWOIHP Assessment Interview Numbers

Initial Interview #'s	Renegotiated #'s	Final #'s
1. Interview 7 separate county mental health divisions	6	6
2. Interview 45 service providers under contract to mental health	34	57*
3. Interview 60 representatives of at least ...	32	44
4. ... 20 separate Indian specific providers, tribal groups or organizations	20	23
5. Interview 10 Native Americans who have utilized local mental health services	4	10**
6. Interview 20 friends or family members of these individuals	0	3
7. Identify and interview any traditional providers or medicine people available to or used by Native Americans	0	5:10***
8. Interview 10 individuals if possible who have utilized traditional providers	0	2
9. Interview 20 friends or family of these individuals	0	3

* Includes individuals contacted in staff meetings
** Includes clients not necessarily designated CMI; also includes one client not within contract system
*** 5 providers interviewed; 10+ identified passing through network.

Methodology

Crucial to the mental health assessment/research strategy has been development of culturally sensitive and useful instruments around which interviews could be structured. Design of these tools began during the earliest stages of field research. At the same time, the state-of-the-art literature search was conducted and used for reference. During the planning phase it became obvious that several instruments would be necessary to reach and adequately evaluate responses from such diverse groups of informants.

First a structured questionnaire (SPQ) was prepared for interviews with mental health service providers (see Appendix B). The questionnaire begins by requesting data on the organization's service to Native Americans and the process of ethnic identification when clients come for treatment. The content and availability of this data are indicators of the status Indian clients are conferred by each agency: whether Indian-ness is acknowledged; whether special mental health problems stand out more in the Native American population than the general one; what processes initially bring Native Americans into mental health agencies; and what percentages of the Native American population are treated, successfully treated, or committed to state institutions.

Next, the questionnaire attempts to elicit information on the diagnostic process and definitions of mental illness. It looks for Indian-specific orientations and sensitivity

to diversity among Native American groups. It goes on to ask for information regarding the backgrounds of mental health personnel vis-a-vis cross-cultural training and experience; it asks whether Native Americans in the area have been utilized by the agency and if so, in what capacity.

In cases where Native Americans were utilized as providers, or where programs or strategies had been usefully developed for Indian people, it was important to learn what had been done and why. If no such program/strategy had been developed, people were asked if they were warranted. The final two questions address: 1) perceptions of the relationship between mental health treatment and incarceration or commitment; and 2) given the strengths and weaknesses of any program what might be developed that would ideally serve both the Native American and general population. The former question elicits more about local situations and philosophies regarding treatment and referral of incarcerated peoples to the mental health system. The final question is for determining an ideal service matrix. By inquiring about perceptions of what programs -- particularly Indian-specific programs -- are going on elsewhere, the scope of a potentially ideal service network is broadened further.

Another research instrument considered for use with Indian clients was the Counselor Satisfaction portion of the Oregon Quality of Life Questionnaire (OQLQ) (see Appendix C). The OQLQ was designed by Dr. Douglas Bigelow

of the State Mental Health Division and has been used widely by mental health agencies in Oregon. It was recommended for use in this study so that Native American answers could be compared to the established data base. Permission was granted to amend the questionnaire in any way that made it more alert to Native American values, as long as the basic structure and integrity of the instrument remained intact. The OQLQ was eventually amended by the researchers but never used.

Lengthy consideration was given to making this choice. To begin with, it was recognized that the number of clients interviewed would not be large enough for a valid comparison. Also, after consultation with several Native Americans, the general response proved negative. With or without Indian-specific amendments, the questionnaire was said to be too long, too cumbersome, too great an invasion of personal thoughts, and most of all, too representative of non-Indian ways in which everything and everyone gets questioned and surveyed almost literally to death (without perceived results).

This last statement was an important one to consider in planning interviews with all Native American respondents. It was decided that these interviews should be left informal and loosely structured in order to attain open and comfortable channels of communication that would be satisfactory to researchers and representatives of the local Indian popula-

tions. The decision included both American Indian clients and providers, although on several occasions Indian-specific mental health professionals were interviewed using the SPQ with very productive results. This methodology, while lacking a quantifiable format, was nevertheless workable as a means of collecting valuable research data. It was also a necessary methodology for forming an honest and straightforward networking basis between the Indian people and the mental health system.

CHAPTER THREE

NATIVE AMERICAN MENTAL HEALTH PROBLEMS AND SERVICE UTILIZATION

Mental Health Status

Early predictions of low service utilization rates among Native Americans in the study area were found to be accurate. Estimates regarding prevalence of emotionally and/or chronically mentally ill Indians were more difficult to determine due to: 1) notable lack of service use by Indians; 2) the invisibility of Native Americans to the mental health service system; 3) the tendency of Indian families to protect, cover up, or take care of problems (including extended families); and 4) problems and inconsistancies within service systems in identifying Native American clients.

The health of Native Americans state-wide is substantially more "at risk" than that of the general population (Staub, 1978: 1138; IHS, 1976). In other words, the probability is greater that Indians will be exposed to negative effects on their health or that they will be afflicted by health problems. Likewise it is generally true that while Indians in the southwest six counties do not share the same recognition or benefits as Indians elsewhere, they do share many of the same problems and stress indicators. This generalization is based largely on the fact that a high percentage of southwest Oregon Native Americans have immigrated to the area and many have reservation backgrounds.

At both state and local levels health and mental health problems are predominantly alcohol-related or reported as such. Current estimates on Indian alcoholism in Oregon averages about 31%. This is based on the national IHS figure of 27% (IHS, 1976), Sweathouse Lodge state estimation of 33% (Sweathouse Lodge, n.d.: 3), and the Lane County projection of 34.8% made by Eugene's Indian Program on Alcohol and Drug Awareness. In Lane County this would average one alcoholic to every Indian family if so distributed (Connelly, 1981). General alcohol and drug abuse figures run about 80% for Indians over age fourteen, with as many families affected (Castro, 1975: 8; Sweathouse Lodge, n.d.: 3). Other figures show:

* Alcohol-related deaths for Indians are five to six times that of the general population (IHS, 1976).

* The average age of death for Native American males is 42. Of these deaths, approximately 21% are directly attributable to alcohol-related diseases (Castro, 1975: 8), i.e., mortality associated with cirrhosis of the liver among Indians is four times that of the general population (Peterson, 1979).

* Suicidal rates among Indians are one-and-a-half to two times that of the general population, with 75% alcohol-related (Peterson, 1979; Peniston, 1978: 17).

Alcohol is also cited as a primary factor in child neglect, divorce, school drop-outs, and failure to arrive at work

(IHS, 1971). Other significant statistics show accidental death rates among Indians are three to four times higher than the general population, and homicide rates are two-and-a-half times those of the general population (IHS, 1976; Peterson, 1979). High unemployment rates (34% in Oregon), and low income ($1800 annually) add to problems in mental and emotional health (Castro, 1975: 8).

Breakdown of statistical information relating to specific mental health problems and treatment modalities among Native Americans (excluding alcohol) is not available at either county or state level. This is due partly to information retrieval problems at both levels and is complicated by inconsistencies in ethnic identification. Furthermore, most mental health professionals agree that the labeling required on State CL-1 forms for each client is one-dimensional and unsatisfactory for purposes other than record-keeping or insurance claims.

A limited categorical breakdown of mental health problems among Indians nationally is available from IHS (1976), however (see Appendix D). Although one expects these figures to have reservation bias, to some extent they reflect off-reservation problems and possible order of problem incidence. Also, the high number of off-reservation Indians in the study area warrants looking at the national statistics. The following table shows discharges from IHS and contract hospitals (1971-77) for specific mental health problems.

Table 3
Discharges from IHS and Contract Hospitals, 1971-1977

Category	1971	1977
Alcoholism & Drug Dependence	3400	4800
Neurosis & Personality Disorders	1000	900
Psychosis (Non-organic)	300	500
Transient/Situational	100	150
Organic Brain Syndrome	110	100
All Other	150	150

Beiser and Attneave (1978: 4-6) also provide a breakdown of IHS patient contacts. According to IHS, 30% of patient contacts excluding alcohol and drug admissions are mental health specific (Tables 4 ,6). In approximately 78,000 contacts the pattern in Table 5 was reported.

Table 4
Breakdown of IHS Patient Contacts by Category

Category	% of Contacts	
Anxiety	7.7	
Depression	6.8	
Marital Conflict	4.4	
Adult-Child Conflict	3.6	
Suicide Attempt	1.8	
Confusion	1.4	
Death in Family	1.0	
Broken Family	0.9	
Delusions	0.6	
Grief Reaction	0.6	
Suicide Thought	0.4	
	29.4%	Total

Table 5

Types of Problems by Frequency of Patient Contacts

Rank	Problem	# of Contacts	% of Contacts
1	Alcohol misuse(patient)	9861	10.5
2	Anxiety	7168	7.7
3	Depressed	6409	6.8
4	Other	5761	6.1
5	Physical disability	4234	4.5
6	Marital conflict	4108	4.4
7	Adult-child relationships	3343	3.6
8	Physical illness, children	3243	3.5
9	Physical illness	3170	3.4
10	Financial needs	2577	2.8
11	Nursing home	2326	2.5
12	Health, home	2054	2.2
13	Financial assistance	1928	2.1
14	School behavior	1870	2.0
15	Suicide attempt	1727	1.8
16	Pregnancy	1565	1.7
17	Drug misuse	1492	1.6
18	Transportation	1435	1.5
19	Confused	1294	1.4
20	Vocational services	1251	1.3
21	Foster home	1200	1.3
22	Alcohol misuse (family)	1150	1.2
23	Administrative	1122	1.2
24	Physical complaint	1107	1.2
25	Housing	1094	1.2
26	Learning difficulties	1000	1.1
27	Death in family	966	1.0
28	Broken family	838	0.9
29	Delusions	582	0.6
30	Juvenile delinquency	567	0.6
31	Grief reaction	543	0.6
32	Unemployment	431	0.5
33	Suicide thought	343	0.4
34	All other problems	139	0.1
		77907	

From: Beiser and Attneave, 1974

If the IHS figures (based on a population of 100,000) are projected against the 1980 Census data for southwest Oregon, the following distribution of mental disorders would conceivably appear in its hospitalized Indian population:

Table 6
Projected Distribution of Mental Disorders

Category	Projected # of Persons
Alcohol & Drug Dependence	55
Neurosis & Personality Disorders	10
Psychosis (Non-organic)	7
Transient/Situational	3
Organic Brain Syndrome	2

Mental Health Service Utilization

It is evident that mental health problem rates are contingent upon the types of services available for treatment. IHS reports mental disorders are the fifth leading cause for hospitalization and treatment of Native Americans (Beiser and Attneave, 1978: 4). From their 30% utilization rate it is clear that where mental health services are perceived as appropriate, they are well-utilized. Findings in southwest Oregon, however, show that service utilization there favors alcohol and drug programs with little participation in county mental health programs (CMHP's). CMHP's average about 1% Indian clients (Table 7), while alcohol and drug programs range between 7-20% (and 100% with some Indian specific alcohol programs). Similar conclusions have been found elsewhere in the state. In a Portland survey, 75% of the Native

Table 7
CMHP Admissions by County (Excluding Alcohol and Drugs)

	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80	Subtotal
Coos							
Am. Indians	8	9	9	12	11	6	55
All Clients	765	829	877	897	873	770	5,011
%	1.0	1.1	1.0	1.3	1.3	0.8	1.1
Curry							
Am. Indians	0	0	12	13	30	11	66
All Clients	158	120	307	251	385	283	1,504
%	0	0	3.9	5.2	7.8	3.9	4.4
Douglas							
Am. Indians	1	0	4	5	1	8	19
All Clients	883	556	1044	1225	1067	1232	6,007
%	0.1	0	0.4	0.4	0.1	0.6	0.3
Jackson*							
Am. Indians	8	6	1	-	-	-	15
All Clients	987	1030	423	-	-	-	2,440
%	0.8	0.6	0.2	-	-	-	0.6
Josephine*							
Am. Indians	1	1	6	4	0	-	12
All Clients	389	356	609	703	2	-	2,059
%	0.3	0.3	1.0	0.6	0.0	-	0.6
Lane							
Am. Indians	8	15	24	8	42	46	143
All Clients	915	1190	1425	1444	2733	2927	10,634
%	0.9	1.3	1.7	0.6	1.5	1.6	1.3
Totals							
Am. Indians	310						
All Clients	27,557						
%	1.1						

*Incomplete due to experimental intake form

Americans contacted said alcoholism was a serious problem, 48% said drug-related problems, 32% said mental health problems -- yet only five clients utilized the CMHP (Borunda and Shore, 1978: 220). State utilization average by Indians is 0.98%, slightly below the study area.

Nevertheless, county totals do reflect a quantitative increase in utilization between 1975-1980. Overall use has nearly tripled, increasing from a low of twenty-six to a high of eighty-four per year. This is a 273% change. Recent statistics fall back slightly, but generally the trend toward increased use seems persistent (Table 8). It is important to note that the figures for Fiscal Years (FY) 1977-1980 do not include Jackson County (beginning FY 1977-78) and Josephine County (beginning FY 1978-79) due to their use of an experimental admissions form (Oregon Mental Health Division, 1981).

Table 8
Native American Admissions to CMHP's -- Totals 1974-80

FY	Admissions	% Change
1974-1975	26	
1975-1976	31	+ 19
1976-1977	56	+ 81
1977-1978	42	- 25
1978-1979	84	+100
1079-1980	71	- 15

Commitment data for the Oregon State Hospital (OSH) show no strong patterns either locally or statewide, although this (like all data) may reflect the extent to which Indians are identified, availability of local crises and residential programs, or local attitudes toward Native Americans (Table 9).

Table 9
Indian Commitments to OSH by County --
% of Total Client Population
(from Oregon Mental Health Division, 1981)

County	%1975-76	%1976-77	%1977-78	%1978-79	%1979-80
Coos	0	2.5	0	1.5	0
Curry	0	0	0	0	5
Douglas	4.5	1	2	.8	2
Jackson	0	3	0	1	0
Josephine	0	0	0	0	0
Lane	2	1.3	.5	1.3	1

A more disturbing pattern appears when OSH commitment rates are compared to State Corrections incarceration rates. Since 1978 there has been a shift toward incarceration rather than commitment to the State Hospital. Where Indians have been sent to OSH, they are more often committed to the Security Unit for criminal convictions and not to open wards (Oregon Mental Health Division, 1981). To some degree this pattern indicates a general preference for criminal rather than civil commitments. In civil cases only short term evaluation is necessary before a person is released, thus effectiveness is lost (Tabizon, 1981; Reynolds, 1981).

The issue is whether Native Americans are being singled out for this kind of treatment instead of less severe alternatives. Preliminary research shows positive indication that Indians do not always receive equal consideration from Oregon's judicial system (Indian Offenders Project, 1980).

Availability of County Mental Health Services

Comprehensive mental health facilities are available in each of the six counties in SWOIHP's service area (Table 10). These facilities have been evaluated in terms of several key priorities or "Indicators of Mental Health Problems" (as defined by the State Plan for MED Persons, 1975). Indicators include: Poverty, Family Status, Social Stress, and Resources (Table11). These were then used by the Western Oregon Health Systems Agency (WOHSA) to establish a ranking of services within western Oregon (WOHSA, 1979). According to WOHSA:

* Coos/Curry subarea ranked sixteenth out of a possible thirty-six statewide and eighth out of eight in the western Oregon division.

* Douglas County ranked eleventh overall and fifth regionally.

* Jackson/Josephine Counties ranked eighth overall and third regionally.

* Lane County ranked thirteenth in the state and sixth regionally.

Table 10

Mental Health Resources Survey: Services for the Mentally and Emotionally Disturbed

AREA	MENTAL HEALTH CATCHMENT AREA	BEDS		MENTAL HEALTH PERSONNEL HOURS							
				FACILITY BASED							
		IN-PATIENT TREATMENT	INTERMEDIATE OR TRANSITIONAL RESIDENTIAL	OUTPATIENT TREATMENT	PREVENTION, CONSULTATION, EDUCATION, TRAINING	EMERGENCY CARE	DAY TREATMENT	INTERMEDIATE OR TRANSITIONAL RESIDENTIAL	IN-PATIENT TREATMENT	CONTINUITY OF CARE	PRIVATE PRACTICE
LANE SUBAREA 5	XII	30.0	11	567	54	250	600	72	1508	332	1120
DOUGLAS SUBAREA 6	XIII	1.0	N/A	294	22	15	200	0	0	40	40
COOS	XIV	2.0	10	234	71	N/A	80	N/A	N/A	84	80
CURRY	XIV	0.0	0	55	8	1	0	0	0	16	0
SUBAREA 7		2.0	10	289	79	1	80	N/A	N/A	100	80
JACKSON	XV	10.3	7	190	40	83	126	N/A	N/A	20	240
JOSEPHINE	XV	1.6	0	203	53	15	141	0	18	21	80
SUBAREA 8		11.9	7	393	93	103	267	N/A	18	41	320
OREGON STATE HOSPITAL		570.0							15460		

Adapted from: MOHSA, 1979.

Table 11

INDICATORS OF MENTAL HEALTH PROBLEMS IN WESTERN OREGON
HEALTH SERVICE AREA COMMUNITY MENTAL HEALTH CATCHMENT AREAS

The indicators listed below were selected by the Oregon State Mental Health Division to rank mental health catchment areas in order of need. For each category, catchment areas are given a numerical ranking (from 1 to 18). These rankings are then totalled to obtain an overall ranking for each catchment area. These priorities, presented in the State Plan for Services to Mentally and Emotionally Disturbed Persons, 1976-1981, are intended for use in the disbursement of federal funds.

Poverty Indicators

a. Percent males in low-status occupations
b. Percent population in poverty
c. Percent population in overcrowded housing
d. Percent infant mortality
e. Percent female-headed families with children in poverty

Family Status Indicators

f. Percent households with husband-wife
g. Percent household heads who are primary individuals
h. Percent aged persons living alone
i. Youth dependency ratio
j. Aged dependency ratio

Social Stress Indicators

k. Percent teenagers not in school
l. Percent working mothers with preschool children
m. Percent recent movers

Resource Indicators

n. Per capita public expenditures for mental health services
o. Outpatient manhours in public programs per 1000 population
p. Acute inpatient beds per 100,000 population

CATCHMENT AREA	COUNTIES IN AREA	STATEWIDE RANK	HSA II RANK
VIII	Marion	4	2
IX	Polk, Yamhill	10	4
X	Benton, Lincoln	14	7
XI	Linn	2	1
XII	Lane	13	6
XIII	Douglas	11	5
XIV	Coos, Curry	16	8
XV	Jackson, Josephine	8	3

The comparative availability of mental health services on a county scale has therefore been established. No strong patterns emerge, however, in reference to Native American service utilization. Once again, the lack of data from Jackson and Josephine Counties makes any comparison difficult to make. To learn if WOHSA's ranking system has any correlation with Indian accessibility to county mental health services would require further refinement and standardization of the data. It is certain that availability of services does not necessarily insure their use, but there may be a point at which greater (or lesser) availability could affect an Indian's determination to utilize them.

Alcohol Programs

Each of the six counties is serviced by one or more alcohol programs, most of which are subcontracted through the State Mental Health Division. As previously noted, these programs serve substantially greater numbers of Indian clients than the mental health programs per se. Research has shown the reasons for this utilization pattern are as much related to the perceived appropriateness of the services offered as it is to the widespread nature of the problem (Otis and Katz, 1981: 27-28). Difficulties persist in southwest Oregon where no IHS or other facilities exist to offer more culturally sensitive mental health treatment to Native Americans. Here it appears that alcohol programs

are serving double-duty, in many instances working with Indian clients whose problems go beyond substance abuse.

Debates continue on the issue of whether alcoholism among Native Americans is a physiological disease, a symptom of a wide constellation of socio-cultural problems (e.g., a spiritual "dis-ease"), or varying combinations of both; programs frequently differ in their approaches to client problems. The question here is not, therefore, whether alcohol abuse is used to mask more complex problems. This is partially true, but to what degree is a matter of interpretation. Rather, the issue is whether Indian people who have mental health problems usually treated by CMHP's are seeking out alcohol programs because those services are perceived as being more responsive to Indian needs.

From interviews with clients and other Native Americans in southwest Oregon, it is obvious that they <u>are</u> more willing to look for services that are more knowledgeable about cultural background and problems. Alcohol programs and personnel exhibit these qualities more frequently than CMHP's. Often Native Americans are more comfortable going to alcohol programs because they know Indian people who have used them in the past or because more Indians are in attendance there currently. Also, there is more public knowledge regarding alcohol programs and what they do; lack of education concerning CMHP's perpetuates the stigma that one must be "crazy" to get mental health counseling.

Because alcohol programs are typically more responsive to Native American issues, they pay greater attention to simply identifying who their Indian clients are. Most CMHP's view ethnic identification as secondary information and this haphazardness is reflected in their reporting methods. Intake varies among secretaries, therapists, and client self-identification, and it may occur (or never occur) at any time during treatment. To the extent these procedures change, one must surmise that available statistics are unreliable. Yet, given the lack of dependable records, they form the only basis for conjecture. In light of these statistics it is not surprising that alcohol programs have higher utilization rates. More often they are careful to document Native American identity, and occasionally tribal diversity as well.

Among the reasons for this heightened sensitivity in the study area are two Indian-specific, Indian-staffed alcohol programs (IPADA in Eugene and the Sweat Lodge Program in Coos Bay), both of which attract relatively large numbers of Native Americans for treatment and demand attention for Indian alcoholism. Two more programs are adjacent to the six county region (Sweathouse Lodge in Corvallis and Stepping Stones in Klamath Falls). A proportion of the Native American population is willing to travel beyond county boundaries to utilize these and other Indian-specific services, e.g., reservation facilities (Warm Springs, Yakima, Umatilla, Hupa),

the Chemawa Indian Health Facility in Salem, or outside family and tribal networks. Each of these will be discussed in greater detail in Chapter Five.

Within Oregon there are an estimated 161,372 alcoholics and alcohol abusers. Based on population size, 6.4% were projected in 1979 to be Native Americans (Tables 12,13). Additional Native Americans were designated as "at risk" (Oregon Mental Health Division, 1979). With the arrival of new census figures showing a sizeable increase in Oregon Native Americans, estimates are clearly below the projected 31% rate of Indian alcoholism. Using the new census numbers broken down by county, Tables 14 and 15 illustrate the discrepancies between past projections and a postulated revision using the state Indian estimate. There is also a comparison between county projections and actual population numbers. The 6.4% state estimate is slightly higher than the county average of 5.2%, thus suggesting lower abuse rates at a county level. Only Curry and Josephine counties approach service levels that match the 31% projected Indian alcoholism rate in Oregon.

Table 12
Estimated Services to Alcoholics/Problem Drinkers
in Oregon, 1978-79
(from Oregon Mental Health Division, 1979)

Demographic Group	Total %	Detox Admissions	Residential Admissions	Outpatient Admissions
American Indians -- All ages, both sexes	6.4%	7.3%	19.3%	9.5%
Blacks -- All ages, both sexes	1.7	2.5	5.1	4.2
Chicanos -- All ages, both sexes	2.6	2.4	2.9	3.6
Women -- All ages, both sexes	39.6	8.4	9.6	21.4
White men -- All ages, both sexes	48.2	72.2	55.8	48.9

Table 13
Estimated Alcoholics/Problem Drinkers by County, 1978-79
(from Oregon Mental Health Division, 1979)*

County	General Population	American Indians	Blacks	Chicanos	Women	White Men
Coos	3,956	186	6	67	1,333	2,197
Curry	909	97	-	13	191	562
Douglas	5,224	231	4	93	1,384	3,247
Jackson	2,857	260	1	131	2,720	4,015
Josephine	2,857	158	1	51	1,092	1,432
Lane	17,624	475	74	368	6,839	9,654

*Demographic breakdown same as in Table 12.

Table 14
Native American Alcoholics by County

County	Native Americans 1980 Census	Alcohol Program Service Estimates	Projected State Estimate (31%)
Coos	1380	186 (14.2%)	406
Curry	332	97 (29.2%)	103
Douglas	1112	231 (20.8%)	345
Jackson	1189	260 (21.9%)	369
Josephine	567	158 (27.9%)	176
Lane	2471	475 (19.2%)	766

Table 15

Comparison of Indian Alcoholics and Actual Populations by County

County	Indian Alcoholics Served vs. General Alcoholic Population	%
Coos	186: 3956	4.7
Curry	97: 909	10.7
Douglas	231: 5224	4.4
Jackson	260: 7489	3.5
Josephine	158: 2857	5.5
Lane	475: 17624	2.7

Table 16

Oregon Alcohol Program Admissions, 1977-79 (from Oregon Mental Health Division, 1979)*

Admissions	American Indians	Blacks	Chicanos	Women	White Men
1977-78	1220	278	350	1857	12,476
1978-79	2287	856	726	3574	14,190
% Increase	87.5%	279%	107.4%	92.4%	13.7%

*Demographic breakdown same as in Tables 12, 13.

Like the mental health programs, utilization of alcohol programs throughout the state appears to be increasing (Table 16). Both trends imply cautious but optimistic changes. Utilization rates are still low and indicate nothing about recidivism or the number of Native Americans who drop out of treatment. A sense of specialized need remains within the Indian population. While the numbers of Indian people exist who could support county mental health and alcohol programs, they are not presently utilizing those services, or they aren't being identified as Native Americans. This indicates that there are real and perceived barriers to program accessibility.

CHAPTER FOUR

HISTORICAL OVERVIEW AND TREATMENT BARRIERS

Native Peoples of Southwest Oregon

While Native Americans in southwest Oregon once lived as separate and autonomous groups, they are now bound together by a shared sense of enforced adaptation to the dominant non-Indian society. Ever since prolonged contact with Euro-American immigrants began in the late 1700's, natives of the Pacific Northwest have faced similar problems in coping with white intrusion into their indigenous way of life. As with Native Americans throughout the country, this intrusion was reflected in the rapid demise of the Indian population through disease, warfare, and cultural disruption. Lack of immunological defense against epidemics of smallpox, measles, and tuberculosis reduced the original population by three-quarters; lack of cultural defense against Western belligerence, tools of warfare, and political chauvinism reduced it further.

Threat of extinction was seen particularly in loss of tribal lands -- the native source for physical and spiritual sustenance. As white settlers moved into southwest Oregon, lands were acquired through unfair treaties, outright possession, and movement of tribal groups onto reservation lands. Of special significance was the 1850 Donation Land Act which gave Indian lands to settlers and stimulated

pioneer movement into the Oregon Territory. By 1855, all coastal Indians had agreed to treaties with the U.S. Government. These treaties promised money, goods, education, and a reservation in return for Native American lands (Beckham, 1977: 117-135); these promises were not kept.

The reservation years ended land conflicts and traditional Indian lifeways. Only tribes with ratified treaties (the minority) were given food or tools, a mixed blessing since the former increased Indian dependence and the latter were valueless to people unaccustomed to their use. The Dawes Severalty Act or General Allotment Act was the final Congressional blow to the Native Americans before western Oregon reservations were totally dissolved. By the time the act was passed in 1887, reservation lands had been reduced to where the Indian population outnumbered the sustaining abilities of its resources. (Even though more Indians died each year than were born, the usable land area was still too small.) The Dawes Act called for division of reservation lands into individual allotments. Under the guise that it would insure each person a piece of land, the Act ultimately reduced total land-holdings and opened more area to the public domain. Some south coast families who had not remained on reservations also received allotments, but these were few. (Beckham, 1977: 147-170).

By the early 1900's, assimilation of southwest Oregon tribal groups into the dominant society seemed inevitable.

Native peoples who had not been destroyed physically were being killed socially, spiritually, and politically. For the tribal groups whose treaties had by chance been ratified in earlier years of Congress, termination became the policy. For those groups whose treaties lay unratified, recognition of any type was an issue. In either case, the United States Government denied responsibility for the health and well-being of Indian people living in southwest Oregon.

For Native Americans at the local level, issues and problems of maintaining an identity appeared insurmountable. For some, the return of their immediate forebears from the disintegrated reservations at Yachats, Grand Ronde and Siletz marked the beginnings of intermarriage with white families. Among those who had managed to stay behind during the reservation years, mixture with the new local inhabitants had already begun.

In hopes of preventing the hardships and discrimination which had marked their own lives, elders taught their children to publicly suppress their Indian identity. Some elders chose to end hundreds of years of oral tradition -- little effort was made to pass down traditional ways of living, language, or tribal history (Hall, 1978: 2). What remained of Native heritage was confined within family networks and a commitment to lands salvaged either through government allotment or non-Indian settlement patterns. Tribal organization and unity became scattered; geographical isolation, typical of Oregon terrain, increased Native invisibility.

The Current Situation

The deleterious results of enforced assimilation into Western culture have become more apparent in Native American lives as time has passed. Not only has there been a failure to preserve traditional ways, but there has often been failure to adjust to non-Indian ones as well. As with other Indian people across the country, local Native peoples and the many Native Americans who have now settled in southwest Oregon suffer from high incidences of unemployment, alcoholism, drug abuse, low income, substandard living conditions, and generally poor health. Furthermore, these conditions are both cause and effect for problems in mental and emotional health. Compounded by publicly re-emerging issues of identity and lack of accessibility to established Indian health facilities, the Native American situation there is fragile and relatively powerless.

Since the termination period of the 1950's, there has been a movement among Native Americans in southwest Oregon to identify themselves and re-establish the remnants of their Indian heritage. This movement has paralleled a much larger, growing Pan American Indian nationalism which is reflected among immigrant Native Americans in the area. Both movements are characterized by desires to settle past grievances in a way which demands the dominant society's attention and monies. They call for the return of, or restitution for, lost tribal lands, health care, and social

services, culturally-specific programs, and most important, freedom to practice traditional ways of life to whatever degree they choose.

As a result of these movements "traditional" has come to represent a variety of Indian backgrounds and in some cases, an amalgamation. From a local perspective, efforts have been made to re-organize tribal entities (not without its problems), learn and participate in Native beliefs and practices, and address issues of cultural concern, e.g., oral traditions, identification of religious sites and burial grounds, and recovery of tribal lands and resources. For some groups reorganization is perceived as a necessary step in regaining federally recognized status and thereby becoming eligible for benefits given to "recognized" tribes. For those Native Americans not needing or wanting to seek federal recognition, the pursuit of self-determination -- particularly in health care -- is an equally valid and meaningful quest.

In addition to local identification, the implications of belonging to the larger Pan-Indian nation are increasingly visible. This sense of identity is augmented by the large number of tribal groups represented in the six county area. Development of Native American organizations, cultural activities, and social events has brought people together from many backgrounds to share experiences and opportunities for increasing Indian awareness and solidarity. Members of

state and nation-wide political groups as well as spiritual leaders from many tribes have come to the area to share their teachings. Within the larger network have emerged some traditions and individuals who stand out in comparison to the less well-preserved customs of southwest Oregon tribes. Invariably, these people and traditions are most visible to the world unacquainted with Indian people.

Native American visibility to the non-Indian world is an important issue in this region. Unfortunately, what many unenlightened non-Indians are looking for is a stereotypical image or movie characterization of how Native Americans should act and look.

> In spite of centuries of contact and the changed condition of Native American lives, Whites picture the "real" Indian as the one before contact or during the early period of that contact. That Whites of earlier centuries should see the Indian as without history makes sense given their lack of knowledge about the past of Native American peoples and the shortness of their encounter. That later Whites should harbor the same assumption seems surprising given the discoveries of archaeology and the changed conditions of the tribes as a result of White contact and policy. Yet most Whites still conceive of the "real" Indian as the aborigine he once was, or as they imagine he once was, rather than as he is now (Berkhofer, 1978: 28-29).

Recognition of the Native person as a socio-cultural entity rather than a biological one is equally or more important in southwest Oregon. Blood quantum is not questioned except where individuals retain specific government alliances. Dwindling numbers of full-blooded Indians make visual identification misleading.

Native American visibility is an issue in other ways. It is a common misperception among southwestern Oregonians that there are no Indians in their area. Contributing to this impression are geographical isolation and seeming lack of tribal organization. To some Indians, tribal fragmentation is real -- they may be the sole tribal representative in their area. For others, family support systems are all that remain of tribal organization and these stay hidden to the casual observer. Finally, visibility is often gauged on how committed one appears in publicly observable Indian functions. As with most group activities, there is a "core group" of Native Americans who get involved in Indian functions and organizations. Unwillingness of others to take part is often mistaken to mean they don't identify themselves as Indian or they simply don't exist.

Barriers to Effective Mental Health Treatment

Diversity of tribal affiliations and experiences precludes making hard-and-fast generalizations about barriers which cause mental health services to be underutilized and/or inappropriate. The unique characteristics of Native American backgrounds compound difficulties in defining needs and providing suitable treatment. The importance of making services available and useful is the issue, and it is to that end similarities are drawn and generalizations put forth. The following section attempts to integrate work of past re-

searchers with fieldwork observations. The purpose is not to criticize the quality of services, but to examine their appropriateness for a population with a demonstrated need.

Physical Barriers -- Geographical and Architectural

Where mental health services are located in relation to the population they serve is a potential barrier to accessibility. Southwest Oregon is composed of six large counties and a basically rural population. Rugged terrain, long distances, and high transportation costs limit the visits a possible client makes into towns where mental health services are available. Lack of any transportation is an issue for clients court-mandated to receive substance abuse treatment but whose drivers' licenses have been revoked. Economic infeasibility of aggressive outreach creates a special problem for programs that recognize underutilization of its services by the rural sector. For Indian people living in isolated areas, the consequence of their invisibility makes the concept of outreach seem even more impracticable to service planners.

In urban areas (e.g., Eugene and Coos Bay), studies have shown that geographical inaccessibility has another dimension. Lack of distinct neighborhoods or city districts occupied by Indians has hindered development or programs suiting the needs of urban Native Americans (Gonzales, 1979: 16). Often these Indians are in transition from reservation

to city and the service need is acute. Without knowledge of the urban environment or identifiable Indian sub-groups, transient or newly moved Native peoples may overlook what services are available.

Architecturally, physical location and design of mental health service buildings should be considered in planning accessibility. An imposing structure, a highly visible structure, or a cold, institutional-looking structure are likely to make Indian clients hesitate before entering. A frequent comment among Native Americans interviewed was that anonymity is a concern for people seeking mental health services. It was suggested that housing the CMHP in a building with several social programs was most desirable and might, in fact, encourage clients to find other beneficial services.

Economic Barriers

Native American economic status is lower than that of any ethnic group in the United States (Gonzales, 1979: 17). The cost of all health care is prohibitive to an economic class whose annual income averages $1800 and to whom medical insurance is relatively unknown (Castro, 1975: 8). Anticipated cost of seemingly intangible services is a primary barrier to mental health service use. Sliding fees available in many programs are a valued alternative, although determination of how much an individual must pay should be done with respect for that person's dignity. (One client reported

that the CMHP had quoted her one price and billed her at a much higher one; when she went for an explanation, she was made to feel that she had lied about her husband's income.)

Studies with some reservation Indians have shown it is not the security of one's income but its source which creates an issue of powerlessness. The myth that all Indians are content living on government money is dispelled by the fact that not all Indians receive federal dollars, and of those who do, good mental health is strongly correlated with employment rather than financial security alone (Maynard and Twiss, 1970: 146). Unfortunately, efforts by the Josephine County Corrections Division to find jobs for several federally supported Indians have been thwarted by the Indians' severe substance abuse problems. These types of complications strengthen the sense of powerlessness contributing to Indians' mental health problems.

Another economic concern of clients is the insistence by some agencies to "pay first, get treatment later." This attitude is traced by Indian clients to: 1) an overemphasis on monetary reimbursement by those people who are already conspicuous in their 'higher' socioeconomic class; 2) the agency's desire to get more money and fill a minority quota all at once; and 3) a lack of trust in a client because he/she is Indian and/or not financially secure. Denial of client honesty is thought to be an avoidable insult. Agencies fearing that clients won't pay should be willing to work out

alternative pay schedules or choices to paying in dollars, i.e., trading work for counseling.

Educational Barriers

Another barrier keeping Native Americans from CMHP's is lack of education -- knowledge of available services and processes for utilizing them. Clients agreed with results from earlier studies showing that Indian people, particularly those coming from reservation areas, lack an understanding of how non-Indian systems work or how to adjust to typical "red (White?) tape," unexplained service delays, non-Indian staff, and distinctive White aggressiveness (Borunda and Shore, 1978: 222). Mental health personnel should not underestimate the immense stigma attached to perceptions of what their services involve. "You have to be crazy to go to mental health" is the most repeated phrase encountered in interviews with Indians, and it is a serious statement to a general lack of public education. Furthermore, there is an expressed fear of being sent away and locked up indefinitely at the State Hospital.

For many Native Americans the stigma and fear of being labeled crazy are complicated by the circumstances which lead one to becoming a client. Indians openly admit they wait until the last minute before voluntarily going for help with most health problems. By the time they seek help at the CMHP, the problem is so severe it becomes identified

by members of the community as the reason mental health services are necessary. While statistics don't appear to uphold this, it is also likely that interpretation of severity differs between the Indian community and mental health professionals. Hesitation to seek services is directed towards both White and Indian organizations. In either place Indian people fear they will be seen by relatives or neighbors who will perpetuate the stigma that he/she is crazy.

Paradoxically, alcohol programs are said to be more and less similar in respect to clients hesitating to seek services. The greater utilization of alcohol programs would, at a glance, support the premise that clients are less hesitant to use their services. While some people indicated fear of being recognized was a motivational factor in their behavior, others suggested getting alcohol treatment was much different than going to the CMHP. Alcohol abuse is so prevalent that going for treatment is fairly commonplace among friends and family. In addition, the large numbers of Indians mandated by the courts to get alcohol counseling are perceived as being "let off the hook" because a judge has ordered it. Voluntary participation in treatment is significantly more embarassing because of the peer pressure involved in continued alcohol abuse.

Research has shown a correlation between education and acculturation in relation to accessibility of mental health services. Greater acculturation into the dominant society

is associated with higher education levels (education defined by non-Indian standards), and both factors are found most among the younger Indian population (Maynard and Twiss, 1970: 172). A positive correlation between education and adaptability also suggests a predisposition towards good mental health (Lidman, 1979: 21), but must also be viewed as an issue of assimilation.

Most reports stress the extreme lack of integration between Native American lifestyles and the surrounding non-Indian culture. According to one source, 51% of all Indian people live away from reservations; of this number, 75% have failed to integrate their lifestyles into their new environment. The educational transition is a difficult one -- the Bureau of Indian Affairs figures a 42% reservation school drop-out rate. Inability to articulate health problems "can result in a break-down in the basic self-concept of the individual, the structure of his family, and his ability to adjust" (EIC, 1979: 35). Treatment is also less effective when information between client and provider is not reliably exchanged (Liberman and Knigge, 1979: 5).

Cultural Barriers

Recognition and/or elimination of cultural barriers is the final key to making mental health services appropriate and therefore useful for Native Americans. CMHP's can improve service utilization by strengthening communications

with key spokespeople, following tribal protocol, and using personal outreach. All are important to the development of trust. It is the knowledge of worthy individuals in the system, not the services themselves which will attract Native Americans to a program.

Since tribal protocol differs among areas, a wise CMHP will learn variations occuring within its service boundaries. In most situations approaching the tribal chairperson is the proper form. In areas where Indian organizations are found, liaisons with agency directors and resource people may improve communication with more dispersed members of the Indian community. It is recommended that service providers attend Indian activities open to the public, e.g. pow wows. Overlap, not patronage, must be shared before effective communication can occur.

Efforts should also be devoted to elimination of cultural barriers impeding the therapeutic process. Therapists must first understand that Indian people have a different world view than that of the dominant society. This view contains a different experiential background and conceptual framework. Ideas of time, respect, personal privacy, and aggressiveness may be interpreted differently by a Native person. For instance, Indian people expect elders to be respectfully treated and will not use services said to do otherwise. Rudeness or rushing an elder through treatment were cited as disrespectful behavior.

Failure to perceive and work through problems within an appropriate cultural framework may be interpreted by a Native American client as further evidence of a therapist's lack of respect. Since denial of ethnicity has been a large part of becoming "American," cultural differences are often neglected. Assumptions that human experience is universal -- that all clients should be treated equally -- are out of context here. Cultural differences are real; human identity is defined in relation to the context or culture in which it develops. To ignore these differences in a therapeutic situation or to avoid ethnic identification in deference to anti-discrimination policies is done with good intentions but no foresight.

> It is true that the purpose of the Fourteenth Amendment is to eliminate racial discrimination. However, many times the courts have held that it is mandatory to provide <u>different treatment</u> for minorities in order to provide them with equal opportunity .... In our diverse and pluralist society, as noted by Justice Douglas, it is many times necessary for the State to take into account cultural diversities in public programs in order to provide equal treatment (Indian Offender Project, 1980: 7).

Beiser and Attneave (1978: 9) speak of "reverse racism" in counseling: "Some persons are so afraid to intervene in a strange cultural setting that they abandon their sense of expertise and become impotent."

Conscious or outright discrimination against Native Americans in the mental health care setting is rarely seen, but subtle forms of discriminatory treatment abound. It is

seen in the tendencies of best-trained staff to avoid high risk patients by referring them to paraprofessionals (Johns, 1976: 23). It may also be seen as a service barrier to referrals. Schoenfeld (1971: 171) showed how client referrals to outside agencies were directly related to staff attitudes. Considering the low referral rates to Indian providers by state agencies and the opinions of numerous Indian service providers that they always need to justify their work, it appears that Schoenfeld's results are relevant to the research area.

Other forms of culturally based discrimination are found in misunderstandings related to diagnosis and/or evaluation of Indian behavior. These problems include: 1) ceremonial use of drugs that may result in psychotic-appearing symptoms; 2) attempts to avoid prejudice which can look like hiding alcohol or drug problems; 3) diagnostically labeling a client can provide an excuse for a self-fulfilling prophecy; and 4) past discrimination, fears, or hatred for the White system may cause some Indians to be more violent when influenced by alcohol or drugs -- more Indians are therefore kept in jail and denied service accessibility. The Indian Offender Project (1980) repeatedly points out that lack of knowledge of cultural differences and inability to perceive Indian needs occurs throughout the Oregon Corrections system.

Obviously, the basis for seeking alternative treatment exists. More often requests are coming from Native Americans asking to explore traditional ways of healing as a means of ameliorating their problems. Reasoning that western knowledge can be employed to redress previous wrongs against Native Americans is true only to a limited extent. Removing the disabilities which keep Indians from participating in society-at-large simply offers them potential to be functional members of a non-Indian world. This has been the thrust of most mental health programs in southwest Oregon.

For Native Americans in the research area the resurgence of traditional living and practicing medicine people is extremely meaningful. While it is expected that Indians in southwest Oregon will continue to utilize non-Indian and Native mental health/health systems, it is necessary to assure both as viable and accessible alternatives. The extent to which these systems are used or integrated may greatly affect the future status of mental health problems among Native Americans.

CHAPTER FIVE

TRADITIONAL MEDICINE IN SOUTHWEST OREGON

Definition and Scope

It has been shown that Native American mental health needs are underserved in southwest Oregon and that this is due, in part, to barriers which reduce accessibility to county services. It has also been shown that services themselves are often barriers to treatment and are therefore perceived as inappropriate by potential clients. The obvious questions arise: 1) Are Native Americans with mental health problems seeking help elsewhere, and if so, where? 2) What services <u>are</u> perceived as appropriate and why? 3) Given the existence of several treatment modalities, which are successful? Can their effectiveness be measured quantitatively?

While generalizations are difficult to make, it is clear that traditional medicine people and other Indian providers are used with some frequency. The heterogeneity of the Native American population is reflected in their service preferences. In addition to tribal dissimilarities, levels of assimilation and proximity to traditional providers are variables affecting an individual's choice of service. As has recurred elsewhere (e.g., Fuchs and Bashshur, 1975), socio-economic factors are less likely to determine whether a person utilizes traditional healers; more important are

cultural factors, such as strength of cultural up-bringing and reinforcement from friends or kin. People with strong religious ties to their Indian heritage are more likely to seek a traditional provider; it is here that the basic teleological difference between Western and Native medicine is found that ultimately decides what a person's choice will be (Isaacs, 1978: 824). Overall, service preferences among the indigenous Native Americans in southwest Oregon lean towards family and tribal support, and in a few cases, local medicine people. Preferences of immigrant Indian people range from program-oriented providers and their attendent medicine or spiritual people to various other support systems.

The traditional providers are an equally diverse group of people and programs who share a dedication to preserving Native American beliefs and to using them for improving Indian health. One need not be Indian to be a provider, although it is preferable. To be a non-Indian provider requires extreme cultural sensitivity and knowledge, as well as Indian friends. For all providers, traditional healing is definable in simple terms. It begins with an understanding of the interconnectedness pervading Native American philosophy and ways of life. One does not speak of Indian medicine without meaning religion; one cannot address their spirituality without knowing about sweat lodges; one cannot pray in the sweat lodge without feeling ties to Mother Earth and to all living things; one cannot feel in harmony with all living things and remain unhealthy.

Traditional healing has its emphasis on knowledge that has been passed down through generations of Indian tribes and families. In some cases the system has survived intact; in other cases it is only a remnant or a mixture of philosophical beliefs. Underlying each of them, however, is the concept that Native mental health problems are created by an imbalance in the individual's total self -- most often, his/her spiritual self. (Among perceptive health practitioners, this overriding sense of spirituality is perceived as unique to Native Americans.) It is the traditional providers' desire to help imbalanced persons regain their spiritual selves and restore inner peace.

> The way of life the Native American once knew is gone forever. Only the presence and power of the Great Spirit remain unchanged .... The teachings of the talking circle are universal. They bring about a sense of belonging, further self-perception and create an atmosphere of caring and sharing .... To live in harmony with the Great Spirit is to live in harmony with one's self. It is the true path to the well-being of body, mind, and spirit (Sweathouse Lodge, n.d.).

Native American beliefs are inextricably tied to the past, and their humanistic philosophy and environmental respect may gain their rightful place in the future. Nevertheless, traditional healing as an on-going system is fraught with transitional uncertainties and it is important to interpret southwest Oregon providers within that context. The transitional phase reflects the continued state of flux and cultural disorganization that Indian people experience as well as the positive changes beginning to emerge. For years

Native Americans have fought to keep their belief systems whole. Where traditional healing has been approached by non-Indians, it has generally been disparaged as a primitive residual or made callous by elaborate and impersonal research data. Neither approach has given appropriate honor to the powerful source of Native American strength; neither has substantially alleviated the struggle for preservation or self-determination.

In recent years significant legislation has been passed that encourages Native Americans to openly seek traditional providers. In 1978 Indians were finally granted Congressional right to practice their own forms of religion ("Religious Rites Confirmed," 1978: 4). Also, for the first time in 25 years, the American Medical Association has rewritten its ethics code, now allowing "nonscientific" professionals (e.g., medicine people) to receive referrals from medical doctors (Goddard, 1980: 3). Other legislative acts (for instance, the Indian Health Care Improvement Act, Public Law 94-437) were stimulated by Native American demands for health care recognition and the right to be involved in problem resolutions. These are positive steps, but it is unfortunate that legislation is necessary; legal sanctioning of traditional processes does not automatically end discrimination or alleviate other reasons for secrecy.

The transitional period is further characterized by the problems encountered as Native Americans are given

greater opportunities to control their own destiny. Indian adaptation to the non-Indian world -- both adaptive and maladaptive -- is well ingrained and difficult to change.

> The Native American person learned to work with other people in ways that could be construed as turning their back on their own people. But this strategy was really an adaptive survival mechanism which was utilized to its fullest extent .... Today there seem to be some American Indian/Alaskan Native people who have adapted to the point where they can again be generous to their people without jeopardizing their own survival. The difficulty arises from the fact that there are few who can do this and be of service to their people (Ryan and Spence, 1978: 17-18).

The uncertainties hinge on this last statement. While there is a resurgence of Native American interest in utilizing traditional healers, the numbers of active medicine people and spiritual leaders have dwindled. There are too many Native Americans who need help and not enough who can give it. Besides this dearth of traditional providers, few Indian people have had the opportunities or incentives to become mental health professionals or to achieve related health positions in the non-Indian world. There is also a lack of traditionally-oriented Native Americans who have the standard organizational skills needed to confront the dominant society and articulate Indian problems. Where organizations do survive, they are loosely structured and tenuously supported by funding pressures. The inadequacies and instability of funding at local levels makes it even more impossible to attract and hold qualified Native American therapists.

The uncertainty of traditional provider availability keeps many Native Americans from seeking their help. Indian people usually wait until a person or program is well-established before they trust its efficacy; this is true for Indian and non-Indian providers. It is especially difficult for Indian providers who are required to justify their work with client numbers based entirely on Native American participation. To counter these uncertainties, many traditional providers in southwest Oregon maintain an open referral network. By supporting each other philosophically and politically, they improve their viability to Indians and funding authorities. Yet because of this bond, it is inappropriate to separate and categorize providers for research's sake alone. The educational value must be recognized and the knowledge returned to correct the system's uncertainties. With that purpose in mind, the following breakdown of traditional Indian providers appears.

Medicine People and Spiritual Leaders

A number of medicine people and spiritual leaders were identified in or adjacent to the service area; five were interviewed. In two additional cases, family members were interviewed. Medicine people and spiritual leaders are perceived as being different, although a precise distinction is somewhat ambiguous. All medicine people are spiritual leaders; the opposite is not always true. Furthermore, a

person rarely declares either honor, even when surrounded by people who would verify it. Instead, one may say that he or she comes from a family of medicine people, or has been given the privilege to lead religious ceremonies. Non-Indians are never medicine people or spiritual leaders.

Generally, it is important to understand the healer's role as a combination of counselor, doctor, religious leader, and tribal historian (Fields, 1976: 13). In a sense, they provide the "technical assistance" which places Native peoples in touch with their spiritual selves (Worden, 1980: 14). With their guidance, a person with a mental health problem -- particularly problems resulting from cultural disruption -- will find support for traditional Indian values and supernatural sanction for being healed. A medicine person's suggestive powers contain the force which the patient needs to get well (Jilek-Aall, 1976: 356). Any serious research effort on the mental health of Native Americans must consider the role of their medicine people and spiritual leaders.

> These traditional native healers can be helpful in determining whether a problem is culturally related and if culturally determined treatment is needed. They are also a source of information about the overall state of the community because they are at the center of most activities and aware of who may be having problems (Ryan, 1980: 510).

Medicine people indigenous to southwest Oregon are scarce. Three were identified along the state's southern border, and all are thought to belong to northern California tribal groups. Two are men; one is a woman. Only one of

them is an active healer. The two remaining medicine people are "retired" -- one is treating his own cancer; the other is very elderly and blind (although still making tribal drums). The active healer was reportedly used by at least one Indian family in the Brookings area for mental health reasons. It was suggested that the Tsurai Health Clinic in Eureka, California -- a well-liked IHS facility -- and its outreach clinic at Smith River attract Native Americans from southern Oregon, thereby reducing the number of Indian people who might otherwise seek a traditional healer. Recent negotiations between Tsurai and SWOIHP have increased client interchange, particularly in Curry County.

A niece of the aforementioned medicine woman affirmed that her aunt had once invited her to become an apprentice to the medicine ways. As a young girl involved in school and its activities, the niece declined. Now grown, the woman realizes what she missed. No one else in her family learned her aunt's skills, and she is anxious to have her own children learn more about their traditional tribal life. A similar generational misfortune was reported at the Siletz Reservation in Lincoln County (where descendents of many southwest Oregon tribes live today). It was said that the two remaining medicine people there have purposefully decided not to pass on their knowledge. It was speculated that their decisions were based on feelings that their potential heirs had not been brought up within the correct cultural context for handling medicine powers.

A number of other medicine people and spiritual leaders were also located within the southwest Oregon service network. A few of these people have moved permanently into the area from other parts of Oregon and Washington. A large portion, however, come from outside the state and pass through on a fairly regular basis. Their circuit is composed of visits to other providers, homes of involved individuals, the sweat lodges, and various Indian community activities, e.g., pow wows, benefits, etc. While their sustained presence is less consistent than other providers, this group of Native Americans is highly respected. Some (i.e., Wallace Black Elk, nephew of the medicine man in J. Niehardt's Black Elk Speaks) are well-known in wider Native American circles; their medicine is reputed as very old and strong. It is usually with these medicine people that special healing ceremonies are held, exclusive teachings are shared, and vision quests are arranged. Spiritually devoted followers are sometimes able to travel with these medicine people and learn the most rigorous paths of Native religious life. The Indian alcohol programs frequently ask the medicine people to lead sweats and visit with their recovering clients. Such interactions are thought to be effective in helping clients resolve their problems. One Indian client interviewed during this research moved from an alcohol detox center through the sweat lodge program and then began traveling with a Sioux medicine man. At last

meeting he was headed to Nevada for the Sundance, an ultimate gesture of self-determination.

In addition to the medicine people, there are a handful of individuals who cannot be so easily defined. A few are deeply spiritual people who understand traditional lifeways and teachings. They may work with visiting medicine people to strengthen their knowledge and through them learn how to help the Indian people. Some are leaders in the sweat lodge and/or have the honor of being pipe-holders (a spiritual position recognized only among some tribal groups). Like medicine people, these individuals are perceived as being special people who listen well to problems and offer good advice. They are usually active in local Indian affairs and hence reinforce Native American values among friends and followers. Several Native Americans said they would rather go (or send family members) with mental health problems to these spiritual leaders than to the county programs. As opposed to the CMHP's, they are accessible, nonauthoritarian and free-of-charge. Unlike medicine people, however, their backgrounds may include no specific instruction or "calling" to that vocation. One man, a Yakima-Wasco Native, remarked that he was interested in obtaining more formalized training; he felt that new skills would help him advise people's more complicated problems.

There is also a marginal group of providers who are either apprentices to medicine people or who hold distinctive

positions of another kind. For instance, one person interviewed was both. On an intermittent basis he has studied with a medicine woman from California; during free time he teaches himself about local herbs and edible wild plants. It is also said that he can "read" rocks -- he finds patterns in them that tell him where the rocks came from and creatures who have passed near them. While the man himself did not mention this ability, he did say he had felt special powers at an early age. When he grew older and began working with the medicine woman, the powers felt more comfortable and he stopped trying to direct them. Although this man is a strong figure in the local Indian community, he does not appear to be someone sought for problem solving, except perhaps by friends. Whether this situation will change as his knowledge matures remains to be seen.

Sweat Lodge Programs

The focal points of most traditional healing activity in southwest Oregon are the sweat lodges and the Native American programs which have developed around them. Sweat lodge use was once nearly universal among Native peoples in North America which makes it particularly adaptable in an area characterized by many tribal backgrounds. While sweat lodges were used by the indigenous Native Americans of southwest Oregon, more lodges have probably been constructed there during the past five years than in the past 150 years.

The loss has been due to cultural destruction; the restoration has resulted from the influx of new traditions, especially the more elaborate sweat rituals of the Sioux tribes. It has only been within the past two years that some sweat ceremonies have begun to show more locally-rooted influences.

The ritual and reasons for sweat participation vary tribally, but there is a common theme of purification -- purification of mind, body, and spirit. As a medicinal ceremony, it cleanses the body and influences spiritual powers for illness prevention and curing. Socially, the sweat bath functions as a meeting place and a place where young people learn their cultural/tribal traditions (NARF, 1981: 12). Symbolically, the ritual expresses the harmonious relationship which existed for hundreds of years between Native Americans and their environment. It is said to be the embodiment of all the powers in the universe and its performance is essential to the continuity of life. The Oglala Sioux call the sweat bath "inikaga" which literally translated means "to recreate a new breath of life" (Highwolf, n.d.: 1).

> Participation in sweat lodge ceremonies is the traditional way to begin the spiritual identification of a person's relationship with all things. We come to the Sacred Circle to pray for guidance, to search, to share, and to learn the power and wisdom of the "Stone People" and their way of helping us address our negative nature -- to improve and enrich our lives (Sweathouse Lodge, n.d.: 2).

Through purification comes healing. Traditionally, men joined a medicine man in the sweat lodge since the healer was obligated to purify himself before attempting cures. Women went separately and were banned from the lodge during their menses ("moon"). It was said that the woman's natural power to cleanse herself monthly was too strong at that time. This holds true today. Otherwise men and women may sweat together or separately -- the overriding emphasis is their common spiritual objectives.

Every aspect of the sweat ritual is rich in meaning and symbolism. "All these things are sacred to us and must be understood deeply if we wish to purify ourselves, for the power of a thing or an act is in the meaning and understanding" ("Rite of Purification," n.d.: 1). Every object, movement and direction makes an important contribution and has been carefully woven from Native American interpretations of their world and its origins. The symbols of the circle and the four directions are vital ones. There is an inner circle of universal truth which is the self. Life is said to begin and end in the South, and all of life is a journey among the four directions -- Caring (South), Respect (East), Feelings (West), and Relationships (North).

After years of suppression the power of the sweat lodge has returned to life in many areas. In prisons, the building of sweats has become the most common form of upholding the religious freedom of Indian inmates. ".... Pris-

on officials typically fail to understand the vast differences between the tribal religions of Indians and the Judao-Christian religions which most people are familiar with, and consequently fail to view a request for a sweat lodge as a valid religious practice" (NARF, 1981: 11). Permission and funding for a sweat lodge built by the Lakota Club at the Oregon State Penitentiary came only after requests were passed several times between the Corrections and Mental Health Divisions.

Most notably, sweat lodges have been put to use in rehabilitating Native American alcoholics and drug abusers. By reuniting clients with their traditional religion, the sweat lodge programs strengthen the spiritual and cultural existence denied them for so long. "The spiritual meaning of the sweat lodge and Sacred Circle, healing ceremonies, drumming and singing, the pipe ceremony -- all are woven together to reintroduce clients to customs that are part of Indian traditions" (Worden, 1980: 14). In doing this it is thought that the identity confusion and disorientation (e.g., physical, socio-cultural, and spiritual) observable in problems of substance abuse may be alleviated.

> There is a holistic, ecological quality about sweat lodge teachings: respect yourself, your body and mind, learn to spurn alcohol and other drugs that disrupt personal integrity. Respect the earth, and the animals of the earth and air. Respect your relatives, those who have prepared the way, and your family. And learn the sacraments, the ceremonies, the Native American traditions and respect them (Worden,1980: 14).

Sweats are held for people who are sober, ready, and willing to participate. Program emphasis is on the philosophy that Native Americans are spiritual people and alcohol has no place in spirituality or being Indian.

There are two Indian alcohol programs in southwest Oregon, the Indian Program on Alcohol and Drug Awareness (IPADA) in Eugene, and the Andrew Eagle Detox Center and Sweat Lodge Program in Coos Bay. IPADA does not have a sweat lodge -- a recent proposal for funding one was turned down. Likewise, the Sweat Lodge Program in Coos Bay was closed down in June 1981 due to lack of funding. While one may argue that money is not needed to build a sweat lodge per se, funding for alcoholic rehabilitation is absolutely necessary. Transportation, public education, counseling and referrals are critical to operating a specialized sweat lodge program.

The Andrew Eagle Detox Center has existed since 1976. It has a strong Indian influence, but it is not exclusively Native American since it doubles as the Coos County Council on Alcoholism. It is named for a Sioux man who was born in 1904 on the Rosebud Reservation and who died in Coos Bay in 1976: he is remembered for his work with Indian alcoholics and relations between Indian and non-Indian communities. Unfortunately, the teachings of Andrew Eagle live on only in his name. Local tribal factionalism has kept the program from realizing its full potential. Despite Lidman's recom-

mendations for continuing a sweat lodge program in Coos County (1979: 30), lack of participation and therefore, justification for funding, contributed to the downfall of the three-year-old Sweat Lodge Program (20-25% of the sweat participants were Indian). Nevertheless, three Native Americans remain on staff (the Detox Center's bylaws require at least one Indian on staff) and cultural sensitivity is highly developed. Contacts with the local Indian community are extensive -- partly due to a strong Native American Alcoholics Anonymous program -- and referrals are made to other Indian programs throughout Oregon, for example, Sweathouse Lodge in Corvallis and the Native American Rehabilitation Association (NARA) in Portland (Joyce, 1981; Wright, 1981; Klein, 1981; Harrison, 1981).

Eugene's Indian Program on Alcohol and Drug Awareness is essentially a counseling and education program. It is entirely Indian-specific, averaging about thirty clients a month (including carry-overs from month to month). Treatment involves an exploration of the client's cultural background (e.g., outstanding myths, spiritual concepts, tribal politics and economics) so that tribal diversity is shown proper respect. Program philosophy concentrates on the belief that alcoholism is a "dis-ease" of the Indian spirit.

> While alcoholism has a great many physical manifestations, the heart of the problem can only be uncovered through spiritual seeking, and the cure only possible through spiritual regeneration. In order for this type of treatment to be genuinely effective, an understanding of and respect for the spiritual awareness of the Native person is necessary (Connelly, 1981).

IPADA strives to "re-think" the predominantly non-Indian processes which have controlled Indian alcoholic rehabilitation in the past. "Nearly all treatment for this disease has been developed and implemented by non-Indians. What this means is that the eye that views the problem, the brain that processes the available data and the system that provides the structure and environment in which the cure takes place are all non-Indian" (Connelly, 1981). The first step toward accomplishing their goal is to have qualified, dedicated, and spiritually oriented personnel to help clients. Two of the four counselors are Native Americans (one is in training), and the other two have extensive backgrounds in cross-cultural counseling and Native American traditions.

IPADA's respectability is growing in the Eugene area. Three years ago people started going there because it was a non-White agency; now they go because it is for Native Americans. Roughly estimated, its treated population consists of 25% volunteers (including clients referred by friends), 35% court referrals, and 40% professional referrals. Client age span is 18-45 with 27 as the average. Successful treatment

is not based on a person's total abstinence from alcohol, but rather on the number of jail repeats and other indicators of the client's ability to support his/herself. "Failures" are placed within the context of a larger success system -- one in which the client will seek several more treatment centers before achieving functional sobriety.

Besides counseling, IPADA has developed three strategies which serve the interests of the entire individual instead of his/her alcohol abuse alone. These are: the Native American Alcoholics Anonymous group, the Native American Issues Committee (designed to deal with cultural issues at a community level), and the Native American Women's Support Group. Effectiveness for any of the groups is measured by client feedback and attendance. To date, the response has been consistantly good (Connelly, 1981; Villigran, 1981; Akiyama, 1981).

While some therapists in the six county mental health programs had knowledge of IPADA and the Coos Bay programs, contacts have been limited for both referrals and educational purposes. This is surprising since both Indian programs are subcontracted through the CMHP by the State Mental Health Division! The liaison is strongest in Eugene where most court-mandated Indian alcohol and drug cases get referred to IPADA, and weekly meetings are held among agency sub-divisions. Yet even with this on-going interaction, communications break down at the level of treatment philosophies and

client identification. In Coos Bay, one individual links the CMHP to the alcohol treatment program. Generally the attitude of both groups is one of extreme separation, if not isolation. When asked at a staff meeting if any Native Americans worked at the Coos CMHP, not one person mentioned the subcontract program two blocks away.

More visible and widely spoken of than either of these programs is Sweathouse Lodge,Inc. in Adair Village (outside Corvallis). Although outside the six county region, it serves Native Americans from there. It is one of the few residential treatment facilities in Oregon specifically designed for Native American alcoholics and drug abusers (IPADA is not residential, and Coos Bay's South Coast Recovery House is geared for court-mandated cases of all ethnic and racial backgrounds). Established in 1975, Sweathouse Lodge has the capacity to treat thirty residents on a 24-hour basis. It is not set up for detoxification, but ut aims to serve clients wanting sustained abstinence from alcohol and drugs. Its annual service population averages 120-180 clients; treatment lasts from thirty to ninety days. Nearly all of the staff is Native American, and medicine people, Indian elders, and other non-client Native Americans often visit. Sweats are held daily. Drumming and singing of traditional songs, dancing, and passing on oral traditions are all part of treatment.

Here, too, success is not measured by how many clients never drink alcohol again, although that is the ultimate

goal. The immediate objective is to teach clients how to create their own community support system within an Indian cultural context -- a support system that eschews use of alcohol or drugs. By eliminating the cultural barriers found in most treatment options, Sweathouse Lodge offers a unique alternative. This in itself is an accomplishment. For some clients, the educational aspect of therapy may increase their ability to search out the cultural traditions most appropriate to their own lives -- or possibly to find standard forms of treatment. Sweathouse Lodge teaches its residents where to look and how to know what is appropriate when they find it. Other clients may respond more immediately to the absence of treatment barriers and dedicate themselves to a life of sobriety (Smith, 1979; Wade, 1981).

Referrals to Sweathouse Lodge from southwest Oregon usually come from the people most aware of its services -- the people working in Native American programs. Client self-referrals may also occur, and occasionally someone is referred from another source. For instance, a former director of the Douglas County Council on Alcoholism had a personal appreciation for the sweat lodge programs and supported their work. According to him, efforts to send clients there were not always successful because of the distance involved and the strong traditionalist approach. His suggestions for constructing a local sweat lodge evoked little response either, probably due to the fragmented Indian population in Douglas

County and a general lack of interest. But he indicated that the cultural aspect of mental health treatment is new, even to Native Americans. His perception is that many "Indian" programs are simply White programs run for Indians. This situation is slowly shifting, with Indian staffs bringing the most benefits. As it changes, he expects potential clients to show a stronger response (Worden, 1981).

Native American Alcoholics Anonymous

Among Native Americans it is sometimes said that a White person's cure is needed to treat a White person's disease. Since alcohol abuse was not a problem for Indian people before the Euro-American contact period, some providers believe there is no traditional "cure" for it. Alcoholism needs to be treated with a combined approach -- one that recognizes its origins in cultural and spiritual disruption as well as the conditions for its perpetuation.

As originally developed, Alcoholics Anonymous (AA) has been helpful to many Indian people. According to Dozier (1966: 83), AA has had an advantage over psychotherapy in working with Indian alcoholics. Because Indian drinking is most often a group phenomenon, individual therapy is less useful. An organizational set-up acts as a substitute group activity. AA philosophy is purposefully ambiguous enough for use by people of all ethnic or religious backgrounds,and it is an established support system almost anywhere a person

chooses to live.

Yet for many other Native Americans, the cultural barriers which have prohibited them from seeking help elsewhere have also kept them from using AA. Some basic conceptual differences exist besides. As Littman (1970: 1782) points out:

> AA has, by and large, not had much appeal among American Indians, perhaps because of its emphasis on the alcoholic's need to admit his personal weakness. This very concept is .... offensive to most Indians. Nor are the religious tones of the AA program acceptable to many alcoholics. Frequently Indians consider this a "White man's program" which is unacceptable to them.

Numerous Indian groups have taken the best aspects of the AA program and combined them with traditional Native American beliefs. The result is Native American Alcoholics Anonymous (NAAA). NAAA accentuates the similarities between the two philosophies -- particularly the use of ritual and sitting in a circle. There is an emphasis on the positive aspects of a client's character and the need to speak straight from one's heart. Sometimes a pipe is passed as an offering to Grandfather, the Great Spirit, and as a sign of friendship. A revised version of AA's Twelve Steps to Sobriety was designed by the Umatilla Tribal Alcohol Program (see Appendix E) and is used by many NAAA groups. Usually clients must work especially hard at resolving guilt associated with <u>not</u> drinking -- peer pressure is extremely difficult to conquer. Unlike AA, NAAA welcomes people with dual or multi-addictions, e.g.,

alcohol and drug addiction.

There are two Native American AA groups in southwest Oregon -- one in Eugene and one in Coos Bay. Interest has been shown towards developing another group in the Medford-Ashland area. Sweathouse Lodge also utilizes NAAA as part of its treatment program. The NAAA in Eugene is facilitated by IPADA and run by a Sioux man who is also a counselor at a non-Indian specific residential treatment house in Eugene. Like most NAAA groups, it meets once a week. According to both IPADA and the NAAA leader, attendance is consistantly good. The Coos Bay program reports a good turn-out also, with greater than 50% Native Americans in attendance. The leader there is of Iroquois descent and is manager of the Andrew Eagle Detox Center (Connelly, 1981; Archambault, 1981; Joyce, 1981).

"Professional" Indian Therapists

Literature on Native American mental health stresses the necessity for planning and training Indian people as mental health workers (e.g., Staub, 1978; Ryan, 1980). Native Americans record the lowest number of health professionals in any ethnic group (EIC, 1979). Yet hiring a Native American counselor is not as difficult a challenge as determining what his/her orientation to the local Indian community might be. Not only are one's personality and tribal affiliations under greater scrutiny at higher levels, but each worker must decide how to integrate traditional values into a non-Indian structure. In addition to the impediments to attaining a professional position, the final objective may end up looking much less appealing. However, for a few Indian people in southwest Oregon, this end has been accomplished and a new category of traditional providers has been formed.

Education opens the door into the non-Indian working world. The mental health field is particularly oriented toward the credentialed society. It requires that one learn lessons as instructed; deviation is not tolerated. It is hard for an Indian person to become a professional in the non-Indian sense and still keep the respect of his/her own people. The "apple" label -- red on the outside, white on the inside -- is quickly and harshly applied. But situa-

tions differ. In the southwest Oregon service area a range of positions and adaptive strategies are found.

Two Native Americans work directly for CMHP's in the six county region. A third person left her position just as research began. The highest (most credentialed) position was that of psychiatric social worker, held by an indigenous southwest Oregon tribal person at the Jackson CMHP. His view is that White oppression is the cause for Indian mental health problems and that services for Indians must be improved. "Knowledge, experience, and understanding in non-Indian mental health workers need serious attention and improvement. Similar training is also often needed by Indian mental health workers." His own experience in providing services to Indian clients have been occasional on-the-job encounters. "No supervision in this respect has ever been provided or, for that matter, has ever been available." The few Native Americans who come to the county program are usually self-referrals. Communication with the local Indian community is in a beginning phase and has the potential to get much better. The man considers himself to be a "very good clinician, therapist, and clinical supervisor," and the interest of himself and others in the agency could sustain a working relationship between the CMHP and the Indian community (Tanner, 1981).

The second Native American employed by the Josephine CMHP is not directly involved in mental health therapy, and

she is not recognized by staff as belonging there. Her job is to work in the homes of mentally retarded and developmentally disabled children, teaching parents and children to live with the handicap. She is related to many Indian people in the area and is recognized by members of the Indian community as being knowledgeable about Native American traditions. When she visits Indian homes she does advocate work for SWOIHP but not the CMHP. Conversely, the CMHP has not approached her to do outreach work for it (Cramblit, 1981).

Outside the CMHP's two more "professional" Native Americans were identified who work in the mental health field. One man is a guidance counselor at a Grants Pass high school. He does not work exclusively with Indian students, but is careful to share his Indian beliefs and values with all students. He integrates traditional ideas within a context of contemporary living so that students will better understand what being an American Indian means and what values can be meaningful in their own lives. Outside of school he is committed to developing a Title IV Indian Education curriculum for the school district and hopes to one day set up a Native American "spiritual survival school" near his home. The school would demonstrate and teach traditional Indian life-ways -- in a sense, a <u>real</u> Indian community (Black Eagle Sun, 1981).

Another professional Indian man has two jobs -- one as the leader of the Eugene NAAA and the other as counselor at Carlton House, a residential house for alcoholics. He sees mental health problems among Native Americans as an issue of self-identification -- a long process of self-exploration involving redefinition of personal values. After this has been accomplished, a person can work toward being happy with oneself.

For alcoholics, building an adequate support system means one must recognize drinking as a problem, not an inevitability. This man's philosophy is to treat clients as human beings first. Sometimes a confrontive approach is best: "You must confront your brother and tell him what to do." Treatment is four-fold -- mental, physical, social, and spiritual -- and focuses on human feelings and self-expression. Next he looks at the problem, "the hurt," and at the systematic rationalizations employed as defense mechanisms for it. This is a powerful experience, one in which spirituality alone is not sufficient.

His goal is to balance one's self-perception with positive reinforcement and build a new image. This is difficult because clients have typically experienced tremendous frustration, not only about themselves, but about their circumstances and other people. Reservation dependency can create especially tough problems. Individuals bring with them low self-esteem, low self-worth, and the sense that nothing is

going well for them. Success is viewed as a "tricky issue" since service providers have only begun addressing the problem. This counselor estimates a 50% success rate among the people he treats (Archambault, 1981).

Family and Tribal Support Systems

Traditionally, family and tribe have been the basic units for Native American identification and support. With cultural breakdown has come family disintegration. Roles and role models have become increasingly incompatible and inadequate for upholding families in a traditional manner. Where families (e.g., extended families) persist as a group, they are crippled by stresses of acculturation and problems that tear individual members apart. The effects on males have been noted in particular; mental health problems seriously impair their abilities to provide direction and economic support for their families. The consequent decline in status reinforces their problems (Maynard and Twiss, 1970: 111).

The variability of family security is perceivable in the comments made by Native peoples in southwest Oregon. As previously noted, many of the Indians in this area have moved there from outside the six counties' boundaries. This in itself divides the larger and extended families. Most references to family support or non-support came from service providers or Indians native to Oregon. A survey

among Native Americans in Coos County indicated that family and friends provided less support for people with alcohol problems than had been expected (Lidman, 1979: 30).

Family weaknesses were seen largely in their powerlessness to take care of individuals exhibiting symptoms of serious mental health problems. In "taking care of its own," family members may attend to the sick person's physical needs, but ignore the problem. Spouse and family may also defend the individual against the social stigma of being "crazy," thereby pressuring the person not to seek help. With alcoholics, the family unit is a source of peer pressure to drink. One client said he had lost four brothers and most of his friends to alcoholism or alcohol-related diseases.

Another client reported, however, that while her family had ignored her during her active alcoholic period, they are now her "staunchest supporters" since she has been sober. With lesser problems the family is clannish and viewed as the appropriate place to turn for help. Another Indian woman said families are helpful and probably limit the extent to which professional counseling is used. One Native American service provider commented on the number of referrals received by his agency from family and friends.

Tribal affiliation is more a source of personal identity than support for mental health problems. Politically the tribe can be a rallying force (i.e., by keeping someone's problem hidden from outsiders), although in southwest Ore-

gon tribal organization is too fragmented and/or scattered to be very useful. Viable tribal groups are usually cognizant of a member's problems but will not interfere unless pressed by the family's request or extreme negligence.

The Clients -- Four Case Studies

Thomas was brought up on a reservation in southern California until age 15 when he moved to Los Angeles. After 18 years of alcohol and drug addiction and 15 years of treatment, he has been through a lot of programs. His sophistication in dealing with the White system is well-developed. When Thomas moved to southwest Oregon, he transferred from a program in California and reserved a place in the Substance Abuse Division of the Jackson CMHP in Oregon.

Thomas says that when a person becomes a junkie, they become part of a different race. "Life goes from technicolor to black and white; being a junkie is the hardest job in the world." He says he spent many years trying to prove that Indians can drink but found out he can't.

The worst program he had encountered used "attack" therapy, in which the client gets pulled totally apart psychologically. "It makes you feel like nothing spiritually." He left that program after ten days. The best program he found used "sensitivity;" it "let you know your good points. Most junkies don't feel like they have any."

Thomas thinks that having an Indian counselor might have been more helpful to him in the beginning, although he said that since Indians are often brought up feeling White people are superior, another Indian may not always be an effective role model or therapist. His biggest lesson was learning that one's counselor doesn't have a magic potion to make the problems disappear. Since coming to Oregon he has succeeded in managing his own problems fairly well, but when he feels the need he makes an appointment at the Substance Abuse Program. He said that if there was an Indian program in the area, he would use it. He would also like to start counseling other Native Americans.

Case 2

Ann was arrested for having a small amount of marijuana, called "kush" by her people and used by them ceremonially. She obtained it from her tribe and used it for ceremonies in her home. Because she has seizures, she also takes doctor-prescribed drugs that leave her feeling "spacey". When she was arrested, she was "given a big run around" in the Jackson CMHP and ended up in the Substance Abuse Program.

Ann has not been happy with her experiences at the CMHP. First she was made to feel like a drug addict, and her therapist did not trust her when she said she was not using the kush anymore. Ann thinks she would prefer a counselor of the opposite sex and one who is a Native American.

She thinks it would help her to talk. She lives by the traditions of her tribe and would like to be respected as an Indian woman whose children have grown up and left home.

Ann is confused about what "they" (agency) are trying to do. She feels very threatened by her counselor, a "White woman over there" who is working at a job a traditional Indian woman wouldn't have, and who advocates that Ann do things a White woman would do, i.e., go out socializing, or get involved in outside activities. Ann is also afraid of her counselor's position of authority and worries that if she complains she will be sent to jail. Ann thinks the counselor is trying to help but doesn't know what she's doing when she is with her Indian client.

Ann's father is a medicine man in northern California. He talks to her on the telephone when he can and she visits him whenever possible. It is helpful for her to talk to him, but since she is court-mandated to go to the CMHP he cannot change her situation.

Case 3

Susan tried to commit suicide and failed. She was sent to the Coos CMHP for professional help. She remained in therapy two weeks and dropped out. First, she was sent to the staff psychiatrist who told her to take stelazine (an anti-depressant) and not talk about her problems. Then Susan was sent to group therapy sessions. There she and

other able clients were encouraged to lead the sessions; she felt like a babysitter and felt she never gained enough attention for her own problems. She never received support to help her get away from the bad home situation that she thought was causing her problems.

When Susan tried to talk about her Native American heritage with several counselors, none were responsive. She was unwilling to push them due to her "respect for a counselor's right to be closed at times." The only constructive alternative that she was offered -- a job -- was not suited to her sense of self-respect. The program placed her in a fast food restaurant -- the people and business were totally foreign to her way of thinking.

Since leaving the CMHP, Susan has gotten involved in local Indian activities, including the sweat lodge and a newly formed Native American women's "Spiritual Survival" group. She works for an Indian organization and with support from her friends has improved her home life. She thinks the sweat lodge program is very helpful. "It really opened my eyes to see that it works for people who haven't had much to do with Native traditions."

Case 4

John walked in and out of several treatment programs before going to Coos Bay and turning himself in as a dual addict at Andrew Eagle Detox Center. As another system-sophisticated Native American, he knew he was looking for something he hadn't found elsewhere. When he walked into the Detox Center in Coos Bay he felt headed in the right direction.

Hardened by years of alcohol and drug use on the streets of Los Angeles and later in Vietnam, John moved to the Northwest to kick his heroin habit and clean up his life. He was partially successful. He switched to less intense drugs, and alcohol was limited to a few three or four-day binges each year. He was able to get good jobs teaching self-defense, working as a mountaineer guide, and as an Emergency Medical Technician.

While living on Oregon's north coast, John became periodically involved in traditional Indian activities, including sweats at Sweathouse Lodge. When his next alcoholic binge came, he knew it was the last one. Still drunk, he went to Coos Bay. There he started getting more deeply involved in their Native American programs -- the Native American AA, the sweat lodge, and talking to the Native American counselors. Together, they made a mutual decision that John should transfer to Sweathouse Lodge. During his wait

for a space to open up there, he was offered a place to stay with a Native family and he was able to continue attending NAAA and sweats.

John went to Sweathouse Lodge for ninety days and became further committed to a path of sobriety and Native spirituality. He was very active in the program, taking sweats, learning traditional songs and drumming, and becoming more aware of his physical and spiritual needs. Through Sweathouse he met a medicine man with whom he later traveled throughout the Northwest. He has dedicated himself to the traditional ways and feels great strength from applying them to his life.

Conclusion

For the purposes of this study, evaluation of program or provider effectiveness can not be measured statistically. Definitions of "successful" treatment differ with each client and therapist. The value of services is best understood at the individual level. Furthermore, it is not the professional skill of the therapist that is questioned so much as the cultural appropriateness and sensitivity of the services he/she provides. These standards are not easily quantified. For those people following traditional Indian healing ways, quantitative evaluation of treatment is important primarily for justifying service provision to outside funding sources.

Utilization of services can be measured to a limited

degree, but current data is unreliable or unavailable. Accuracy is affected by the methods and frequency of identifying Native American clients and what happens to that information during and after treatment. Although client records are computerized by the State Mental Health Division, they are difficult and expensive to retrieve. Recidivism rates have never been computed with ethnic or racial breakdowns, and client follow-ups after treatment are impossible for most agencies or providers.

CHAPTER SIX

SELF-DETERMINATION IN MENTAL HEALTH CARE

Definition

To cultural anthropologists, the phrase "self-determination" sums up years of interpreting, reinterpreting, and defending various peoples; it is the culmination of their fight against ethnocentricity and cross-cultural ignorance. Having passed through an era of research for curiosity's sake, anthropologists have begun learning to "apply" their knowledge to the demonstrated needs of the people involved. "Self-determination" describes the logical outcome of that application. It refers to the right of any people, in this case Native Americans, to decide their own cultural destiny.

While self-determination is a "right" in the minds of anthropologists and Native Americans, it is still a relatively new concept in the minds of most non-Indians -- particularly those who control Indian affairs from a distance. However, given the history of federal involvement in Indian affairs, it is not surprising that Native Americans become suspicious when government representatives broach the subject. Apprehensive Indians ask: Does ".... self-determination ultimately mean 'termination' or the government's intention to discontinue federally sponsored care?" (Bittker, 1973:178).

Native Americans do not think self-determination and federal sponsorship are necessarily exclusive of one another. There is a time-worn responsibility owed to Native peoples that has been ignored and misapplied but which can be rectified with appropriate funding and/or sensitivity -- i.e., sensitivity without interference. As Leon (1968: 235) states: "I think the federal government will have to get out of the business of being the initiator of programs and into the business of developing constructive responses to the wishes of the Indian people." This is particularly true with traditional medicine. It is necessary for Indian health planners to know when to leave it alone and when to advocate its integration into a more structured format.

Federal policies regarding Native American self-determination have shown greater tolerance toward alcohol programs, largely because of influences from the National Institute of Alcohol Abuse and Alcoholism (NIAAA).

> Federal policies so far have allowed many Indian alcohol treatment programs to carry cultural relativity and self-determination to their logical conclusions.... As a result, many Indian groups have been able to develop and run their programs in their own way; to take part in training and evaluation; to incorporate traditional native healing methods, practitioners, and revitalization movements; and even to "Indianize" the formerly sacrosanct AA's approach to a point where it is unrecognizeable to non-Indians (Leland, 1979: 95).

The 1978 transfer of "mature" Indian alcohol programs from NIAAA to the less flexible Indian Health Service jurisdiction has caused some animosity, even though IHS is

recognized by most programs as a more stable funding source. Lost flexibility means less freedom for working out new alternatives. "For those familiar with the history of Indian affairs in this country .... it implies, 'we helped you get started, now why can't you help yourselves, the way White folks do'" (Leland, 1979: 45). IHS's more conservative medical approach and extensive years of service to Indians is considered by some to be more usefully related to the popular diagnosis of alcoholism as a disease. On the other hand, the transfer to IHS has intimated loss of Indian control and aggravated existing resentments between reservation and urban Indian programs (the former are supervised by Area Offices while the latter report to Washington, D.C.'s central office) (Leland, 1979: 96).

Self-Determination in Southwest Oregon

In the field of Native American mental health, self-determination can be divided into three levels: the individual, the program, and the culture. In southwest Oregon, the cultural level is found in its broadest, Pan-Indian, sense as well as in its tribal heterogeneity. Unfortunately, self-determination is also linked to Indian status. For indigenous Oregon Natives, it is a matter of gaining tribal recognition and recovering traditions that are important to improving their self-perceptions and general mental health. For immigrant Native Americans, self-determination means

keeping a tribal identity and surviving reservation dependency. For all of these people, it demands that alternatives to the existing non-Indian mental health care system be made and kept available.

As long as medicine people and spiritual leaders are free to practice their medicine/religion, then Native Americans will have the option to utilize these most traditional of Indian providers. One gets the idea, however, that despite politically observable advances in this area, constant government harassment plagues the better known, more influential members of this group. It is said that medicine people are kept under closer scrutiny than Indian militant leaders due to their strong influence on Indian decision-making. If this is true, one must question the restraints it puts on their healing abilities.

Self-determination among southwest Oregon programs utilizing traditional providers is also unnecessarily related to tribal and individual Indian status. As Bittker (1973: 173) indicates, off-reservation and urban Indians are caught in a Catch-22 situation: the government considers them federal wards, yet denies them federal services.

> It seems by Indian Health policy provisions that off-reservation Indians <u>are</u> included .... Mitigating against this interpretation, however, is the presumed "intent of Congress" to consider Indian people who leave the reservation as beyond the scope of federal programs. The "intent" is reflected in Congressional funding patterns which maintain a studied reluctance to consider off-reservation consumers when funding IHS facilities (Bittker, 1973: 176).

This attitude is further perpetuated by State and local attitudes toward Indian people. Lack of communication between and within agencies makes staff members unaware of Indian resources in their own organizations and communities. Insufficient knowledge of cross-cultural issues causes indifference within county mental health programs, and therefore denies Native Americans appropriate and desirable treatment through the one established and allowed system. State or county funding for Indian providers requires more "proof" that their services are needed. One hardly expects corroboration to come from mental health agencies who are competing for the same funds.

Self-determination for Indian mental health care providers in southwest Oregon depends primarily on the persistance of Native Americans in that area. Existing Indian programs are held together by the efforts of a relatively small number of hard-working individuals. Traditional providers are attracted to these programs because they offer a meeting place for the generally fragmented and "invisible" Indian population. Yet it is unlikely that funding agencies or resource networks will heed Indian requests for assistance until a larger, more vocal group of Native Americans is able to articulate their needs in non-Indian terms. Sadly, this returns to the root of the self-determination issue -- Native Americans can do what they please as long as it fits into the political and economic regulations of the dominant society.

Self-determination at a personal level is also important. To the traditionally-oriented Native American, self-determination is a way of life. In a sense it is a stubborn insistence that, "I will be who I want to be," even if it doesn't always turn out that way. Traditional providers understand this attitude and realize the extent to which standard social work intervention opposes it (Good Tracks, 1973: 30). For these providers, Indian mental health rehabilitation goes beyond accepting their past -- it lets their viable heritage be a part of them. It takes away the causes for mental health problems, not their symptoms.

> For the reservation Indian, this may mean becoming more of a traditionalist, seeking answers within the Native religion and lifestyle of ceremonialism .... For the urban Indian who cannot readily go back to a life that was never his, helping him recover is helping him to develop and refine urban coping skills to survive within the metropolitan milieu. He must be habilitated, with new skills and knowledge and a sense of his/her heritage created which adapts to the new environment (Dumore, 1980: 5).

Integrity vs. Integration

Considerable success has been found in the Pacific Northwest where integration of traditional Indian "therapies" with Western health care systems has evolved (e.g., Shore, 1977; Jilek-AAll, 1976). In these situations, careful thought has been given to the critical differences between typically western psychotherapists and traditionally-oriented Native clients. Conclusions suggest that western-

trained therapists can be culturally sensitized to treat Native American clients, but they must also be taught to recognize when a traditional Native healer should be used. Level of acculturation and adherence to traditional values and beliefs must be included in diagnosis and consequent treatment.

Additionally, it is proposed that working relationships with Native providers can be arranged so that the basic integrity of the Native healing system will not be disturbed. This depends, in part, on the provider's personal charisma -- whether or not he/she is accepted by the professional and general Indian community. It is also dependent, once again, on the abilities of mental health personnel to create and sustain such a relationship.

Finally, it is recognized that Indian people themselves can be valuable assets to a structured mental health system. This is based on the fact that some Indian people will always prefer or require a less traditionally-oriented system, but one which acknowledges their Native identity. For these people it is often more beneficial to discuss their problems with another Native person.

Resistance to the integration of the traditional healing system with Western health care comes primarily from Native Americans who honor the privacy of traditional Native healing and its practioners. They want to see what is left of it remain intact. Further caution is made against current

inclinations toward placing Indian medicine "under the guise of holistic health;" it is feared that medicine people will be imperiled by the "dominant medical and bureaucratic processes" which "can only subvert spiritually individualized services into a standard item of health care" (Bates, 1980:1). Distrust of non-Indian health care systems is deeply rooted, and traditionalists cringe at the thought of integration's probable results:

> What do I do? Nobody can tell you that. That's mine .... There's nothing to buy -- no amount of money can buy this .... offering money is an insult .... I have nothing to sell! .... If I follow the Indian views completely, then I'm going to be protected (Rolling Thunder, Shoshone medicine man) (Bates, 1980: 20).

Outlook for the Future

It has been suggested that southwest Oregon Native Americans are in a transitional phase in terms of mental health care. Generally it is a phase of awakening to the prospects of new alternatives -- alternatives that address Indian identity, issues relating to treatment barriers, and restoration of the old spiritual ways of life. Traditional providers -- medicine people, spiritual leaders, Indian alcohol programs, and professional Native peoples -- have contributed greatly to this awakening period. Services are beginning to establish themselves within the communities and county service networks.

The transition will continue as non-Indian providers realize their inadequacies and Native peoples become more convinced and articulate about their diverse needs and wants. It is primarily a transition that will take place locally as awareness grows in both groups and better communication develops. Given increasing economic limitations which are seriously threatening urban and off- reservation Indian programs (and affecting the State Mental Health system as well), it will be necessary to use local networks and expertise to their best advantage. For Native Americans who suffer from mental health problems, the option of using traditionally-oriented providers must be encouraged even more within the context of their own self-determination.

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Appendix A

IHS Definition of "Indian"
IHS Eligibility Requirements for Medical Care

IHS Definition of "Indian"
(from Dumore, 1980: 8)

As currently recognized by IHS, this definition of an "Indian" means a person of Indian descent who:

(1) Is a member of any recognized Indian tribe now under Federal jurisdiction;

(2) Is a descendant of such members who were, on June 1, 1934, residing within the present boundaries of any reservation;

(3) All other individuals of one-half or more Indian blood, from tribes indigenous to the United States;

(4) Eskimos and other aboriginal peoples of Alaska;

(5) Until September 24, 1979, a descendent of at least one-quarter degree Indian ancestry of a currently federally recognized tribe whose rolls have been closed by an act of Congress.

The IHS definition excludes those peoples who have gone through termination and whose descendents are not able to be recognized by the Federal Register of August 13, 1954.

IHS Eligibility Requirements for Medical Care
(from Bittker, 1973: 176)

Persons to Whom Services May be Provided

A person may be regarded as within the scope of the Indian Health program if he is not otherwise excluded therefrom by provision of law, and:

A. Is of Indian and/or Alaska Native descent as evidenced by one or more of the following factors:

   (1) Is regarded by the community in which he lives as an Indian or Alaska Native;

   (2) Is a member, enrolled or otherwise, of an Indian or Alaska Native tribe or group under federal supervision;

   (3) Resides on tax-exempt land or owns restricted property;

   (4) Actively participates in tribal affairs;

   (5) Any other reasonable factor indicative of Indian descent; or

B. Is an Indian of Canadian or Mexican origin recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program; or

C. Is a dependent (Indian or non-Indian) of a person qualifying under A or B above, and resides in the household of such qualifying person (Indian Health Manual 1971).

Appendix B

Service Provider Questionnaire (SPQ)

Southwest Oregon Indian Health Project

Questionnaire for Mental Health Professionals

1. What # of Indians do you/your agency see each month/year?
   a. How are they identified? Are they? By whom?
   b. Is this a satisfactory method? Why/why not?

2. What data/types of data do you have? How much is available to us? Do you know:
   a. # of Indians treated vs. treated population in general?
   b. % of Indians who return for further treatment?
      % successfully treated?
   c. # of voluntary clients/court referrals/professional referrals?
   d. # of Indians committed to the State Hospital?

3. What process does a client go through when he/she comes to your agency?
   a. What is the diagnostic process? If "chronic", then how is "chronic mental illness" defined? What categorical distinctions do you make? Is this process Indian specific? In what way?
   b. Do you distinguish differences between/within Indian groups (i.e., native vs. immigrant)?
   c. What would you characterize as the major causes for severe mental illness among Indians? Is this true for the population in general?
   d. Where/to whom do you make/receive Indian referrals?

4. What experience do you have in providing services to Indian clients?
   a. As mental health professionals, are you required to have training in cross-cultural counseling/treatment?
   b. What is your background personally? Is it Indian specific?
   c. Do you see this as important? Why/why not? Could it be improved? How?

5. Do you utilize professional/support personnel from the Indian community?
   a. Do you have Indian people working for you? How many? In what capacity?
   b. How would you evaluate their effectiveness in dealing with other Indians/Indian specific issues?

6. Have you developed programs/strategies which have been especially useful in treating Indians?
   a. If so, what are they? Who designed them? How is their effectiveness measured?
   b. In what way are they distinguished from other treatment programs? How successful have they been? What is your assessment process?
   c. Do Indians come to your agency aware of an Indian specific program/strategy? How is it made known to them?
   d. How would you characterize communication between your agency and the Indian community in your area? What would improve it?
   e. If no Indian specific programs/strategies exist, are they warranted?

7. How do you perceive the relationship between mental health treatment and incarceration?
   a. Do you feel there is adequate responsiveness to mental health problems vs. commitments/incarceration in general?
   b. Are there issues that relate specifically to the Indian community?

8. Ideally, what services would you like to see developed for mentally ill Indians? For the mentally ill in general?
   a. What are the strengths/weaknesses of your program? What additional services would you like to be involved with/see created?
   b. What are your perceptions of what is going on elsewhere? Are you aware of other specifically Indian oriented mental health programs?

Note: If you have any suggestions regarding programs, people, additional questions, etc., then please let us know. Thank you.

Appendix C

Oregon Quality of Life Questionnaire (OQLQ)

Your counselor may have done some of the things listed below. These questions ask how helpful you feel these things were.

Did your counselor listen to you?	yes no	DK/R
Did listening have an effect?	yes no	DK/R
Was listening helpful or harmful?	very helpful helpful no effect harmful very harmful	DK/R DNA
Did your counselor care about you?	yes no	DK/R
Did caring have an effect?	very helpful helpful no effect harmful very harmful	DK/R DNA
Did your counselor encourage you?	yes no	DK/R
Did encouraging have an effect? ... helpful or harmful?	very helpful helpful no effect harmful very harmful	DK/R DNA
Did your counselor attempt to calm your worries?	yes no	DK/R
Did calming your worries have an effect? ... helpful or harmful?	very helpful helpful no effect harmful very harmful	DK/R DNA
Did your counselor try to help you understand yourself -- the way you feel, think, and behave and why?	yes no	DK/R
Did working on your self-understanding have an effect? ... helpful or harmful?	very helpful helpful no effect harmful very harmful	DK/R DNA

Did your counselor tell you about housing, jobs, services, and other things which are available to meet your needs in the community?

yes no DK/R

Did telling you about things have an effect? ...helpful or harmful?

very helpful DK/R
helpful DNA
no effect
harmful
very harmful

Was your counselor sensitive to your cultural differences?

very sensitive DK/R
sensitive DNA
indifferent
insensitive
very insensitive

Did your counselor set limits for you or try to help to change your problem behaviors?

yes no DK/R

Did the limits that were set show an understanding of Indian people?

yes no DK/R

Did setting limits have an effect? ... helpful or harmful?

very helpful DK/R
helpful DNA
no effect
harmful
very harmful

Did the counselor make you feel that you could rely on him/her?

yes no DK/R

Did that have an effect? ...helpful or harmful?

very helpful DK/R
helpful DNA
no effect
harmful
very harmful

Was your counselor also an Indian?

yes no DK/R

Did that have an effect? ... helpful or harmful?

very helpful DK/R
helpful DNA
no effect
harmful
very harmful

On the whole, did your counselor have an effect on your problem? ... helpful or harmful?

very helpful
helpful
no effect
harmful
very harmful
DK/R
DNA

The following are some other services your counselor may have provided for you.

Did _____ help you get hospitalization?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ help you in being discharged from the hospital?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ provide emergency service?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ provide (or help you with) medications?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ try to help you obtain income, medical benefits?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ try to help you find housing?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ help you with transportation?

provided
helped get
got elsewhere by self
did not get
DK/R
DNA

Did ____ help you with your family?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ help you with your friends?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ help you get contact with other people?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ provide (or help you get) job training or job counseling?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ provide or help you get a job?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ provide support for you?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ provide daytime, evening, or weekend activities for you?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ help you with school?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ help you with legal problems?

provided DK/R
helped get DNA
got elsewhere by self
did not get

Did ____ help you make contact with any Indian programs?

provided DK/R
helped get DNA
got elsewhere by self
did not get

These questions ask about help you got from people and services other than ____.

Did you have friends?	yes	no	DK/R
Did friends have an effect on the problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Do you have any religious associations?	yes	no	DK/R
Do you consider your religious associations traditional?	yes	no	DK/R
Did religious associations affect your problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Did you have a counselor in other programs or a private counselor?	yes	no	DK/R
Did other counselor(s) have an effect? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Did keeping busy have an effect on the problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Did being with people have an effect on the problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Did you do physical activity?	yes	no	DK/R

Did the activity have any effect on the problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Did your family have an effect on the problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Did you have a family doctor?	yes	no	DK/R
Did the family doctor have an effect on the problem? ... helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Does your family doctor use any traditional healing methods?	yes	no	DK/R
Would you consult a traditional healer on this matter?	yes	no	DK/R
Have you ever consulted a traditional healer on other matters?	yes	no	DK/R
Did you find traditional methods to be helpful or harmful?	very helpful helpful no effect harmful very harmful		DK/R DNA
Would you be willing to discuss this alternative treatment with someone at a later time?	yes	no	DK/R

These questions ask about the services you received at ____.

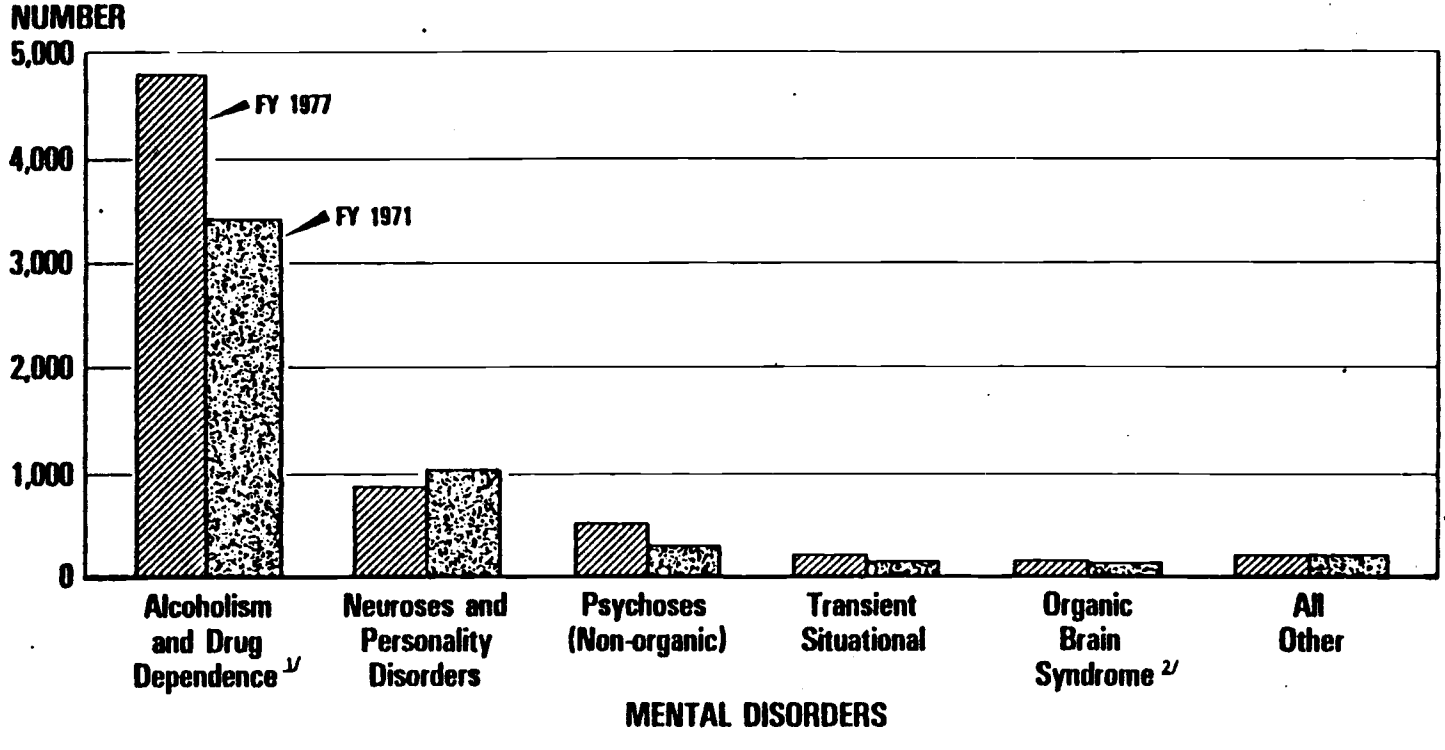
Did you have any difficulty finding out about ____?	yes	no	DK/R

Did you have any difficulty getting into ____?	yes	no	DK/R
Did you come to ____ voluntarily?	yes	no	DK/R
When you came to ____, did the receptionist make you feel comfortable?	yes	no	DK/R
Was the waiting room satisfactory -- its comfort, privacy, quietness, etc.?	yes	no	DK/R
Was your first contact with ____ satisfactory (when you discussed why you had come, etc.)?	yes	no	DK/R
Was your counselor's attitude toward you satisfactory?	yes	no	DK/R
Was your counselor accessible to you - could you get to your counselor when you needed to?	yes	no	DK/R
Did you have any trouble with appointments because of distance or time of the appointment, etc.?	yes	no	DK/R
Was the attitude of staff toward you as a client satisfactory?	yes	no	DK/R
Was the decision to end your participation in ____made in a satisfactory way?	yes	no	DK/R
Were you satisfied with the way you were charged?	yes	no	DK/R
Did you get the kind of service you wanted?	yes	no	DK/R
If you were to seek help again, would you go back to ____?	yes	no	DK/R
Do you have any comments, criticisms, or suggestions about ____?	yes	no	DK/R

Appendix D

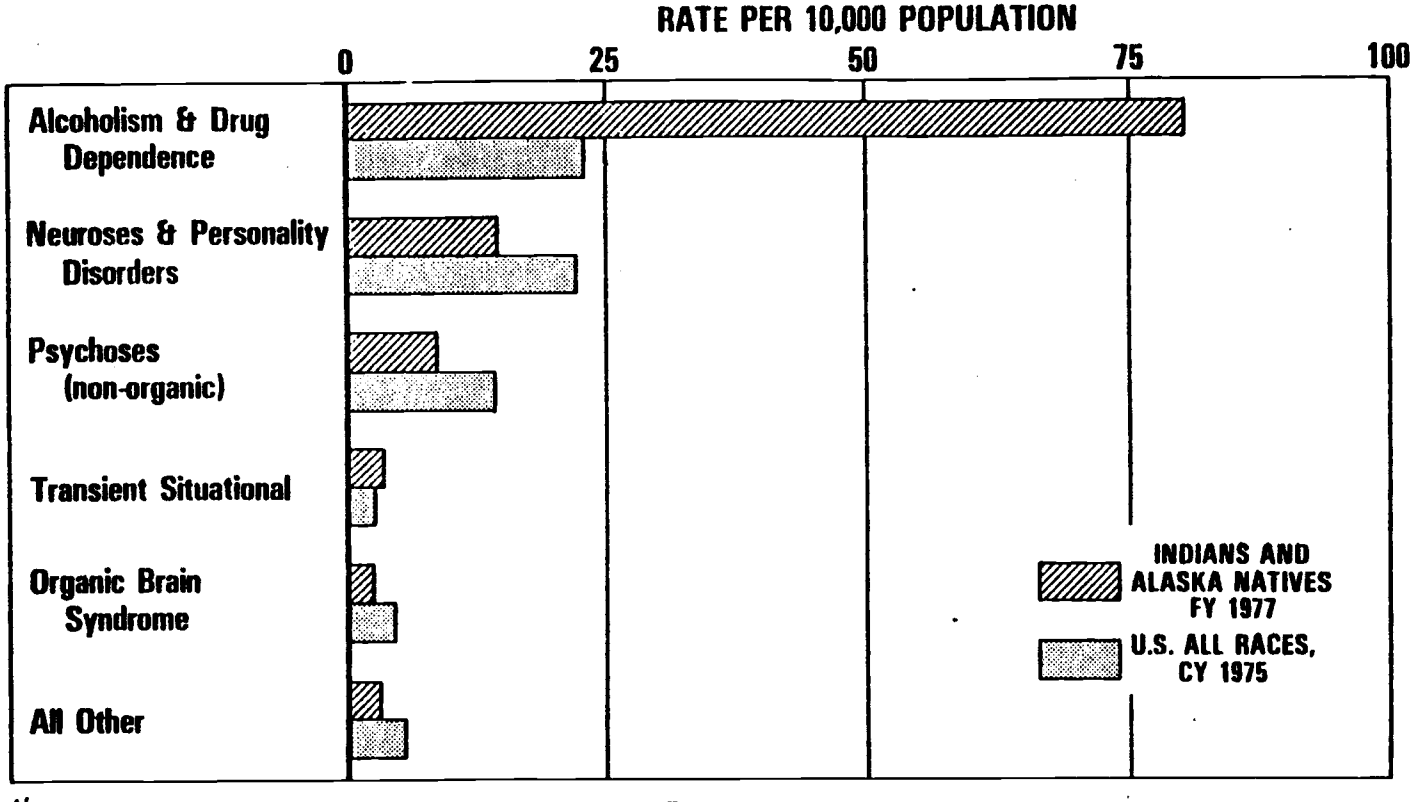
Native American Mental Health Status

NUMBER OF DISCHARGES FROM IHS AND CONTRACT HOSPITALS
BY TYPE OF MENTAL DISORDER
FISCAL YEARS 1971 AND 1977



From:
'Trajectory of Indian Health Care'
Indian Health Service (IHS) Data,
1976

DISCHARGE[1/] RATES FOR MENTAL DISORDERS
INDIANS AND ALASKA NATIVES, U.S. ALL RACES

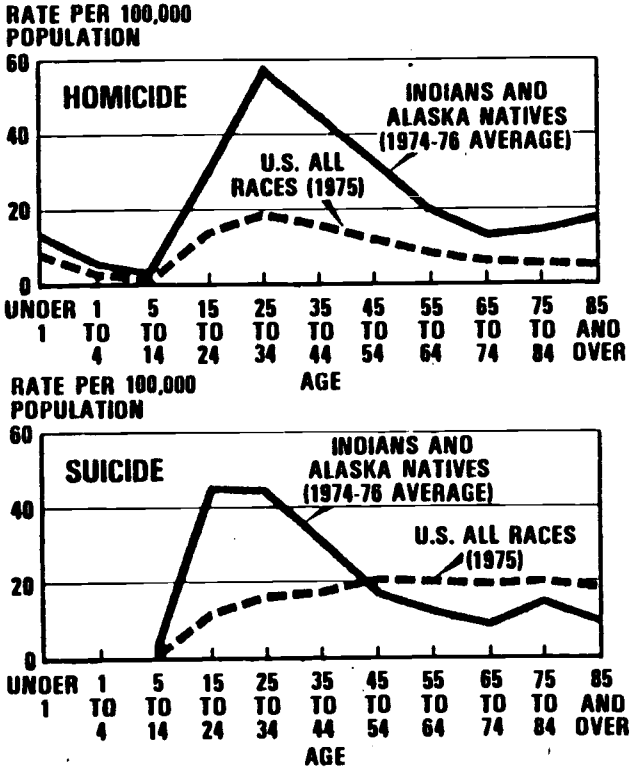


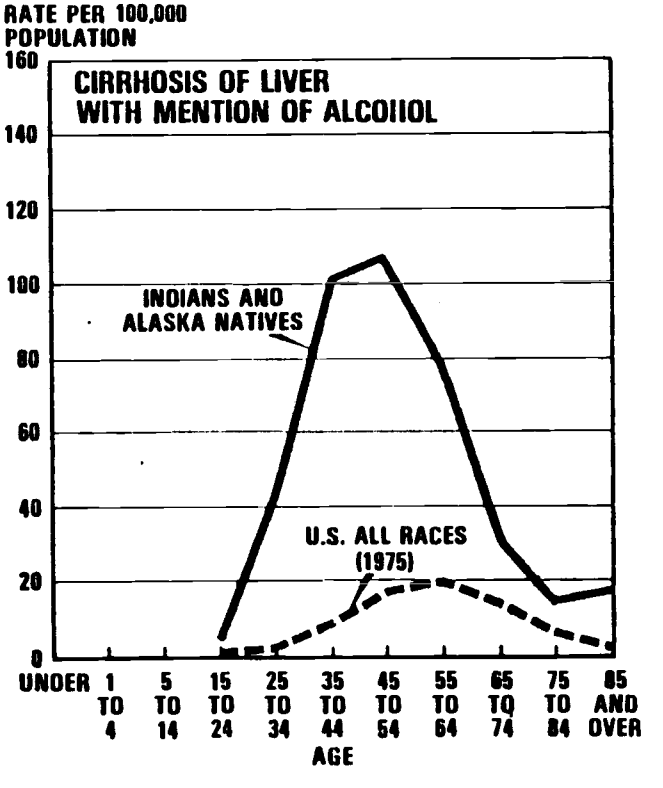
[1/] IHS AND CONTRACT HOSPITAL.

From:
'Trajectory of Indian Health Care'
Indian Health Service (IHS) Data,
1976

AGE SPECIFIC HOMICIDE, SUICIDE, AND CIRRHOSIS OF LIVER DEATH RATE

INDIANS AND ALASKA NATIVES, U.S. ALL RACES





From:

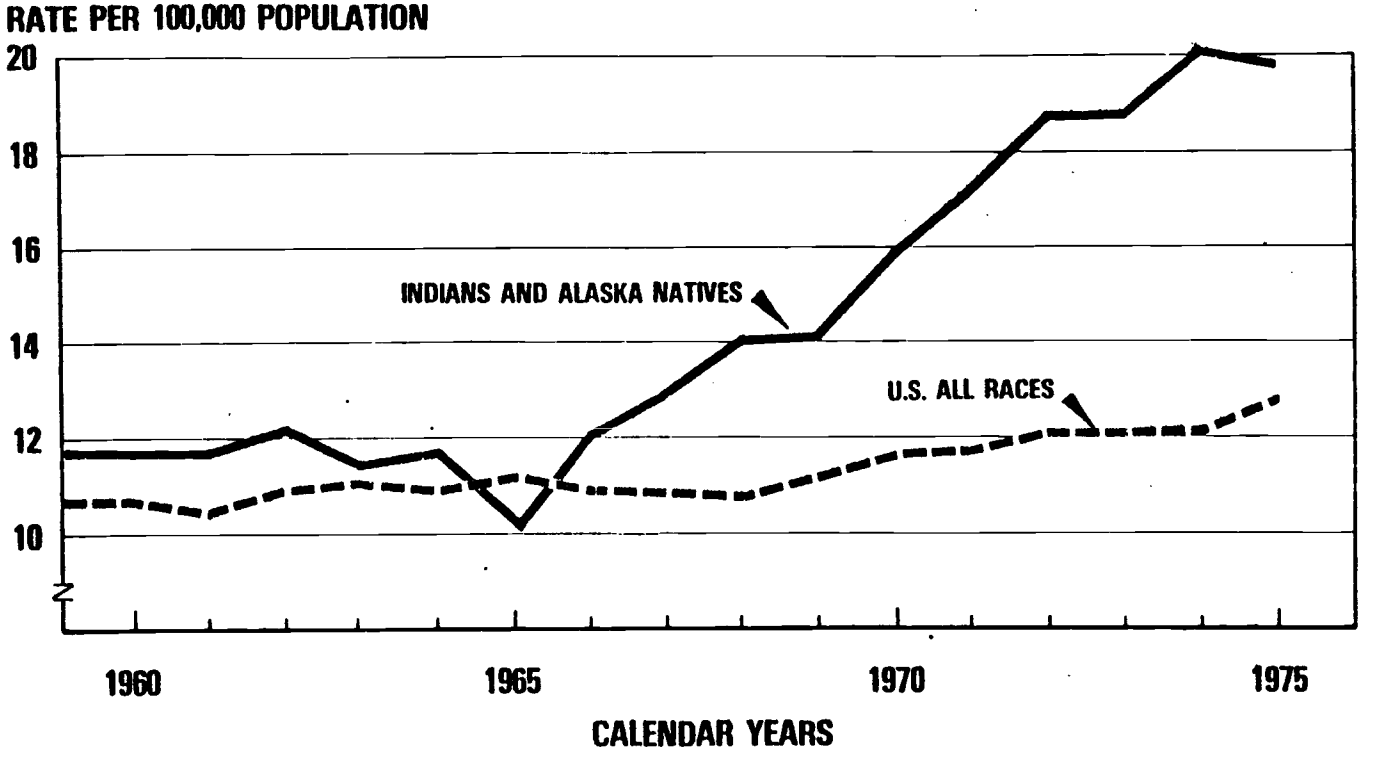
'Trajectory of Indian Health Care'

Indian Health Service (IHS) Data

1976

SUICIDE DEATH RATES

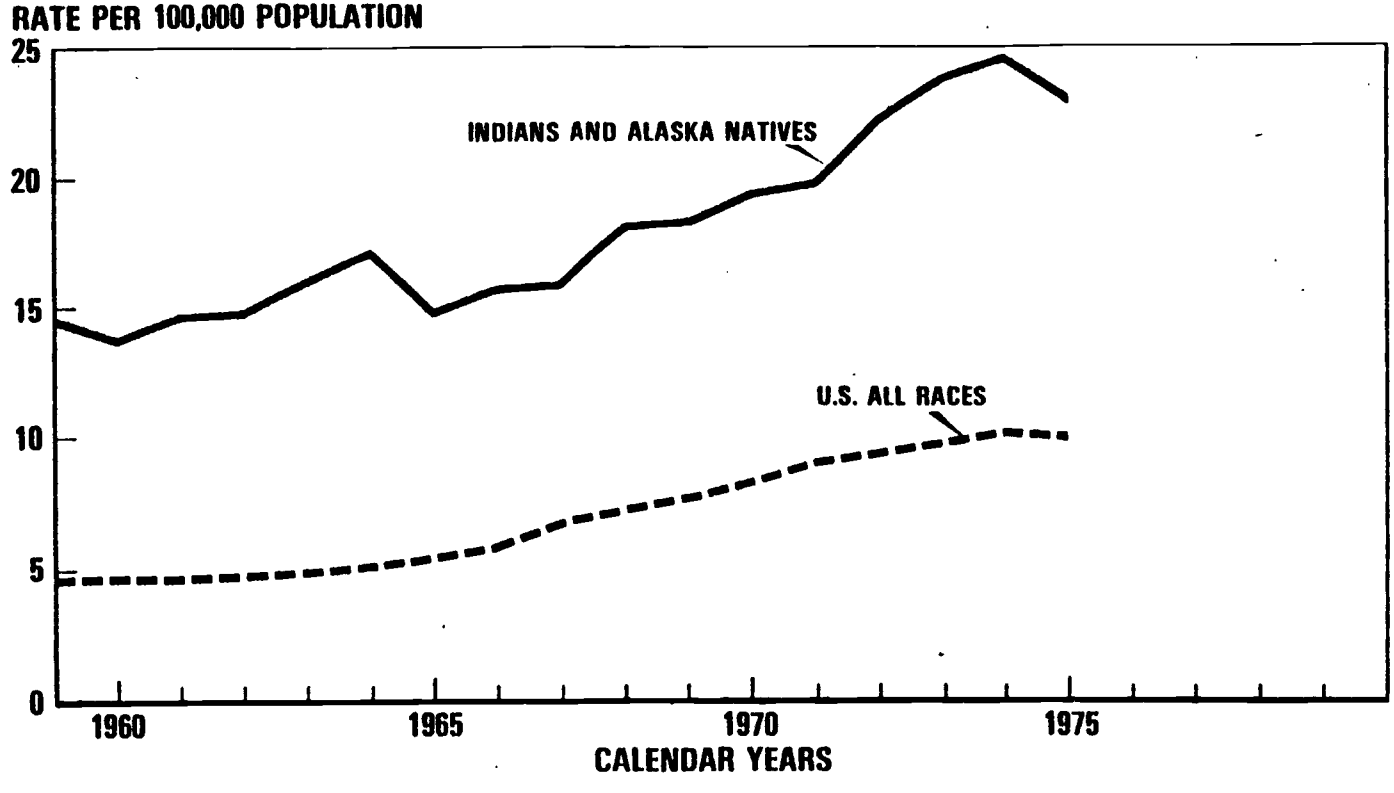
INDIANS AND ALASKA NATIVES, U.S. ALL RACES



INDIAN AND ALASKA NATIVE RATES ARE BASED ON 3-YEAR MOVING AVERAGE CENTERED AT YEAR SPECIFIED (E.G. 1975 AVERAGE = DEATHS IN 1974-1976). U.S. ALL RACES RATES ARE SINGLE YEAR.

From:
'Trajectory of Indian Health Care'
Indian Health Service (IHS) Data
1976

HOMICIDE DEATH RATES
INDIANS AND ALASKA NATIVES, AND U.S. ALL RACES



INDIAN AND ALASKA NATIVE RATES ARE BASED ON 3-YEAR MOVING AVERAGES CENTERED AT THE YEAR SPECIFIED. (E.G. 1975 AVERAGE = DEATHS IN 1974-1976). U.S. ALL RACES RATES ARE SINGLE YEAR.

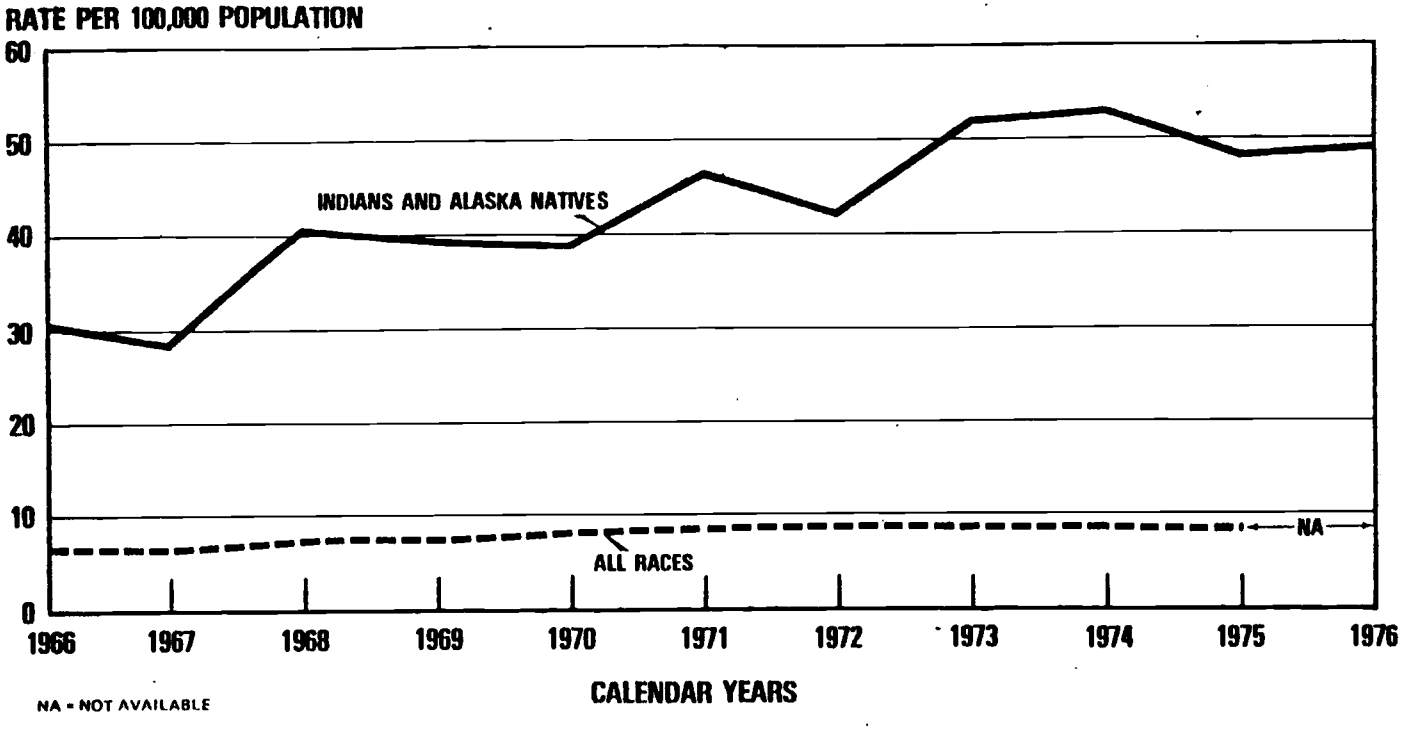
From:

'Trajectory of Indian Health Care'

Indian Health Service (IHS) Data

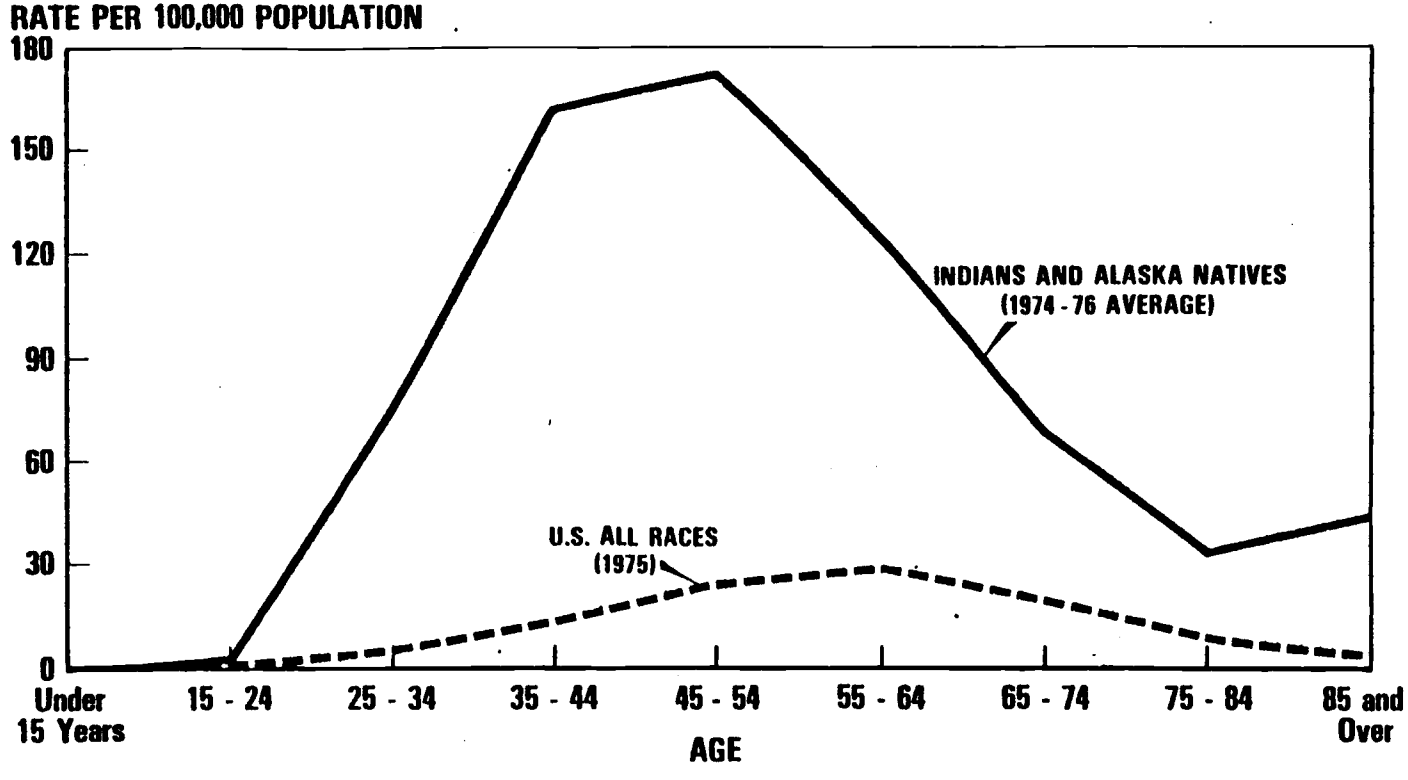
1976

ALCOHOLISM DEATH RATES
INDIANS AND ALASKA NATIVES COMPARED TO U.S. ALL RACES



From:
'Trajectory of Indian Health Care'
Indian Health Service (IHS) Data
1976

AGE SPECIFIC ALCOHOLISM DEATH RATES
INDIANS AND ALASKA NATIVES, U.S. ALL RACES



From:
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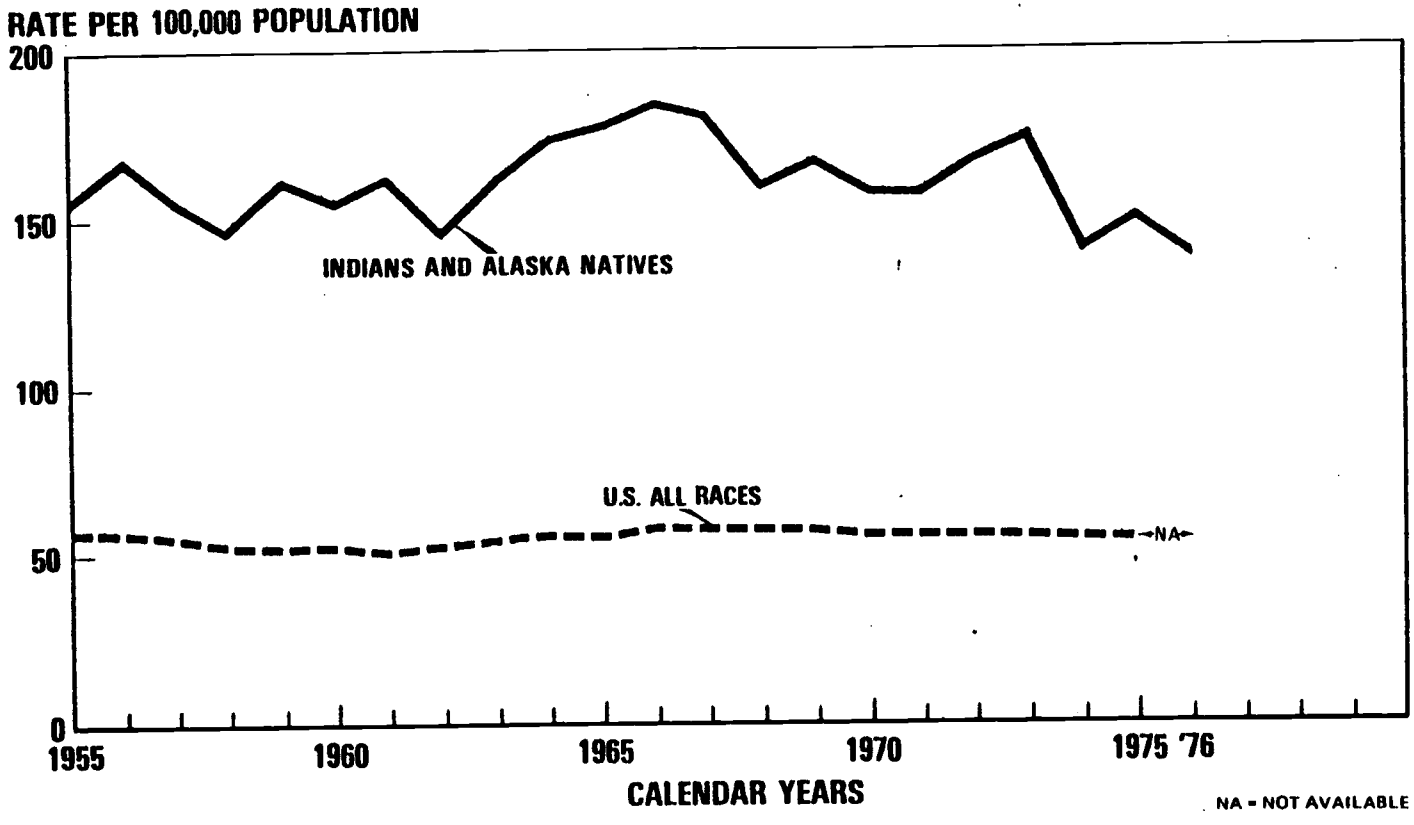
Indian Health Service (IHS) Data
1976

ACCIDENT DEATH RATES
INDIANS AND ALASKA NATIVES, U.S. ALL RACES



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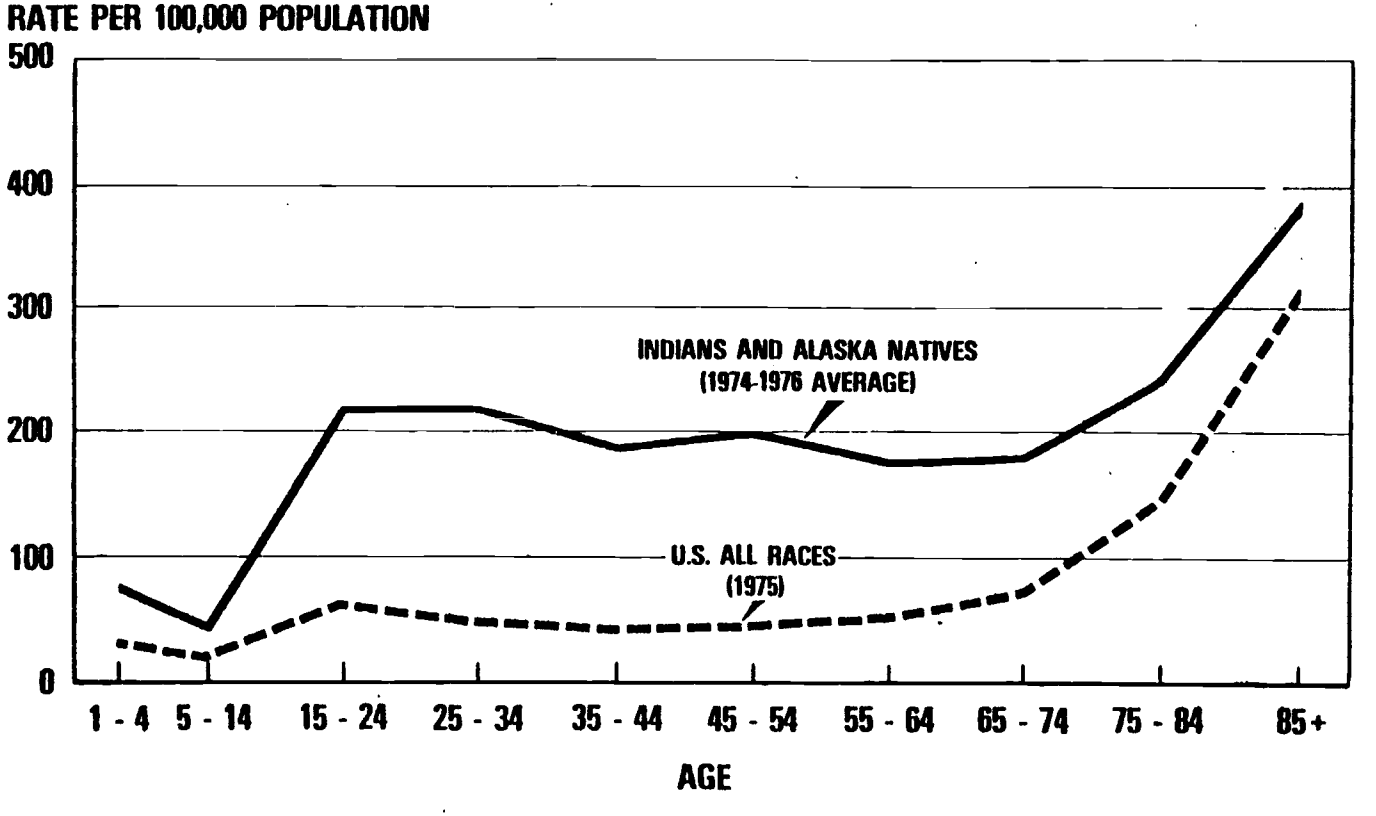
'Trajectory of Indian Health Care'
Indian Health Service (IHS) Data
1976

AGE SPECIFIC ACCIDENT DEATH RATES
INDIANS AND ALASKA NATIVES, U.S. ALL RACES



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'Trajectory of Indian Health Care'
Indian Health Service (IHS) Data
1976

Appendix E

Native American Alcoholics Anonymous -- 12 Steps to Sobriety

PUBLISHED BY THE:

UMATILLA TRIBAL ALCOHOL PROGRAM
PENDLETON, OREGON 97801

AND

NORTHWEST INDIAN TRAINING INSTITUTE
OLD GARFIELD SCHOOL
528 COTTAGE STREET, N.E.
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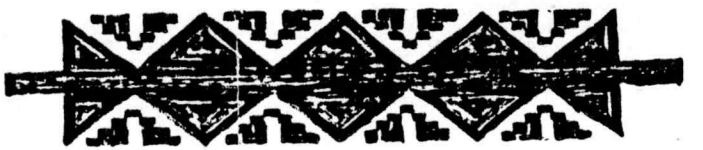
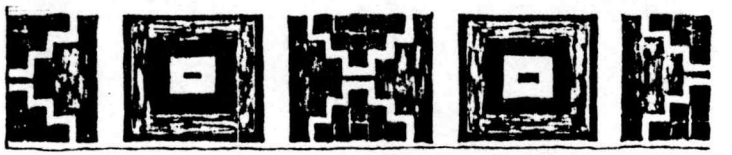


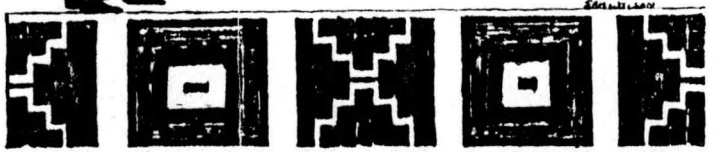
BASED ON THE TWELVE STEPS
OF ALCOHOLICS ANONYMOUS
AND ESPECIALLY PREPARED
FOR NATIVE AMERICANS
BY THE UMATILLA TRIBAL
ALCOHOL PROGRAM

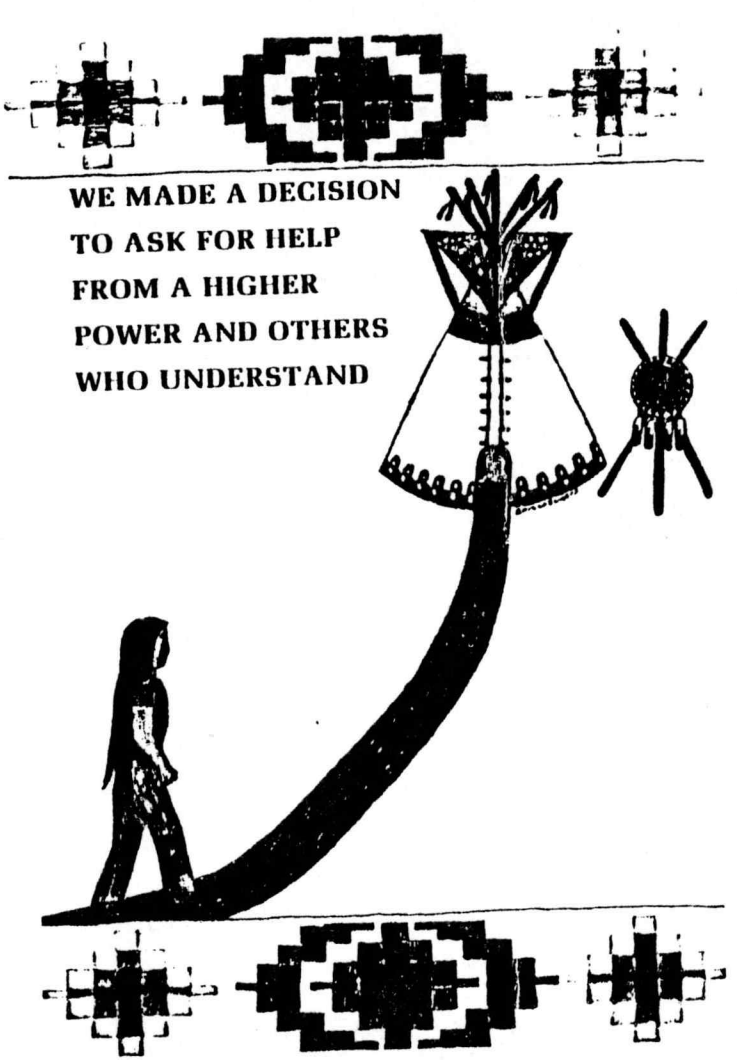
ARTIST: SAM WILSON

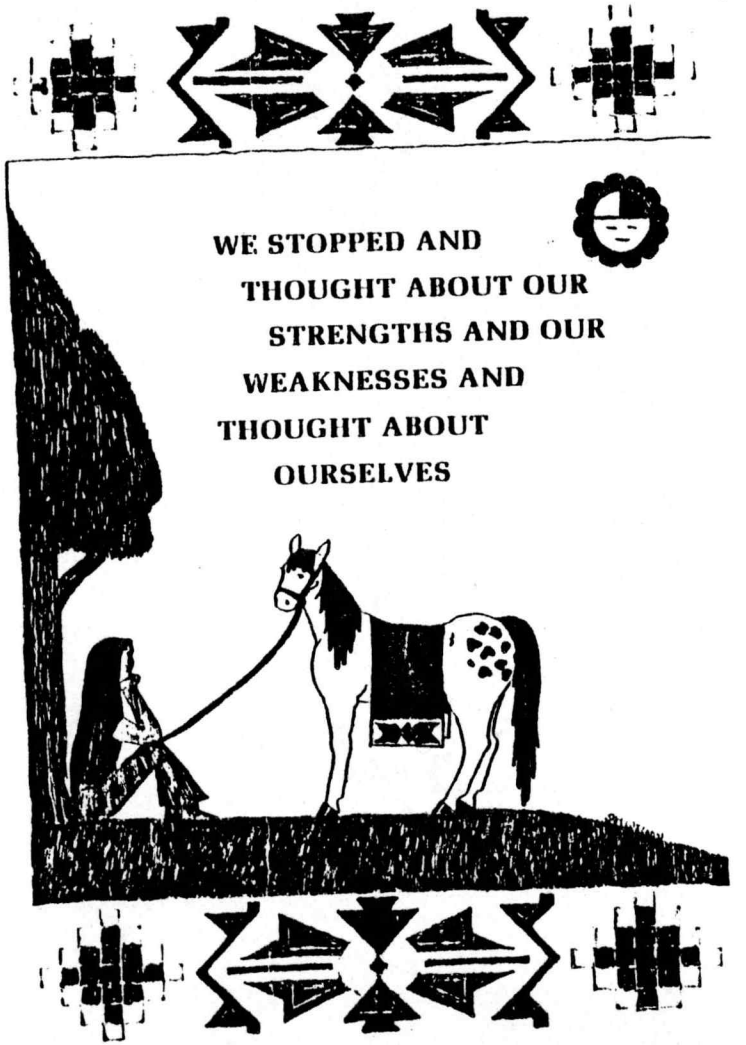
WE ADMITTED WE
WERE POWERLESS
OVER ALCOHOL—
THAT WE HAD
LOST CONTROL
OF OUR LIVES

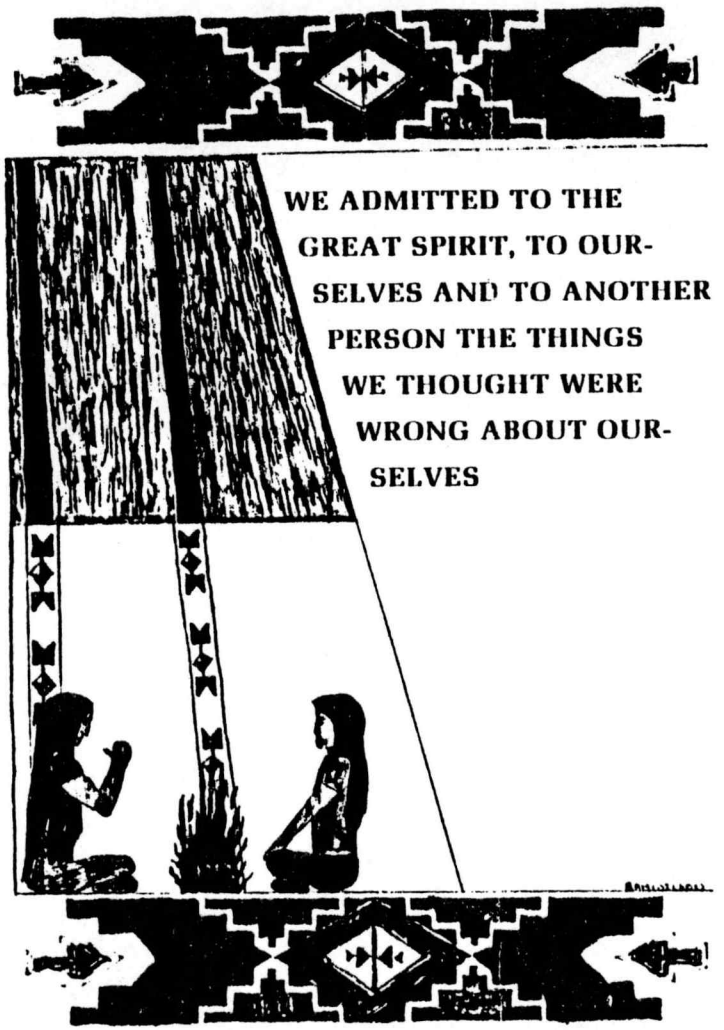


WE CAME TO BELIEVE
THAT A POWER
GREATER THAN
OURSELVES COULD
HELP US REGAIN
CONTROL




WE MADE A DECISION
TO ASK FOR HELP
FROM A HIGHER
POWER AND OTHERS
WHO UNDERSTAND


WE STOPPED AND
THOUGHT ABOUT OUR
STRENGTHS AND OUR
WEAKNESSES AND
THOUGHT ABOUT
OURSELVES



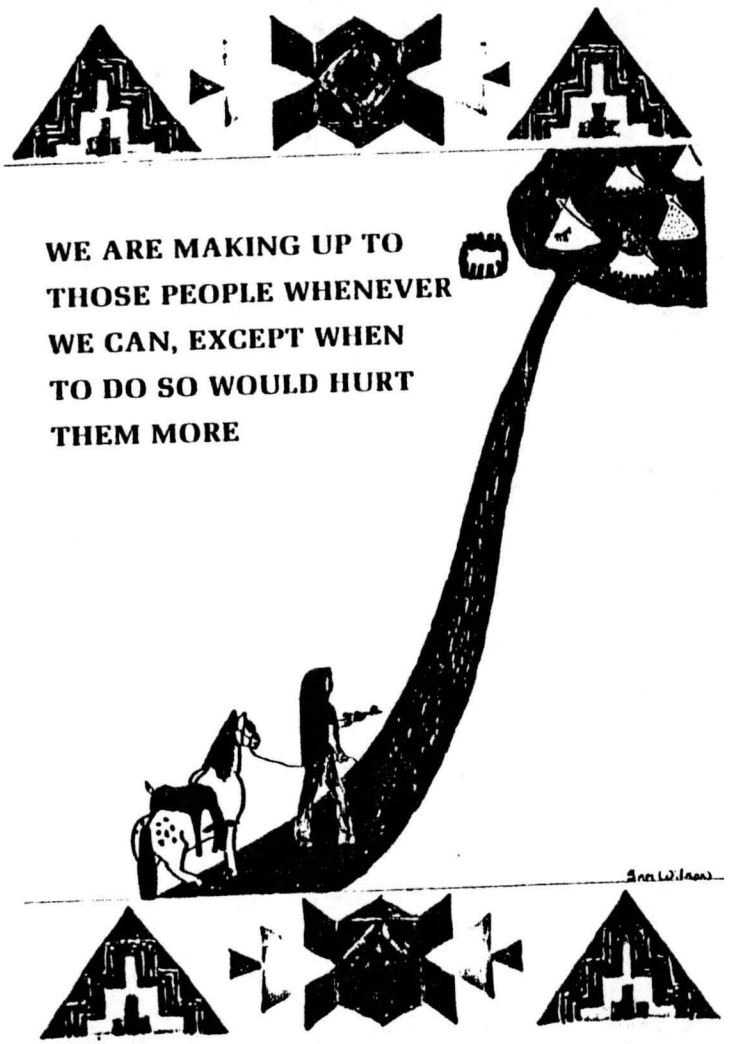
WE ADMITTED TO THE GREAT SPIRIT, TO OURSELVES AND TO ANOTHER PERSON THE THINGS WE THOUGHT WERE WRONG ABOUT OURSELVES

WE ARE READY, WITH THE HELP OF THE GREAT SPIRIT, TO CHANGE

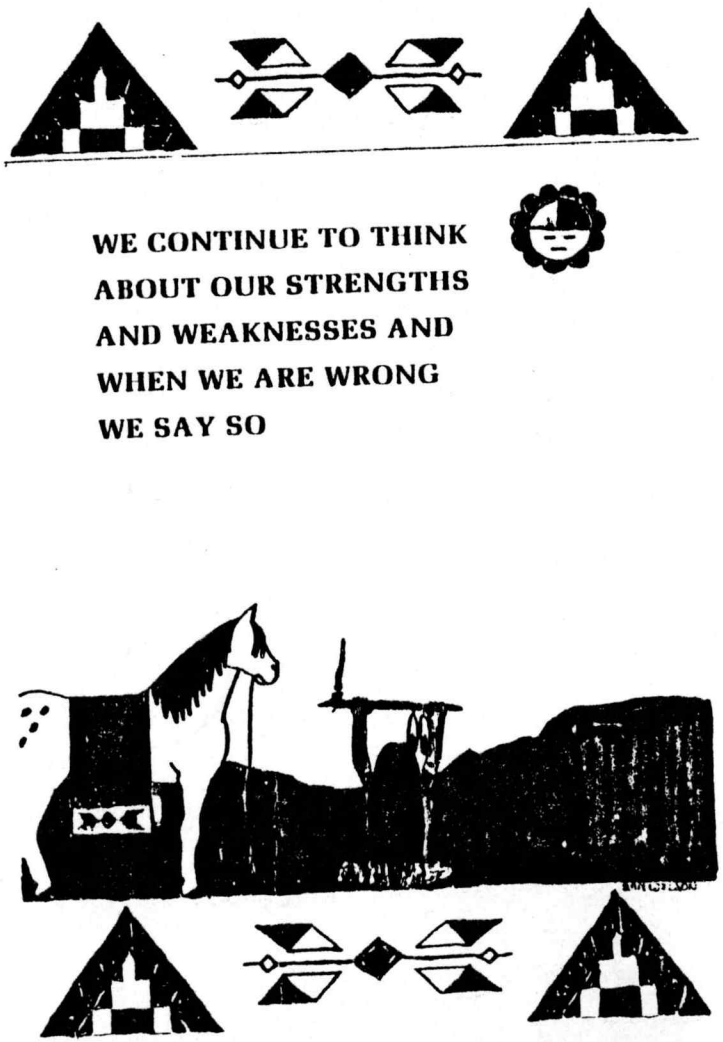
WE HUMBLY ASK
A HIGHER POWER
AND OUR FRIENDS
TO HELP US CHANGE

WE MADE A LIST OF
PEOPLE WHO WERE
HURT BY OUR

DRINKING AND WANT
TO MAKE UP FOR
THESE HURTS



WE ARE MAKING UP TO
THOSE PEOPLE WHENEVER
WE CAN, EXCEPT WHEN
TO DO SO WOULD HURT
THEM MORE



WE CONTINUE TO THINK
ABOUT OUR STRENGTHS
AND WEAKNESSES AND
WHEN WE ARE WRONG
WE SAY SO