Colonization and Madness: Involuntary Psychiatric Commitment Law and Policy Frameworks as Applied to American Indians

by

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ABSTRACT

This dissertation project is a legal and policy analysis of California's involuntary psychiatric commitment laws and policy as applied to American Indians (AI). Mental health-based civil commitment and conservatorships constitute some of the most severe intrusions into personal liberties and freedom outside of the criminal justice system. In the context of AI peoples and tribal Nations, however, these intrusions implicate not only individual freedoms and well-being but also larger notions of tribal sovereignty, self-determination, culture, and the dialectic relationship between individual identity and community knowledge related to definitions of health, illness and the social meaning of difference. Yet, in the context of involuntary psychiatric commitments, the law reflects a failure to understand this relationship, alternating between strategic use of the sovereignty doctrine to deny access to services or, alternatively, wholly absenting issues of sovereignty and Indigenous worldviews from legal discourse. This project explores the nuanced ways in which these issues are weaved into the fabric of mental health law and policy and how they function to codify, enact and maintain colonization for AI peoples and Nations.

DEDICATION

It is a strange thing to write a dedication to my family knowing that no words will ever truly capture the depths of appreciation, love and thanks I wish to express to them for all they have done, all they have put up with, in getting me to the point of completing a dissertation. Through every anxiety-producing decision, every joy and every long road ahead, my family has been steadfast in their support, love and patience. A dedication in a dissertation hardly seems sufficient recognition. Nevertheless, I would like to take this moment to thank them for being mine, for sticking with me and for loving me no matter what. I love you all very much and appreciate each of you everyday.

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PREFACE

Writing on Indigenous law and policy as an outsider requires both a thoughtful approach grounded in mentorship and, I think, a bit of explanation regarding positionality and accountability with regards to who I am, how I came to this project, and what I intend in its writing. My name is Heather Robyn Gough. I am the daughter of Marcia and Richard, granddaughter of Max and Jean (Ženya) on my mother's side and granddaughter of Richard and Thelma on my father's side. My maternal family is Ashkenazi Jew with roots in Russia, having arrived on American shores after fleeing the Russian pogroms against Jewish families in the early 1900's and after losing all but three members of the family to the Holocaust. The lessons learned about the importance of homeland, of the potential for both good and evil ever present in human nature and the stories of loss but also of resistance and resilience formed a familial narrative – a way of knowing about the world, transmitted from generation to generation – a narrative that informs who I am and how I approach this work. I am also a sister to four siblings – one of whom is severely physically and developmentally disabled and in the course of my parents' fight to get him even the most basic services, I learned the importance of law and social work advocacy, both in terms of accessing rights and also how these professions can, at times, get in the way. There is much to say about my family, whom I love, but this is a short journey and so I will limit my comments here to say that they are my foundation: my roots and my sunlight and all that that implies.

In terms of the socio-political spaces I occupy, I move through the world as a middle class, Semitic/Anglo (though often perceived simply as white), bi-sexual woman,

able-bodied (generally) and well educated in formal academic institutions having trained as both a lawyer and a social worker. I came back to academia from practice in law and social work because I felt something was missing – that principles of justice and systemic uprootings of oppressive social structures had been disappeared from praxis – and I feared that my life would be spent upholding these systems of violence, kindly meting out spoonfuls of sorrow and injustice and growing fat on swallowing my own indignation and hurts when those same violent measures of exclusion deemed me an other, cast out of a social contract, cut by the very pen that wrote it.

This dissertation follows from my experience working as a social worker an attorney in mental health and foster care systems, often with Indigenous clients. It was there that I first came to realize the import of civil commitment/conservatorship law and colonization with regards to American Indian peoples and tribal nations. Although I followed the law dutifully and conducted my portion of the trials mindful of preserving as much human dignity as such hearings would allow, I nevertheless had the distinct impression that our efforts to save lives in grave danger were intimately intertwined with the realities of state power, colonization, and a serious disconnect between Western-centric notions of "helping" and the varied worldviews of American Indians subject to this system. I entered my Ph.D. program deeply troubled by what I had seen regarding the experiences of American Indians in mental health law, haunted by the silences, the things professionals never acknowledged, the poor outcomes and stories of suicide or clients jumping out of second story windows to escape coercive helping. I returned to school to understand and with the hope of doing things differently, better. I took courses related to Indigenous epistemologies, ontologies, axiologies, and research methodologies taught by

Indigenous scholars. I listened, a lot. I found that my experiences in the courtroom were echoed in the decades worth of work by Indian nations, community members and tribal advocacy groups to reform federal law governing Indian health care, particularly in their efforts to reform behavioral health services and to bring the law in line with the wide range of Indigenous values regarding care, wellness, and Indian self-determination (for discussion, see e.g., Somers, 2010; see also Reforming the Indian Health Care System, 2009). I continued reading Indigenous scholarship and learned not just to hear but to listen.

Slowly, I began re-orienting my thinking, gaining a vocabulary to both describe and critique what I had seen as an attorney/social worker. In learning these things, my aim was never to claim (or usurp) any sort of expertise or authority in Indigenous worldviews – I was (and am) clear about my status as an outsider and understand the deeply harmful impacts for Indigenous peoples associated with the piracy of knowledges and histories by non-Indigenous scholars. I have listened deeply to the admonitions of Indigenous scholars such as Linda Tuhiwai Smith, Vine Deloria, and many others about the harms of research through Western eyes – of research *on* Indigenous peoples or research done for communities with no community guidance, with no tangible benefit to them, and no control over knowledge, disseminated as afterthoughts with little or no accountability - often times getting it wrong and leaving behind caricatures of Indigenous peoples that at times have become internalized as grotesque "truths." I also paid heed to the wide-ranging discussions on when, how and if ever non-Indigenous allies should be involved in research with American Indian communities. I have sought much guidance as to whether I have any place in conducting this research at all and if so,

to what extent my role and the research itself should be limited. After much consultation and thought about the relationship between research, colonization, respect and accountability, I chose to limit the scope of the project to elucidating the connections between colonization and the law and policy of mental health – making the systems the object of the research - and to offer this research as a point of discussion, one of many beginning points for actual change. It is offered as a tool of sorts that could be used if it were found to be helpful to AI communities and, perhaps equally as important, as a point of reflection for non-Indigenous power-brokers in mental health, a call and a sign post for doing things differently, for listening and making change collaboratively. There is more to it than this summary provides but my hope is that this preface is, at a minimum, a starting point for me as a writer and for the reader, a set of coordinates to locate the geo-political space in which I live, write and humbly offer these thoughts.

Chapter 1

Introduction

We begin with this journey on the relationship between colonization and mental health law/policy with the story of Rita Quintero. I am going to tell you some things – things about Rita and I want you to pay attention to these things because they will become very important in just a minute. Rita Quintero is a Rarámuri/Tarahumara Indian – her tribe comes from high, high up in the mountains, so high that her people refer to themselves as "the people from the sky." The difficult terrain has protected the tribe from significant influence by other cultures, allowing them to maintain the Rarámuri language as the primary, and often only, language spoken by tribal members and to continue traditional practices ranging from ways of being in the world to cosmological concerns. The Rarámuri also continue to mark the passage of time by phases of the moon rather than the Euro-centric based Gregorian calendar. In this high mountain region, temperatures can drop fast into the extreme colds. To adapt, the Rarámuri people have adopted a number of strategies – ways of life essential to their survival passed from generation to generation. These customs include such things as layering clothing to keep warm, limiting bathing to prevent exposure to the elements, and prayer dancing as an integral part of maintaining health and relational balance. The Rarámuri are a semi-nomadic people and so it is not unusual for them to travel great distances and this was the case for Rita.

Back in the early 1980's she found her way up to Kansas where she came into contact with local authorities while scavenging for food and ended up at the Larned State Hospital, held in a locked psychiatric facility for evaluation by trained mental health

staff. Realizing Rita did not speak English, the staff brought in Portuguese interpreters. But Rita did not speak Portuguese. They brought in Spanish interpreters. But Rita did not speak Spanish…and so they decided to proceed with her evaluation despite the lack of an appropriate translator. These trained mental health professionals evaluated Rita, and without a translator, diagnosed Rita as schizophrenic. They sought to have her institutionalized in the hospital's locked psychiatric ward. "But wait," you might say, "Rita was not schizophrenic. So how did they reach this conclusion?" Well, remember those things I told you about, things about the Rarámuri, about Rita…

These trained mental health providers argued to the court that Rita had a debilitating mental illness requiring confinement and as evidence of her grave disability, they cited what they called Rita's disheveled appearance of multiple layers of clothing; they argued she was unable to care for herself and that this was evidenced by what the staff described as "infrequent" bathing and her seemingly odd behavior of "mumbling" to herself while dancing on the ward. As further evidence of her supposed madness, the staff claimed she was disoriented as to time and place because when asked where she came from, Rita had told them in the little Spanish she did know that she came "from the sky, from heaven." The staff said she seemed confused when they asked her to state the date – a day, month and year which of course did not make sense to Rita, both because she did not speak English or Spanish or Portuguese but also because they did not ask about the lunar cycle and the seasons. And so the court, with little more than a brief objection from

her court-appointed defense attorney, found that Rita could be legally committed to the locked facility "for her own protection."[1]

Rita languished in the facility for 12 years, with increasing impairments to her speech, gait and affect resulting from side effects of heavy doses of anti-psychotic medications she took on doctor's orders for an illness she did not have. Rita continued to pray through dance and eventually her case came to the attention of the disability rights group, Kansas Advocacy and Protective Services (KAPS), who happened to be reviewing long-term institutionalization cases. The group located her family – who had been searching for Rita for 12 years and did not know what had happened to her – and with the help of KAPS and a proper Rarámuri translator, Rita escaped her 12 years of "treatment," returning to her family in the mountains high in the sky (Blackwood, 2000; *Quintero v. Encarnacion*, 2000; Welker, 2012).

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Rita's case is a dramatic illustration of the tragedies which occur at the intersection of mental health and colonization and while her circumstances were worsened by language barriers, alleged professional ineptitude and apathy, there had to be something wrong, systemically, structurally, wrong that would allow 12 years worth of social workers, psychiatrists, facility staff, administrators, attorneys, and judges to proceed without pause, using elements of culture and traditional practices developed over generations for the survival and growth of an entire people as evidence of madness. Rita's case leaves us wondering how many other Indigenous peoples are adjudicated as

[1] Non-consensual state action taken "for the protection" of Indigenous persons runs deep in American history. For example, President Andrew Jackson justified the forcible removal of American Indians from their homelands by claiming it was for their own protection from white colonizer-settlers.
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mad and confined on the basis of cultural mis-understandings and mis-matched worldviews. How many more tragedies occur in this liminal space of care and coercion – cases that go largely unnoticed or are understood by practitioners as un-problematic, normal, just the way things are? How does the law, as one of our key structural institutions create, codify, and enact colonization in mental health and what can be done to change this? It is with theses questions in mind – with Rita in mind - that we now turn to the dissertation project. [2]

This dissertation is a legal and historical policy analysis of the law of involuntary psychiatric commitment, including civil commitment and conservatorship law, as applied to American Indian[3] (hereinafter "AI") persons and nations. *Mental health-based civil commitment law* is the law governing involuntary commitment to locked psychiatric facilities. Civil commitments come in a variety of forms and circumstances. Psychiatric civil commitments may refer to those related to psychiatric emergencies and longer-term mental health-based commitments or they may be civil commitments related to criminal justice issues such as when a defendant is found incompetent to stand trial, is found guilty by reason of insanity, or post-sentence commitment for sexually violent predators. This project is limited to non-criminal, mental health based psychiatric civil commitments. In these cases, involuntary commitment does not imply that the person did anything wrong or broke any law, rather, involuntary commitment occurs only when a judge finds that as

[2] While Rita Quintero is a Tarahumara Indian hailing from the mountain regions of Northern Mexico, this dissertation focuses on U.S. law and is limited to American Indians/Native Americans. Nevertheless, her story provides a compelling example of the collision that occurs between Indigenous cultural norms/worldviews and American psychiatric law.

[3] I use the term "American Indian" here as one of many possible identifiers used by individuals and communities. I selected the term based on terminology in modern day literature written by American Indian scholars. Other terms used in both the literature and in communities include Native American, Indigenous peoples, Native person, Indian or refer directly to the tribe or band name of a particular group.

a result of mental illness, the person is a danger to self or others or is gravely disabled such that he/she cannot meet basic survival needs such as the provision of food, clothing, and shelter. The legal process for involuntary civil commitments vary from state to state, but generally they are limited in duration and each subsequent period of confinement requires additional layers of judicial review, both for the purposes of confinement and for the involuntary administration of psychiatric medications.

Taking the process one step further, *conservatorships* entail the appointment of a legal guardian over an adult individual such that the guardian, referred to as a conservator, has legal authority over decision-making regarding personal and/or financial matters for the individual. The court appoints the conservator, often a family member or in their absence, a county official (a "Public Guardian"), who has the legal authority to make decisions about all aspects of daily life, from spending money and contact with friends to residence, medical decisions, and financial planning matters. Conservatorships are renewed on an annual basis and are often established to protect the elderly or for people with serious and long-standing mental illness resulting in grave disability. Particularly in the case of mental illness, conservatorships may result in a decision by the conservator to place the individual in a locked psychiatric facility, even when the individual strongly objects to such placement. Conservatorship law thus implicates the law and policy of involuntary psychiatric commitment and for this reason, mental health based conservatorships are included within the scope of this project.

While mental health law does provide for protections of patient rights, civil commitment and conservatorships constitute some of the most severe intrusions into

personal liberties and freedom outside of the criminal justice system,[4] subjecting both body and mind to state control and the machinations of Western-centric helping professions. Individuals may be confined to locked psychiatric facilities and forcibly medicated, with confinement periods ranging from as little as 72 hours to as long as a year with the possibility of multiple annual extensions over the life-course. Beyond the restrictions on liberty, commitment to a mental institution often carries with it significant stigma and may have long-term ramifications for individuals with regards to how they are treated by their families and communities after release (Winick, 2005).

In the context of American Indians and tribal nations, however, these intrusions implicate not only individual freedoms and well-being but also larger notions of sovereignty, self-determination, colonialism, cultural genocide, and the dialectic relationship between individual identity and community knowledge related to definitions of health, illness and the social meaning of difference. For AI peoples, individual and community well-being are often intricately linked and embedded in notions of culture, sovereignty and self-determination. Moreover, for many AI peoples, colonialism is not a historical relic but a modern day reality, lived in every day experiences at every level, from the internal world of self to structures and institutions.

By colonialism, I refer both to land occupation/seizures as well as to colonization as an institutionalized practice of excluding and marginalizing Indigenous worldviews implicating mind, body, and culture. Colonialism or colonization is often understood only in the limited context of the period beginning with 16th century European project of empire building through conquest and settlement of foreign lands, often deemed empty

[4] See *Jones v. United States*, 463 U.S. 354 (1983); see also *Foucha v. Louisiana*, 504 U.S. 71 (1992) and *Vitek v. Jones*, 445 U.S. 480 (1980).

by Euro-centric legal doctrines despite the reality of Indigenous peoples living on/with those lands. While the era of imperial empire building through conquest has largely passed, causing some to claim we are in a time of post-colonialism, for American Indian peoples and their respective Nations, the settler-colonizers never left. Colonization continues on not only in the form of land occupation but in the experience of every-day living. Colonialism continues today through knowledge and power structures dominated by Euro-American worldviews commonly operating to the exclusion and/or marginalization of Indigenous epistemologies, cosmologies and ontologies (Brayboy, 2005; Smith, 1999). Colonization is thus endemic.

In the context of emergency mental health services, the law reflects a failure to understand the relevance of colonization, alternating between strategic use of the sovereignty doctrine to deny access to services or, alternatively, wholly absenting issues of sovereignty, Indigenous jurisprudence and Indigenous worldviews from legal discourse. The colonizing implications of these practices are often made invisible or silenced through language of legal neutrality, of "helping" discourse, and the failure of mental health policy to reflect American Indian identity as both racial *and* political in nature. On the therapeutic end, emerging work has focused on methods for undercutting colonialism in mental health through the inclusion of "culturally responsive" therapeutic models for AI peoples. The inclusion of AI-centered therapeutic modalities into the Western-centric corpus of knowledge is itself a complicated matter, implicating colonization even as attempts are made to change. Nevertheless, there is at least a burgeoning awareness among practitioners and scholars that there are issues that need

tending to here (and of course long-standing awareness of this need by many Indigenous practitioners, scholars, and community members).

In the law, however, the legal processes governing mental health generally, and involuntary commitment specifically, continue to be silent on the relationships between colonization, law and mental health. The legal and policy frameworks for delivery of emergency psychiatric care are often the first point of contact for the provision of mental health services for American Indians. Yet, high rates of reported distress and suicide rates that are 83% higher than the general population evidence that the system, grounded in Western-centric models of healing and law, is failing. (Indian Health Service, 2011). Issues of service delivery and culturally appropriate care cannot be divorced from the legal frameworks governing these processes, ranging from admissions and jurisdictional issues to confinement, forced medication and release. Civil commitment and conservatorship law implicate culturally-dependent social constructions of madness, of Truth and of which stories we treat as legitimate evidence (Hodge, Limb, & Cross, 2009). This body of law governs how the courts define who is ill, what rights they will have, which courts can recognize their claims or force them to receive culturally contingent treatment. None of these things are culturally or politically neutral. Issues of wellness/madness, as well as the rights frameworks which animate them, are enculturated projects and as such, inherently implicate issues of power, history, and hegemonic[5] cultural norms. This body of law reaches into the heart of Indian territory, extending and at times distorting federal law, and because the legal framework for psychiatric

[5] By hegemonic norms, I refer to Antonio Gramsci's notion of power and dominance by one group over another, manufactured and maintained through socio-cultural, discursive and structural processes which normalize the dominant group's epistemological, ontological, axiological and social worldviews as natural, right, and superior (Gramsci, 1933, 1975).

commitments remains deeply embedded in colonial jurisprudence, both the legal process and the people bear the scars of a system that fails to conceptualize health needs in political terms (or at least to do so in a way favorable to AI communities).

Using Tribal Critical Race Theory (TriablCrit) as a guide, this project seeks to make visible the ways in which mental health-based civil commitment and conservatorship laws function to create, maintain and, in some cases, obfuscate colonizing tendencies with regards the treatment of American Indians. By understanding the ways in which mental health law and policy functionally create, codify, and carry-out colonizing practices, we open the possibility of imagining more culturally and politically appropriate services and legal frameworks that honor both Tribal self-determination and the federal government's trust responsibility to ensure the health of American Indian peoples. In addition to the longstanding, and often unexamined issues of colonialism within mental health law for AI populations, there are two major shifts in the law that make this study timely: first, the permanent reauthorization of the Indian Health Care Improvement Act (2010) and section 709, which creates a quasi mandate for the first Indian Health Service-run psychiatric hospital for AI persons since the closure of the Canton Asylum for Insane Indians in the 1930's – a place with a dark history of torture, politically motivated commitments and cultural genocide embedded within the discourse of the helping professions (Leahy, 2009). Secondly, in the last 6 years, a number of cases have expanded the reach of the state into Indian Country for civil matters, with the Supreme Court tacitly approving this incursion into Tribal sovereignty through denial of certiorari (e.g., refusing to review the lower court decisions). Thus the analysis is relevant not only to individual wellbeing but to larger justices issues relating to Tribal

sovereignty and community self-determination. This analysis relies on critical legal analysis contextualized broadly by the historical currents of federal Indian policy and, using California as an exemplar state, seeks to explore the nuanced ways in which colonization is weaved into the fabric of mental health law and policy.

Chapter 2

Literature Review

The federal government provides health care, including behavioral/mental health services, to approximately 1.9 million American Indians and Alaska Natives[6] (AI/AN) belonging to 566 federally recognized tribes [7] (Indian Affairs, Bureau, 2012; Bureau of Indian Affairs, 2011; Indian Health Service, 2011a). Services are provided at no charge through the Indian Health Service (hereinafter "IHS"), tribally run facilities and contracted community providers[8] (Indian Health Service, 2011a). The federal government's provision of health care services is framed by the federal trust obligation - a legal and ethical duty to provide for the health, wellbeing and education of AI peoples arising out of the often violent expropriation of millions of acres of land from Tribal nations and the forcible relocation of AI peoples to reservation lands (Coffey & Tsosie, 2001; DeJong, 2011; LaFramboise, 1988; Pevar, 2004). While tribes remain sovereign, under American law, Indian nations are constructed as "domestic dependent nations" – sovereign but still subject ultimately to federal law and Congressional powers (see e.g., *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831)). The complicated relationship between

[6] Much of the statistical data available are in aggregate form, grouping American Indian and Alaska Native populations under one category. These two groups (which are internally quite diverse reflecting the histories, traditions and politics of hundreds of Tribal Nations) have unique histories with regards to federal Indian law. Due to the varied histories and the particular law and policy differences between American Indian and Alaskan Native populations, this study focuses solely on American Indians and does not include mental health policy analysis for Alaska Natives.

[7] There are additional tribes, bands and nations that are not recognized by the federal government. Federal recognition is often a determinative factor in eligibility for federal Indian programs such as economic, health, infrastructure, education and other programs (Pevar, 2004).

[8] According to the IHS fact sheet, the federal IHS system "consists of 29 hospitals, 63 health centers, and 28 health stations. In addition, 34 urban Indian health projects provide a variety of health and referral services. Through P.L. 93-638 Self-Determination contracts, American Indian tribes and Alaska Native corporations administer 16 hospitals, 250 health centers, 93 health stations, and 166 Alaska village clinics" Indian Health Service (2011b).

the tribes and the federal government is summarized in the Federally Recognized Indian Tribe List Act of 1994 ("List Act"), Pub. L. No. 103-454, §§ 101-104, 108 Stat. 4791 (1994), codified at 25 U.S.C. § 479a *et seq.*, which states that "the Constitution, as interpreted by Federal case law, invests Congress with plenary authority over Indian Affairs," and "ancillary to that authority, the United States has a trust responsibility to recognized Indian tribes, maintains a government-to-government relationship with those tribes, and recognizes the sovereignty of those tribes" (Pub. L. No. 103-454, §§ 103(1), 103(2)). This trust relationship creates a set of moral and legal obligations for the government to "ensure the survival and welfare of Indian tribes and people…provid[ing] those services required to protect and enhance Indian lands, resources, and self-government [as well as]…those economic and social programs…necessary to raise the standard of living and social well-being of the Indian people" (Senate American Indian Policy Review Commission, 1977, p. 130). This trust obligation is often characterized within the context of a ward and guardian relationship wherein the federal government has fiduciary and moral/legal duties owed to the tribes to act in their best interests. While scholars and politicians may debate the scope of this trust obligation and the extent to which it creates legally enforceable obligations versus moral imperatives, the trust doctrine remains a backbone of U.S.-Indian relations and consistently forms the foundation for enforcement of Tribal rights (Wilkins & Lomawaima, 2001).

So too in the context of health care, the federal government has a trust obligation to provide for the health and well being of AI peoples. However, in executing this trust responsibility, the federal government has a dismal record in the quality and quantity of care provided, ranging from a total failure to provide care at all to chronically

underfunded, hard to access and culturally inconsistent programs[9] (DeJong, 2011; Leahy, 2009, Manson, 2001, Shelton, 2001). Thus, despite the fact that the federal government "has charged itself with moral obligations of the highest responsibility and trust" owed to Indian peoples and tribes (*United States v. Jicarilla Apache Tribe*, 131 S.Ct. 2313, 2324 (2011)),[10] the federal government's provision of care has frequently failed to live up to these legal/moral duties, resulting in poor health outcomes for AI individuals and communities.

Health Statistics

While the last 30 years have seen modest improvements in health outcomes for AI/AN populations, with life expectancy increasing by 9 years since 1973 and death rates due to preventable diseases decreasing overall, health disparities between AI/AN peoples and the general population remain extreme (Conway, 2010; DeJong, 2011). IHS reports that:

> American Indians and Alaska Natives born today have a life expectancy that is 5.2 years less than the U.S. all races population (72.6 years to 77.8 years, respectively; 2003-2005 rates). American Indians and Alaska Natives die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (514% higher), diabetes (177% higher), unintentional injuries (140% higher), and homicide (92% higher) (Indian Health Service, 2011c).

Moreover, IHS appropriated funding "provides only about 55% of the necessary federal

[9] The federal government has also failed in its trust responsibilities in a number of other areas beyond health care as well. For more information, see Pevar (2012) and Wilkins & Lomawaima (2001).

[10] Citing *Seminole Nation v. United States*, 316 U.S. 286, 296-297 (1942) and *Heckman v. United States*, 224 U.S. 413, 437 (1912).

funding to assure mainstream personal health care services to American Indians and Alaska Natives using the IHS system" (Indian Health Service, 2011b).

In terms of behavioral/mental health, the numbers are difficult to assess, in part because individuals may be hesitant to engage with IHS or health researchers and also due to differences in the definition of mental health/mental illness. Nevertheless, there are some clear indicators of distress: AI/AN suicide rates are 82% higher than the general population, with the vast majority of these among Indian youth, particularly among young men (Indian Health Service, 2011c; U.S. Department of Health and Human Services, 2006). Substance abuse issues are also problematic – though the rate of alcohol use is lower among AI/AN populations than for Whites, the rates of abuse and addiction for those who do use alcohol or other substances is higher than compared to the general population (Substance Abuse and Mental Health Services Administration, 2007). In terms of mental health and institutional contact, IHS reports indicate that in 2006, mental disorder diagnoses ranked in the top ten leading causes for AI/AN hospitalizations for all age groups between 5-54, ranking in the top six for 5-14 year olds and in the top four for both 15-24 year olds and 24-44 year olds (U.S. Department of Health and Human Services, 2006). Mental health hospitalizations for Indian men were higher than for Indian women (7% vs. 3.1%, respectively) (U.S. Department of Health and Human Services, 2006).

These numbers are consistent with national data from 2005-2006, with 25.9% of AI/AN adult respondents in these studies indicating they struggled with serious

psychological distress – the highest rate across all racial[11] groups (though the overall rate of mental illness among AI/AN populations is consistent with the general population) (U.S. Department of Health and Human Services, 2001). In 2006, AI/AN individuals received mental health treatment at a rate of 11.9 % (Substance Abuse and Mental Health Services Administration, 2007). Notably data on perceived benefits from therapeutic service were not available for AI/AN respondents (Substance Abuse and Mental Health Services Administration, 2007). Of particular relevance to civil commitment law, Lutterman and Gonzalez (2004) write that of the 59,431 AI/AN persons receiving mental health services through state mental health supported programs in 2004, 2% received that care in an institutional (e.g., locked) setting. In addition, while overall inpatient psychiatric commitment for AI/AN individuals is consistent with other groups, this group had the highest rate of readmission to state psychiatric facilities after 30 days (Lutterman & Gonzalez, 2004).[12]

Mental Health Treatment, Culture and the Law

Despite efforts to increase cultural responsiveness within mental health services, the underlying model and conceptualization of social work and mental health diagnosis, etiology, intervention and treatment are Euro-centric and Western-centric in nature (see e.g., Four Arrows, Cajete, & Lee, 2010; Gone, 2006, 2008; Waldram, 2004; Weaver, 2010). This makes a difference both in terms of evaluating the statistical mental health indicators above and for the approaches taken to define and alleviate distress. IHS

[11] Health data on AI/AN populations generally classifies the group as a racial minority. However, it is important to note that AI/AN identity is constituted not only by social constructions of race but also by their unique political-legal status in the United States. See Wilkins (2007); Brayboy (2005).

[12] California maintains county level data on civil commitment and conservatorships but does not break them down by group.

services generally feature Western-centric approaches to conceptualizing and addressing mental health issues (DeJong, 2011). However, over the last thirty years, IHS has increasingly sought to incorporate traditional notions of healing and spirituality within the overarching framework of Western medical models (DeJong, 2011). This commitment, along with increased Tribal administration, funding workarounds to use IHS monies to pay for traditional healers, and a general resurgence in endogenic Indigenous healing approaches (built on traditional healing practices that have continued in spite of colonization), culturally appropriate behavioral health options are improving. Also growing is Indigenous scholarship on culturally specific, linguistically appropriate[13] approaches to healing and mental/physical wellness (for review, see Gray, Coates, & Yellow Bird, 2010; see also Hodge et al., 2009). These initiatives range from those that try to meld beneficial aspects of Western behavioral health with pan-Indian traditional healing concepts (see e.g., Nebelkopf & King, 2004; Mills, 2004) to those that seek to entirely (re)frame notions of helping and healing using the traditions of particular Indigenous knowledge systems, understanding tradition as both deeply rooted and evolving to adapt to current contexts (see e.g., Bigfoot & Dunlap, 2006; Hart, 2010; Parrish, 2004).

However, the law and policy of behavioral health has been slow to embrace the idea of Indigene-centered care, particularly in going beyond basic calls for "culturally

[13] By way of example of the relevance of language, for many tribes, there is little differentiation between physical and emotional distress and the words central to Western mental health diagnoses such as "depressed" and "anxious" do not exist in many Native languages, requiring approaches that fit within the context of the cultural and linguistic formulations of wellbeing specific to each tribe (U.S. Department of Health and Human Services, 2001).

appropriate" care for all individuals. Recent legislative approaches[14] have sought to increase Tribal input and control, citing the values of self-determination and respect for sovereignty. While this is better than some of the alternative approaches taken by Congress throughout history, the law of mental health continues to treat tribes as dependents rather than as equals and, as discussed below with respect to civil commitment and conservatorship law, to pretend that facially neutral legal language and silence as to American Indian sovereignty is in fact neutral – that is to say that this erasure of Indigenous approaches to jurisprudence from American law is somehow not a political choice. To better explicate this link between behavioral health law and the politics of colonization, power and sovereignty, this study will explore the genealogy of mental health law as it relates to federal Indian policy, placing it in historical context and drawing parallels between larger federal policy goals and the development of mental health law/policy for Native peoples.

[14] Such as the Indian Health Care Improvement Act of 1976 (revised and reauthorized in 2010) and the Indian Self-determination and Education Assistance Act (1975).

Chapter 3

Framing the Project: Theory & Design

This chapter outlines the theoretical frame guiding the analysis, Tribal Critical Race Theory, and lays out the project design. After delineating the genealogy, central tenets and related issues relevant to the theory, the chapter moves on to detail the research questions and design including methodological considerations, methods, sampling, and limitations.

Theoretical Frame: Tribal Critical Race Theory

Legal scholarship on AI/AN specific issues has traditionally relied heavily on theoretical frames created doctrinally through federal Indian law, with more critical approaches drawing on Critical Race Theory and one of its sub-theories, American Indian Crit (see e.g., Coffey & Tsosie, 2001; Deloria & Wilkins, 1999; Parker, 1916; Torres & Milun, 1995; Wilkins & Lomawaima, 2001; Williams, 2000). However, emerging literature on AI/AN *policy issues* has increasingly turned to a more tailored, American Indian specific theory, Tribal Critical Race Theory or TribalCrit, developed by Lumbee scholar Dr. Bryan Brayboy, to address the unique histories and current realities of AI/AN populations (Brayboy, 2005; see also Castagno & Lee, 2007; De La Mare, 2010). TribalCrit's central tenet is that colonization is endemic to society. Accordingly, critical analysis must account for the history and present day realities of colonization as a central and organizing theme.

TribalCrit: Genealogy

In his formative work introducing the theory as TribalCrit, Brayboy (2005) explains that TribalCrit finds its origins in legal scholarship *and* in communities, writing

"TribalCrit is rooted in the [commonalities between the] multiple, nuanced, and historically – and geographically- located epistemologies and ontologies found in Indigenous communities" (pp. 427). Built through Indigenous worldviews and theoretical traditions, TribalCrit builds on the work of Indigenous scholars such as Arthur C. Parker (1916), Vine Deloria Jr. (1970), and Robert Williams (2000), among others and draws on the body of scholarship developed through Critical Race Theory (CRT) and CRT's progenitor, Critical Legal Studies (CLS).

Emerging during the 1960's, CLS was an intellectual movement of leftist legal scholars who critiqued the classical liberal state and the role of law in creating and maintaining legal ideologies which construct and support oppression, particularly class hierarchies (see e.g., Cook, 1995; Crenshaw, 1988; Tushnet, 1990). CLS rejected the idea that law was neutral or objective and introduced into legal parlance sociological concepts such as social construction, ideologies of legitimation, false consciousness, and the myths of meritocracy (Cook, 1995). However, with its primary focus on class, CLS failed to recognize the import and ubiquitous nature of racism within socio-legal-political and economic systems and further failed to seek out perspectives from scholars of color who, as Cook (1995) writes, "have in different contexts endured the problems of most concern to CLS – problems associated with hierarchy, powerlessness, and legitimating ideologies" (pp. 85).

In response, scholars, particularly scholars of color, developed Critical Race Theory (CRT) – a theoretical frame accounting for the historical and present day ways in which race, complicated by gender, class and other categories, plays a primary role in legal and socio-political structures which perpetuate oppression, particularly with regards

to civil rights legislation. Delgado and Stefancic (2001, pp. 6-9) outline six basic tenets of CRT, drawing on the works of critical scholars such as Derrick Bell, Alan Freeman, Kimberlé Crenshaw, Angela Harris, Charles Lawrence, Mari Matsuda, Patricia Williams, Neil Gotanda, Robert Williams, and Ian Haney López, among others. The tenets, outlined below, represent an evolving and fluid representation of the foundational principles of CRT and in many ways have influenced TribalCrit theory. The primary organizing CRT tenets are as follows:

1. Racism is ordinary and endemic to society – CRT posits that racism is an everyday occurrence, not an aberration and that it infiltrates every aspect of daily life from the very personal to the most abstract concepts in law and government. Moreover, despite claims of neutrality and objectivity, racism and racially defined power hierarchies animate laws and social structures (see e.g., Delgado and Stefancic, 2000);
2. Interest convergence/material determinism – White-dominant racial hegemony results in material and physical benefits to White elites and the White working class, resulting in a disincentive for these power brokers to eradicate racism (see e.g. Bell, 1995);
3. Race is a social construction – Race as a culturally contingent creation of the social imagination is not rooted in any scientific reality, changing over time to suit the political and economic needs of the day (see e.g., Haney López, 2000);
4. Racialization – Society racializes groups through the production of images and stereotypes to serve particular political agendas (such as proliferating stereotypes

of the happy Sambo content to serve White masters or the racialized, sexualized model minority myths of demure Asian women) (see e.g., Cho, 1997);

5. Intersectionality and anti-essentialism – Personhood is constituted by many intersecting identities, shifting over time and varied by individual experience. The intersection of multiple identities creates multiple and nuanced experiences of oppression for various sub-groups, creating a need for more complex analysis of disparate impacts in law and policy for these various groups (see e.g., Crenshaw, 1989); and
6. Counter-stories and a unique voice of color – By virtue of their experiences as racialized individuals, people of color may bring perspectives to the discussion that are otherwise unseen or not understood by dominant groups. Such voices may also provide counter-narratives or counter-stories to the hegemonic narratives articulated in the dominant culture and in so doing, assist individuals in reframing or revealing oppression in a manner that is accessible (see e.g. Matsuda, 1995).

Crenshaw, Gotanda, Peller, and Thomas (1995) add that because scholarship, as a production of knowledge, is inevitably political, CRT scholars seek both to explicate the ways in which race is implicated in social inequity and also to change those structures through the marriage of theory and activism, or praxis. CRT further embraces experiential knowledge and the value of counter-narratives as sources of data to oppose and change systemic oppressions (Brayboy, 2005, pp. 428).

However, as CRT developed in response to the lack of race-specific analysis in CLS, early approaches tended to focus on only a Black-White binary within civil rights law. Subsequently, Yosso and Solórzano (2005) explain that other critical theories "have

since expanded the CRT family tree to incorporate their racialized experiences as women [FemCrit], as Latinas/os [LatCrit], as Native Americans [TribalCrit], and as Asian Americans [AsianCrit]…in [an] ongoing search for a framework that addresses racism and its accompanying oppressions beyond the Black/White binary" (pp. 120). Speaking to the need to develop a critical frame that could account for the specific realities of American Indians, Brayboy (2005) writes:

> While CRT serves as a framework in and of itself, it does not address the specific needs of tribal peoples because it does not address the American Indians' liminality as both legal/political and racialized beings or the experience of colonization…The basic premise of CRT is that racism is endemic to society. In contrast, the basic tenets of TribalCrit emphasize that colonization is endemic to society" (pp. 428-429, citing Brayboy, 2001).

While TribalCrit draws on the work of CRT scholars, by focusing on the endemic nature of colonization as well as on Indigenous epistemologies/ontologies and the lived experiences of Indigenous peoples in the United States, TribalCrit as a distinct analytical frame "offers a more culturally nuanced analytical lens for examining the lives and experiences of formerly [*sic*] colonized Indigenous peoples in (post)colonial societies" (Kaomea, 2009, pp. 114). Moreover, absent a theoretical frame which accounts for all of the TribalCrit tenets, an AI/AN-centered policy-legal analysis would miss crucial aspects of the socio-legal-political dynamics at play and may function to reify hegemonic notions of the current socio-legal-political order, thereby supporting colonialist agendas by failing to question key underlying assumptions at the structural level. This of course begs the question: what are TribalCrit's central tenets? It is to this issue we now turn.

Tribal Critical Race Theory: Central Tenets

Writing originally in the context of education policy and drawing on the work of prior Indigenous scholars and Indigenous worldviews, Brayboy (2005) articulated TribalCrit with nine central tenets which are outlined here and discussed in more depth below. The nine tenets of TribalCrit are as follows:

1. Colonization is endemic to society;
2. U.S. policies toward Indigenous peoples are rooted in imperialism, White supremacy, and a desire for material gain;
3. Indigenous people occupy a liminal space that accounts for both the political and racialized natures of [Indigenous] identities;
4. Indigenous peoples have a desire to obtain and forge tribal sovereignty, tribal autonomy, self-determination, and self-identification;
5. The concepts of culture, knowledge, and power take on new meaning when examined through an Indigenous lens;
6. Governmental policies and educational policies toward Indigenous peoples are intimately linked around the problematic goal of assimilation;
7. Tribal philosophies, beliefs, customs, traditions, and visions for the future are central to understanding the lived realities of Indigenous peoples, but they also illustrate the differences and adaptability among individuals and groups;
8. Stories are not separate from theory; they make up the theory and are, therefore, real and legitimate sources of data and ways of being; and
9. Theory and practice are connected in deep and explicit ways such that scholars must work towards social change (Brayboy, 2005, p. 429-430).

Colonization is endemic to society.

The first and primary tenet of TribalCrit is that colonization is endemic to society. Not only does the fact of land occupation remain a reality for AI peoples, colonization is also endemic in that "European American thoughts, knowledge and power structures dominate present day society in the United States" (Brayboy, 2005, pp. 430). Alfred (2005) adds that colonization is "the historical process and political reality defined in the structures and techniques of government that consolidate the domination of Indigenous peoples by a foreign yet sovereign settler state" (pp. 33). Understanding the ubiquitous, evolving nature of colonization is a complicated task. Native Hawaiian law professor Melody Kapilialoha MacKenzie (2006) likens the task to wrestling with a slippery, multifaceted and often camouflaged He'e (octopus), as colonization in the modern context implicates a wide range of socio-structural phenomenon including, law, policy, knowledge production, language, schooling, media, economics, and meta-frameworks for how we conceptualize each of these areas (see e.g., Alfred, 2005; Battiste, 2002; Garrison, 2002; Hermes, 2005; Lomawaima & McCarty, 2002; Russell, 2004; Smith, 1999; Warrior, 1995; Wilkins, 2002).

Often framed in the context of "helping" or in earlier eras, "civilizing" American Indian peoples, policies and practices have ranged in their explicitness regarding colonial objectives. For example, such policies include outright genocidal policies, removal of American Indians from tribal lands in the name of "protecting" them from Whites (Prucha, 1969), boarding school policies intended to "kill the Indian, save the man" (see e.g. Grinde, 2004), media representations of the "vanishing" Indian or satirized Indian mascots (Buken, 2002; Fryberg, Markus, Oyserman, & Stone, 2008); and case law

double-handedly recognizing sovereignty and yet attempting to reconstruct it as a mere right of occupancy (Deloria & Wilkins, 1999). Colonization thus shapes not only law and policy but culture, identity and dreams of the future. As Brayboy (2005) writes, "colonization and its debilitating influences are at the heart of TribalCrit: all other ideas are offshoots of this vital concept" (pp. 431).

Policy, imperialism, supremacy and material gain.

TribalCrit's second tenet holds that U.S. policies toward Indigenous peoples are rooted in imperialism, White supremacy, and a desire for material gain. From the moment of contact, White settlers imposed legal regimes and ideologies that would legitimize the taking and privatization of tribal lands (Williams, 2000). For example, to legalize and justify the taking of Indian lands, settlers adopted the legal concept of *terra nullius*. Derived from Roman law, terra nullius created in law a declaration that where the claimant nation-state deemed the local population uncivilized or where the local population had failed to cultivate (e.g., dominate) the land according to divine directive, the law would treat such lands as open, un-owned, unoccupied and available for the taking (Bratspies & Miller, 2006).

Other self-serving concepts facilitating land dispossession included ideas such as the Norman Yoke, which held that "not only do individuals have a right to utilize and exploit natural resources on lands that are considered 'vacant,' but they also have a moral obligation to do so" (Brayboy, 2005, p. 432). Coupled with westward expansion driven by God's plan per the doctrine of Manifest Destiny, White settlers created legal doctrines that sought to deny the full scope of American Indian sovereignties and began a process of normalization of Euro-centric knowledge as the most advanced, civilized, scientific

and valuable, linking these processes to those of power and hierarchy (see e.g., Smith, 1999; Alfred 2005; Williams, 2000). And as noted by CRT scholars, the impetus for dismantling the resultant oppressive systems as a matter of justice diminishes when it becomes clear that it is not in the dominant group's economic and positional interest to do so. Thus, TribalCrit encourages us to examine the ways in which U.S. policies are rooted in imperialism, White supremacy, and desire for material gain.

Liminality.

The third TribalCrit tenet states that Indigenous people occupy a liminal space that accounts for both the legal/political and racialized natures of Indigenous identities (Brayboy, 2005, pp. 432). Through their tribal status, American Indians, tribes and the United States federal government have a unique (extra)constitutional relationship, both in that they relate as sovereign government to government entities, and because of the trust responsibilities owed to tribes by virtue of treaties and case law. Thus, American Indians occupy a particular legal-political space setting them apart from other racialized groups in the U.S. (Wilkins & Lomawaima, 2001).

However, Brayboy (2005) notes that while American Indian identities are shaped both by this legal/political reality and through processes of racialization (as well as other identity concepts such as gender, etc.), "the racialized status of American Indians appears to be the main emphasis of most members of U.S. society; this status ignores the legal/political one, and is directly tied to notions of colonialism, because the larger society is unaware of the multiple statuses of Indigenous peoples" (pp. 433). Understanding that AI peoples occupy this liminal space of racialized and political identity is critical to comprehensive, accurate policy analysis.

Autonomy, self-determination, and sovereignty.

The fourth TribalCrit tenet is that Indigenous communities desire to obtain and forge tribal autonomy, self-determination, and self-identification constitutive of tribal sovereignty. Brayboy (2005) defines *tribal autonomy* as "the ability of communities and tribal nations to have control over existing land bases, natural resources and tribal national boundaries…[as well as] the ability to interact with the U.S. and other nations on a nation-to-nation basis" (pp. 433-434). Brayboy further defines *self-determination* as the ability to direct tribal autonomy without having to ask for permission from the federal government. Autonomy and self-determination vest ultimate decision-making and legal powers within the tribes, rejecting a ward-guardian style relationship with the federal government while still maintaining in tact obligations of the federal government inherent to the trust doctrine established through treaties and federal Indian law. In addition to autonomy and self-determination, TribalCrit is rooted in the goal of self-identification - "the ability and legitimacy for groups to define themselves and to create what it means to be Indian" (Brayboy, 2005, pp. 434). Unlike its predecessor, CRT, TribalCrit sees issues of self-determination, sovereignty and autonomy as central to any AI/AN related analysis.

Indigenous epistemologies.

In addition to problematizing Western-centric notions of culture, knowledge, and power, TribalCrit is additive in that it seeks to offer "alternative ways of understanding [such issues] through an Indigenous lens" (Brayboy, 2005, pp. 434). TribalCrit highlights power, culture and knowledge as a triad because they exist in a dialogic relationship, each informing and animating the other. Recognizing rich cultural knowledges rooted in

centuries of traditions, as well as the evolving processes of cultural production that form the basis for knew knowledge, TribalCrit applies Indigenous lenses to cultural knowledge, knowledge of survival and academic knowledge (Brayboy, 2005). TribalCrit focuses on the ways in which these forms of knowledge inform one another as well as how they are informed by the multiple knowledge systems with which they come into contact. Through these lenses, knowledge relates directly to power where power is defined as "the ability to survive, rooted in the capacity to adapt and adjust to changing landscapes, times, ideas, circumstances and situations" (Brayboy, 2005, pp. 435).

Linked to self-determination and understood not as a possession but as an ability to determine one's own/communities place in the world, *power* through a TribalCrit perspective is a matter of survivance: survival and dynamic resistance through adaptation and strategic accommodation in order to ensure both survival and continued community growth (Vizenor, 1994; 1998; see also, Deloria, 1970). Survivance depends on community knowledge, past and present, firmly rooted in a fluid, yet "anchored" sense of culture, cultural knowledge and power (Brayboy, 2005). TribalCrit thus seeks to make traditional and evolving Indigenous worldviews central in the (re)conceptualization of power, culture and knowledge, finding value there not only as a critique of dominant paradigms but as a wholly formed alternative way of being, knowing, doing, and surviving.

Assimilation and policy.

This sixth element asserts that governmental policies and educational policies toward Indigenous peoples are intimately linked around the problematic goal of assimilation. Here Brayboy (2005) points to the historical record of American Indian

education policy which began explicitly as an endeavor to "civilize" (read colonize and assimilate) AI children through the extermination of Indigenous knowledge systems, language, culture, and identity. Educational programs have since shifted to provide more support for Indigenous-centered learning models, however, the funding for such programs are most often still tied to non-Indigenous markers of success such as test scores and classroom attendance – markers which dictate whether programs will continue to receive funding and constrain program design in that programs must function in a way that will produce the specific types of measurable outcomes which Western science counts as legitimate and relevant measures of success (see e.g., Lomawaima & McCarty, 2002; Roehl, 2010).

Of course, assimilationist policies are certainly not limited to education. In the health care context, for example, assimilation has had a complicated relationship with both colonization and the trust obligations of the federal government. Obliged by treaty and law to provide for the health of American Indian tribes, the federal government has long provided exclusively Western-style health care options through the Indian Health Service (Shelton, 2001). On the one hand, the government was meeting its obligations to provide critical care (although most often doing so quite poorly), and yet through this process, the government suppressed and replaced many traditional forms of medicine both through the lack of financial mechanism to pay traditional healers and by promoting the idea that Western medicine was the gold standard (Dixon & Roubideaux, 2001; LaFramboise, 1988). Assimilation also took on a coercive tone in the context of mental health policy where American Indians who objected to assimilationist policies generally or were politically unruly on reservations were shipped off without recourse to Canton

Asylum for Insane Indians (during the late 1800's, early 1900's) (Leahy, 2009). Thus, TribalCrit's focus on the interwoven connections between government policy and assimilationist agendas is critically important not only in the educational policy context but in mental health and other areas as well.

Epistemologies, lived realities, and diversity.

According the seventh tenet, TribalCrit "emphasizes the importance of tribal philosophies, beliefs, customs, traditions, and visions for the future…honoring the adaptability of groups and recognizing the differences within individuals and between people and groups" (Brayboy, 2005. pp. 437). Though a thorough explanation of Indigenous knowledge systems is beyond the scope of this discussion, the commonalities between communities in their knowledge systems as well as group and individual differences in opinion, belief, and vision are central to self-determination and form a platform from which to analyze policy choices. The import of Indigenous epistemologies and diversity of ideas to self-determination and policy development are also central to framing discussions on AI health policy and law, both with respect to (de)colonization of policy choices and in rebuilding for the future.

Stories as theory and knowledge.

The eighth prong of TribalCrit asserts that "stories are not separate from theory; they make up the theory and are therefore, real and legitimate sources of data and ways of being" – and this holds whether the stories are written or oral, academically codified or simply grandmother approved (Brayboy, 2005, pp. 430). In Western academia and philosophy, theories are abstractions that attempt to order the world, to provide a generalized frame for understanding the particular workings of social-natural-political-

economic phenomenon. Theorizing in the Western tradition is built upon data drawn from individual experience, thought, experimentation and testing.

However, as Brian Yazzie Burkhart (2004) explains, this approach to knowledge and philosophical development reflects a bias in Western thought systems towards valuing individual experience, a Cartesian bias expressed in Descartes "I think therefore I am." Native philosophy, Yazzie Burkhart argues, is oriented by a "we are, therefore I am" principle such that to get a right understanding of the world, *all* experiences, not just individual experiences, must be accounted for. It is the data of the "we" experience which matters – the experiences of all others, communities, families, animals, land, water, spirit and more – data from all of these sources are transmitted through stories (Yazzie Burkhart, 2004). Knowledge of these experiences develops through observation of the world in real time, of how systems function together, and observations are revised over time to reflect changes in knowledge. This knowledge is then reflected and taught through stories (Yazzie Burkhart, 2004).

Stories then become a source of data but also function as theoretical constructs themselves, teaching each generation a theory of ethics, ontologies, cosmologies – they are powerful, creating a "space of being, of identity, of knowing [one's] place in the world…of what it mean[s] to be human"…what it means to be *of a people* (Waters, 2004, pp. 163). Brayboy (2005) continues that "for many Indigenous people, stories serve as the basis for how [Indigenous] communities work…theory is not simply an abstract thought or idea that explains overarching structures of societies and communities: theories through stories and other media, are roadmaps…and reminders of…individual responsibilities to the survival of [Indigenous] communities" (pp. 427). Experiential in

nature, both in their formation and in the telling/hearing, stories are "guardians of cumulative knowledges that hold a place in the psyches of the group members, memories of tradition, and reflections on power" (Brayboy, 2005, pp. 440). For these reasons, TribalCrit recognizes that stories and oral knowledge are legitimate sources of scientific data and theory.

Praxis and social activism.

In the ninth and final tenet, TribalCrit raises the obligation and responsibility for scholars to engage in social activism through their work. Similar to a CRT, TribalCrit calls on scholars to make their scholarship relevant to the needs of American Indian communities in real and tangible ways – to go beyond abstract theory or deconstruction, affirmatively creating or supporting the development of structures that promote self-determination and social change. In addition, Brayboy (2005) argues:

> No research should be conducted with Indigenous peoples that is not in some way directed by a community and aimed toward improving the life chances and situations of specific communities and American Indians writ large. The research must be relevant and address the problems of the community; there is little room for abstract ideas in real communities (pp. 440).

This form of praxis, grounded in and directed by communities, serves the overarching goals of self-determination, autonomy and tribal sovereignty.

Uses of TribalCrit in the Academic Literature

TribalCrit as a formal and complete (if evolving) theory remains a relative newcomer to many academicians, with its first debut as a formal theory in 2005, and is only just beginning to be engaged deeply as a framework by scholars publishing in

academic journals. Despite this, TribalCrit appears widely accepted as part of the post-2004 Critical Race Theory canon and is regularly listed among the family of CRT sub-theories (see e.g., Burton, 2009; Chapman, 2011; Garcia, 2006; Liu, 2009; Yosso, 2005; Yosso, & Solórzano, 2005). Emerging scholars, in particular, are increasingly using TribalCrit substantively in their dissertation research and beyond (see e.g., De La Mare, 2010, Kupo, 2009; Scott, 2008).

Written originally in the context of education, scholars have taken up TribalCrit in a myriad of ways, though the primary focus remains on AI/AN educational issues (see e.g., Kaomea, 2009; Quijada & Murakami-Ramalho, 2009; and Lindley, 2009). Within the realm of education, TribalCrit frames a number of different studies including constructs ranging from achievement, language, and leadership to higher education and gendered experiences of college life for Indigenous women. Studies using TribalCrit as an analytical frame include: a 2009 study on academic attainment for Arapaho college women (Lindley, 2009); an analysis of multicultural education (Haynes Writer, 2008); the impact of speaking the Lumbee dialect on AI student achievement and identity (Scott, 2008); disenfranchisement of Indigenous youth (Quijada & Murakami-Ramalho, 2009); legal challenges to Indigenous-only education (Kaomea, 2009); AI leadership experiences in Indigenous educational settings (Johnson, 2009); First Nations/Aboriginal teacher development programs (Kitchen, Cherubini, Trudeau, & Hodson, 2010); and distance education for Ndee (White Mountain Apache) women at the collegiate level (Stemmler, 2010).

TribalCrit also appears in the literature used in conjunction with other frameworks to capture multiple aspects of identity or concepts highlighted in alternative theoretical

frames. For example, in Castagno and Lee's (2007) work on Native mascots and ethnic fraud in higher education, the authors use TribalCrit and CRT interest convergence principles to create a multilayered analytic lens for examining University institutional policies. Similarly, Kupo (2009) combines TribalCrit with aspects of other theoretical frames, specifically intersectionality and identity performance constructs, in her study on Native Hawaiian college women's identities to highlight the ways in which race, colonization and gender impact educational identity. Stemmler (2010) cited above, uses TribalCrit alongside feminist theory to analyze the collegiate experiences of Ndee women and in yet another example, De La Mare (2010) combines TribalCrit with Whiteness Theory to analyze the impact of non-indigenous teacher alignment with school structures in their service to AI high school students in Montana.

Scholars have also extended TribalCrit beyond its origins by applying it to different populations and beyond the confines of education policy scholarship. For example, Xiong (2009) uses TriablCrit to explore notions of knowledge production in traditional Hmong communities. Xiong argues for an extension of TribalCrit for use in understanding Hmong epistemological traditions because, unlike AsianCrit or Critical Race Theory more generally, TribalCrit centers issues of colonization, tribal epistemologies, and the value of oral traditions in knowledge and theory production – all issues Xiong posits are critical to contextualizing the lived realities of Hmong peoples with regards to what it means to "really be educated" (Xiong, 2009).

Xiong is not alone in his sentiments that TribalCrit provides a key remedy to the general lack of focus on colonization within CRT and its various offspring. Sabina Elena Vaught's (2011) work on Sa'moan high school students highlights the need for a critical

theory that can account for more than students' racialized status. While the study focuses on racialization, examined through CRT methods of defamiliarization and counter-storytelling, Vaught argues that TribalCrit's emphasis on the primacy of colonization as endemic to policy and society constitutes a critical component in understanding the context of Sa'moan youth.

In yet another study, Jewell (2008) extends TribalCrit beyond the education context, applying the theoretical frame to his research on the child rearing practices of the Martu people (in the Western Australian Desert region) and implications for child welfare policy. Using TribalCrit as a theoretical frame for this study sponsored by the Ngangganawili Aboriginal Health Service, Jewell is able to explore Martu child rearing through locally produced theories/knowledge developed over the course of generations and within the context of colonization, all with aim towards meeting community needs for improved service provision and autonomy (Jewell, 2008).

TribalCrit's focus on colonization also adds to the growing literature on the racial politics of health policy (see Molina, 2006; Shah, 2001), suggesting not only that American Indians should be part of this race-based discussion on health policy but suggests there may be other concepts instead of, or in addition to, race that are central understanding health politics with regards to particular populations. As discussed by Xiong (2009) and Vaught (2011), truly understanding phenomenological data and policy outcomes for colonized peoples, whether American Indian or otherwise, requires a frame which conceptualizes colonization as endemic and embraces the intersectional and liminal spaces in which these groups function. Thus, TribalCrit is a valuable tool in meeting the significant need for frameworks capable of addressing the centrality of

colonization in the lives and experiences of people who also find themselves in the liminal spaces created by colonization.

TribalCrit: Methodological Implications for Project Design

Following TribalCrit tenets as a guide, this research highlights the ways in which colonization functions in mental health law. TribalCrit also argues for project designs to be deeply embedded in community relationships, with community control over every aspect of the project, from question development and research design, to veto power over publication of content and future uses. The ninth tenet of TribalCrit is explicit on this point as Brayboy (2005) writes that "no research should be conducted with Indigenous peoples that is not in some way directed by a community" (pp. 440). However, as discussed by Four Arrows (2008), in the context of dissertation research, community control and relationality are complicated matters. As an inherently solo endeavor (at least as currently defined in Western academic institutions), the dissertation does not necessarily lend itself to collaborative efforts nor to community control over topic, design, data inclusion/exclusion, writing or ultimately whether and what will be published. Moreover, the push to "just get the research done" before funding runs out and to follow a linear progression of data collection inherent to most dissertations does not always mesh well with the inevitable ebb and flow of building relationships. The challenge then is to find a way to make the research consistent with the animating features of the theory/frame: relationality, respect, responsibility, service, community, reciprocity, self-determination, sovereignty, Indigenous epistemologies and

decolonization[15] – while still meeting the requirements of dissertation research. Taking into account the limitations of dissertation research as well as Brayboy's call to ground research in communities, this dissertation project should be *narrowly tailored* in the following ways:

a. To ground the work in community defined goals, the research questions and design are is based on issues raised by AI community leaders over the last decade in advocacy efforts to reform the Indian Health Care Improvement Act and behavioral health services;[16]
b. The scope of the dissertation is limited – the analysis should be understood as one small piece of a larger project, laying groundwork for future collaborative efforts after the dissertation;
c. Within that limited scope, the research questions are driven by community-identified concerns in the literature and contextualized in the work of American Indian scholars/activists;
d. The law and policy of behavioral health are the object of the study rather than making AI/AN peoples the object of study;
e. To maximize its utility and minimize the risk of functioning as a colonizing agent, the study methods focus on gathering data about the system, including: the numbers of American Indians conserved; data on the use and accessibility of Indigenous healing as treatment options

[15] For additional information on Critical Indigenous Research Methodologies, see Brayboy, Gough, Leonard, Roehl, & Solyom (in press).

[16] See e.g., National Indian Health Board, 2011; Reforming the Indian Health Care System, 2009; and Somers, 2010.

for conserved AI peoples; and the actual laws that govern civil commitment/conservatorship with analysis of the possible points of inquiry that could be useful to later collaborative efforts;

f. The law and policy analysis is grounded in the work of Indigenous scholars and community members writing/speaking on issues of sovereignty, law and behavioral health policy, both in regards to needs and implications of law/policy;

g. The analysis must be animated by a sense of responsibility and accountability for how the work may be taken up after publication;

h. The design and methods should reflect the grounding principles of TribalCrit theory, orienting the research away from research approaches that functionally reinforce colonization (as described above) and guided by the vision of self-determination and sovereignty discussed in TribalCrit theory.

Project Design - Research Questions

Following the logic of TribalCrit theory regarding the endemic nature of colonization and the idea that those colonizing features are codified in and animated by the American legal system, it stands to reason that colonization would also be endemic to mental health-based civil commitment and conservatorship law. Thus, this project asks the following research question:

Using the lens of TribalCrit theory, what might an examination of California's mental health-based civil commitment and conservatorship law tell us about the ways in

which these areas of law reflect, reify and re-enact colonialism in the context of American Indians peoples and nations? Specifically:

1. In what ways do mental health-based civil commitment and conservatorship law and policy affirmatively embrace or extend colonizing federal Indian policy, including colonization through assimilation and/or termination;
2. How do mental health-based civil commitment and conservatorship law and policy evidence the presence or absence of colonialism implicitly through the civil commitment/conservatorship process?

Methods

This study is a critical historical and legal analysis utilizing primary documentary data from case studies, as well as historical information, law and federal Indian policy to explore California's mental health-based civil commitment and conservatorship law as applied to American Indians. TribalCrit theory frames the inquiry. The analysis begins by contextualizing AI mental health law within the meta-frame of federal Indian policy. Historical comparisons are drawn to illustrate how colonization and mental health law/policy have co-evolved. Historical analysis also provides analytical/contextual guidance for understanding modern-day law and policy in this arena. Legal analysis draws on this historical accounting in exploring issues of legal doctrine and emerging case law issues. Legal data include case law, legislation, federal Indian law/policy, and legal doctrine relevant to sovereignty and mental health service provision in the American Indian context. Legal analysis and data collection focus on California, selected for its large AI/AN population, including both reservation and urban Indians, and for its complex jurisdictional issues related to federal conferrals of civil jurisdiction. While

California law is central, the study includes persuasive authority from similarly situated states. For the documentary portion of the data, the project utilized 2 California counties, Los Angeles County and Humboldt County, as case studies, providing exploratory documentary evidence and a frame for grounding the legal analysis. Selection criterion for the counties included size and diversity of AI populations (e.g., urban Indian and reservation-based populations). Documentary data were collected under California's Public Records Act (CA Gov. Code §§ 6250-6276.48) from each of the case study counties for the last 5 years. Public Record Act requests to County Mental Health and the Public Guardian/Public Administrator included petitions for documents concerning demographic data, Tribal agreement/MOU's, and policies regarding treatment options specific to AI/AN culture (see Appendix A).

Design Limits – Avoiding Risk of Harm

While survey data and interviews would be useful in this analysis, the study is purposively limited to primary documentary/legal data to minimize the risk of harm. Legal issues in this area are unsettled and intrusive questioning of legal practices could result in re-examination of county policies or holding back potentially life saving services until the legal issues were satisfactorily resolved. To avoid this risk, the study used historical and comparative document analysis, among the least obtrusive forms of research methods (Rubbin & Babbie, 2008). This allowed for a thorough examination of the legal and policy issues without causing alarm among county attorneys, health providers or service recipients. Moreover, limiting the scope of the study is appropriate until such time that the project could be expanded (post-dissertation) with the active guidance of AI community members and stake-holders.

Chapter 4

Historical Analysis: AI Mental Health Law and Federal Indian Policy

Health care law and policy for American Indians is a complicated matter, implicating a myriad of legislative, jurisdictional and policy regimes across tribal, federal, state and community levels, and embedded within a larger context of the various policy agendas of the United States federal government with regards to Indigenous peoples. The strength of the linkage between overarching goals of federal Indian policy and the development of health care policy, mental health law inclusive, for AI peoples cannot be overstated. The design and implementation of health care policy is intimately intertwined with issues of land expropriation and colonization, treaty rights and federal trust responsibilities towards tribes, and policies of assimilation, termination, and self-determination. To account for the interplay between political agendas and health care policy and to convey the ways in which these policies frame both the development and implementation of health policy, this section will explore developments in American Indian health policy, and mental health policy in particular, across the various eras of federal Indian policy.[17]

Indigenous Health: Pre-Contact Era

The health care story really begins centuries ago, before European contact and colonization. It begins with sophisticated, complex, and varied systems of healing grounded in Indigenous knowledge systems, each with its own deep well of knowledge regarding illness, medicine, well-being, treatments and procedures including surgery

[17] There is a great deal more known and written about federal Indian policy beyond that presented here. However, this should provide a basic frame for understanding the linkages between policy agendas and health policy development.

(Weatherford, 1988). Although there were/are significant variations on healing practices between and a times within tribes, common themes in AI/AN approaches to health included mental, physical, spiritual and community health as relational and intertwined, each informing the other (Hart, 2010; Parrish, 2004; Murillo, 2004). Healing practices occurred in a multitude of different settings, reflecting the diversity in pre-contact social organization and environments including "nomadic hunting tribes, settled farming communities," fishing-based tribes, "and dazzling civilizations within cities as large as any then on earth" (Wright, 1993, pg 3-4).

For many communities, storytelling and narratives served (and still serve today) as theoretical and ontological guides, including instruction on how to cope with stress, trauma, and family or community difficulties (Witko, 2006). The medicine wheel was (and is) another tool used in traditional healing practices (Gone, 2011; McCabe, 2008). While grounded in the particulars of a band or tribe's particular culture, generally the medicine wheel was/is divided into four parts (physical, mental/intellectual, emotional, spiritual), each "addressed through the sacred directions" (Witko, 2006, pg. 8; see also Mawhiney & Nabigon, 2011). Talking circles and elders with deep and well-developed knowledge regarding well-being were/are also central to community and individual health (Witko, 2006).

These were and are systems evolving over centuries, grounded in traditional knowledge and continually subject to real-time evaluation to allow for change, empirical testing based on observation and practice experience as well as the incorporation of new knowledge into the various traditions. While this is not meant to imply that these systems were immune from problems or utopian in nature, they were holistic, well-formed

systems integrated into the social fabric of everyday life and consistent with the worldviews of the people (see Parrish, 2004; Waldram, 2004). Many of these traditional and evolving notions of Indigenous healing have survived, resisted and continued to develop in spite of efforts to eradicate them in the name of "civilizing the noble savage" (Shelton, 2001; Dixon and Roubideaux, 2001; Mills, 2004), although they have undeniably been impacted by the advent of colonization and the variety of federal policies designed to eradicate, assimilate, or marginalize Indigenous worldviews.

Post-Contact to 1828: From Freedom and Treaty-making to Removal

The years after contact up to the pre-revolutionary war period were largely characterized by tribal independence (Pevar, 2004). As settlement populations grew, colonists secured land and supplies through agreements with local tribes (Pevar, 2004). In-fighting between European colonial powers resulted in promises to respect tribal lands and sovereignty in exchange for their allegiance vis-à-vis competing powers (Pevar, 2012). While the British in particular sought to limit expansion into tribal lands to prevent turning these potential allies into enemies, colonists often ignored land protection agreements, steeling lands and justifying their behavior through concepts such as the Norman Yoke, which held that "not only do individuals have a right to utilize and exploit natural resources on lands that are considered 'vacant' but they have a moral obligation to do so" (Brayboy, 2005, p. 432). Increasing tensions between tribes and settlers resulted in clashes, which exploded during the revolutionary war as colonists, fearing tribal alliances with the British Crown, raided tribal lands and burned villages and food supplies, pushing many tribes who had formerly been neutral in the revolutionary war into the conflict in favor of the British Crown (Deloria & Wilkins, 1999).

Ultimately, upon the establishment of the Unites States government, federal policy officially was to treat Indian tribes as sovereign foreign nations with whom the government sought to encourage trade and avoid military conflict, a policy reflecting the relative strength of Indian militaries to the exhausted post-revolutionary war state of the U.S. army (Deloria & Wilkins, 1999). Treaty making with sovereign Indian tribes would also serve the function of legitimating the U.S. as a true sovereign itself, capable of conducting its own foreign policy with other sovereign nations (as opposed to colonies under the British Crown which lacked standing or power to conduct foreign policy) (Pevar, 2004). In the Northwest Ordinance of 1787, Congress declared that "the utmost good faith shall always be observed towards Indians; their land and property shall never be taken from them without their consent." Unofficially, however, the government was turning a blind eye to land grabs made by its citizenry and, as revealed in the Federalist Papers, Constitutional framers regarded Indian tribes as savage enemies blocking westward expansion and capable of forming dangerous alliances with other sovereign governments (Deloria and Wilkins, 1999, citing Alexander Hamilton in *Federalist* No. 24).

As a result, the government sought to engage tribes in treaty making in order to acquire land and, through the Articles of Confederation's assumption of authority over Indian affairs, began laying the legal ground work for expropriation of Indian lands as well as establishing plenary power of federal law over Indian tribes (Wilkins, 2007). In 1823, in one of a series of landmark legal cases, the Supreme Court in *Johnson v. McIntosh* (1823), adopted the "doctrine of discovery" - a legal doctrine originally developed by the Spanish Crown which granted exclusive legal title to, and sovereign

status over, lands "discovered" by European countries (or acquired by negotiated land exchanges between European sovereigns) (Wilkins & Lomawaima, 2001). This, along with the doctrine of conquest, which held that lands won in battle included full title to the lands and the right to control/remove the local population, allowed the Courts and federal lawmakers to chip away at notions of tribal sovereignty, suggesting instead that tribal sovereignty implied a mere right of occupancy (Deloria & Wilkins, 1999). This would set the stage for later policies of removal and related case law legitimating the notion that the American legal framework was the natural and exclusive framework of laws within the territorial boundaries of the U.S. As Deloria and Wilkins (1999) explain:

> The heritage of the European/Euro-American claim of legal title to Indian lands has remained constant…The nomenclature used to discuss Indian land rights has changed a bit, and we now describe Indian lands as being held "in trust" by the United States, a euphemism that simply avoids the necessity of remembering that Indians, with some rare anomalies, are not thought to own the legal title to their lands and can be dispossessed by the U.S. government at any time (p. 7).

Federal Indian health policy post-contact-1828.

In terms of federal government health policy during this period, the U.S. Army provided the first governmental health services to Indigenous peoples in the early 1800's, largely as a matter of self-interest to curb infectious diseases near army posts – diseases originally brought by settlers and army men and which had devastating consequences for native populations (Shelton, 2001). The government also provided funds to religious and philanthropic agencies for health and education of Indians in order to bring them the gospel and "civilize" the Indian (Shelton, 2001; Deloria & Wilkins, 1999). The

government understood there was a link between health service provision and assimilation. In capitalizing on the eager willingness of citizens to "help save the Indians," the government used health services as an assimilative tool through exposure to European/Western culture in the course of service provision. The assimilative nature of these policies is also clear in that by linking potentially life saving care provided by federally funded religious and philanthropic groups with requirements for Indian care recipients to Anglicize their dress, behavior, language, as well as changing the relational status to one of dependent/subordinate as Indians had to ask for help to cure the very illnesses colonizers gave them in the first place. In conceptualizing health policy as "helping" and as a useful tool in assimilation, we see the first explicit uses of Indian health policy as a tool of colonization.

1828 – 1887: Removal and the Trust Relationship

With the arrival of Andrew Jackson into the U.S. Presidency in 1829, federal Indian policy shifted dramatically from treaties between equals to a new federal policy of Indian removal (Pevar, 2004). In a thinly veiled, self-serving justification for taking Indian lands, Jackson argued that removal of Indians from their lands was necessary for their own protection from White encroachment (Prucha, 1969). Driven to seize lands for westward expansion, Congress passed the Indian Removal Act of 1830. Tribes, under the threat of death and diminished by disease and relentless westward expansion, ceded vast tracts of land in exchange for federal promises of protection, respect for Indian sovereignty on the new land bases, and guarantees that the federal government would provide for the health, general welfare and education of Indian peoples (Wilkins & Lomawaima, 2001).

Beyond the real and destructive consequences these relocations had on Indian peoples, this notion of the federal government as guarantor or protector implicated a host of responsibilities and legal obligations towards the tribes which would become the foundations of federal Indian law and in particular, would frame the federal government's obligation to provide health care to American Indian peoples. Through a series of cases interpreting treaty obligations, the Supreme Court recognized the special relationship between the federal government and Indian tribes, who were defined as "domestic dependent nations" (*Cherokee Nation v. Georgia,* 1831). The Court repeatedly held that in entering into these treaties for millions of acres of land, the federal government had obligations of the "highest responsibility and trust" towards Indian tribes (*Seminole Nation v. U.S.,* 1942, at 296-297) and this obligation extended beyond specific treaties to a broader duty to protect tribal lands, guarantee continued tribal sovereignty and to promote economic and social policies that would support Indian survival and wellbeing (Pevar, 2004). This responsibility to protect and support American Indian development became known as the *trust doctrine* and would evolve from conceptualization as a ward/dependent-guardian relationship to a fiduciary one of trustee-beneficiary (Pevar, 2004).

Federal Indian health policy in the removal era: 1828-1887.

As part of trust doctrine, the federal government became obligated to provide for the health and wellbeing of Indian people, including the provision of health care and behavioral health services (Dixon & Roubideaux, 2001). Understanding that the trust responsibility frames the provision of health services to American Indians is critical, not only because it suggests a certain level of quality should be provided (which has rarely

been met) but also because there is a propensity among the general non-Indian public to complain that American Indians get free health care from the federal government: to wit, it was not free – they paid for it with their lives, their freedom and millions of acres of land. Moreover, the government has often failed to live up to its responsibility in providing health care.

In 1832, two years after passage of the Indian Removal Act, Congress made its first appropriations for AI health care in order to secure small pox vaccines (Act of May 5, 1832) but little else was done despite numerous treaty obligations and this evolving trust responsibility. In 1849, responsibility for American Indians was transferred from the War Department to the Department of the Interior and the Bureau of Indian Affairs (BIA), however, despite its obligation to provide health services, the BIA did not attempt its first health care initiative until 24 years later when, in 1873[18] the BIA created a handful of underfunded health programs lasting only four years (Shelton, 2001).

Health policy in this period became characterized by utter neglect or, in some cases, active attempts to destroy AI cultures through the replacement of AI treatment modalities with Euro-centric/Western models of health and intervention or by criminalizing traditional care. For example, as federal policy was dominated in this era by efforts to remove and silence the politically unwilling, federal health law and policy took a particularly aggressive turn as traditional healers, who played central roles within communities, were as seen as a threat. While affirmative policies to provide health care, as required by treaty and the trust obligations, did not begin in earnest until 1908

[18] This first, weak attempt at health care services occurred two years after Congress declared, in 1871, the end of treaty-making between the federal government and the tribes (Deloria & Wilkins, 1999; Pevar, 2004).

(Shelton, 2001), the government actively sought to destroy Indian health and wellness practices (Pevar, 2004). A letter written by H.M. Teller, Secretary of the Interior, in 1882 is revealing in this regard, illuminating governmental attitudes that presaged federal health and larger federal Indian policy in the years to come. Writing to Hiram Price, Commissioner of Indian Affairs, Teller explained:

> Another great hindrance to the civilization of the Indians is the influence of the medicine men…The medicine men resort to various artifacts and devices to keep the people under their influence and are especially active in preventing the attendance of children at public schools, using their conjurer's arts to prevent the people from abandoning their heathenish rights and customs…Their services are not required even for the administration of the few simple remedies they are competent to recommend, for the Government supplies the several agencies with skillful physicians, who practice among the Indians without charge to them. Steps should be taken to compel these imposters to abandon this deception and discontinue their practices (H.M. Teller, Secretary of the Interior, to Hiram Price, Commissioner of Indian Affairs, Dec. 2. 1882).

The following year, the federal government banned Sun Dances and made it a crime to practice traditional medicine – an Indian Offense punishable by a prison term of indeterminate length, ending only upon an acceptable showing to the court and to the reservation agent that the "medicine man" intended to forever abandon his practice (Shelton, 2001). In addition to these frontal attacks on Tribal healers, the government began its program to "kill the Indian, save the man" through the creation of boarding schools where thousands of Indian children, often forcibly removed from their

communities, were stripped of all things rooting them to their culture and way of life including native language, dress, religious practices, and familial/community contact (Adams, 1995). Boarding schools were an explicit attempt at cultural genocide masked as "helping" and bringing the Indian into civilized modernity (Adams, 1995; Pevar, 2004). Of particular relevance to issues of health and healing, boarding schools interrupted inter-generational knowledge transmission, including knowledge about how to live in ways that would promote balance and health, as well as specific knowledge about the healing arts. The boarding schools also impacted health long term as trauma from these assimilative policies and rampant sexual and physical abuse at the schools rippled through generations of families (Adams, 1995). Though boarding schools would begin during the removal era (with the first federal boarding schools opened in 1875), they would last well into the 1920's as part of an overall federal policy of assimilation and their use would mirror similar developments in mental health policy in the era following removal vis-à-vis the use of insane asylums to "help cure" the Indians of "madness and savagery" (Leahy, 2009).

1887-1934: Assimilation and Allotment

According to Pevar (2004), federal Indian policy between 1887 and 1934 was characterized by two themes: the desire to take additional land from Indians for settlement by Whites and the widely held belief "that the best way to help Indians overcome their poverty was by encouraging them to assimilate into White society" (pg. 8). In accordance with these goals, Congress passed the General Allotment Act of 1887(the "Dawes Act") (25 U.S.C. § 331 et seq.) which parceled out reservation land to individual, male heads of households to be held as private rather than communal

property, with "excess" parcels conveniently sold to non-Indians and with funds from the sale of land to be held in trust by the federal government[19] (Shelton, 2001). The goal was to end collective ownership of land, further erode property holdings of the tribes, and force assimilation into White culture. This policy was exceptionally successful in achieving the goal of coercive land transfers from Indians to non-Indigenous populations and also exceptional in its marked failure to pull Indians out of poverty, in fact driving many even deeper into poverty (Pevar, 2004). Federal policy continued to push assimilation, despite widespread resistance, through its boarding school policies and in, 1924, Congress passed legislation conferring U.S. citizenship on all Indian peoples (8 U.S.C. § 1401b).[20]

Federal Indian health policy 1887-1934: The Canton Asylum.

It is in this period of assimilation that we see the advent of the first formal mental health policy for American Indians in the form of a locked psychiatric facility: the Canton (Hiawatha) Asylum for Insane Indians (Leahy, 2009).[21] Falsely claiming that there was an epidemic of "demented Indians" who would suffer needlessly on their reservations without federal intervention, in June of 1897 Senator Richard Pettigrew of South Dakota

[19] Years later, through the exhaustive efforts of several American Indian plaintiffs, it came to light that the Department of the Interior had grossly mismanaged trust accounts resulting in losses to American Indian beneficiaries in excess of $176 billion. After more than ten years of litigation and appeals, in December of 2009, both sides agreed to a settlement of $3.4 billion, with checks issuing in the early half of 2013. See *Cobell v. Salazar* (previously *Cobell v. Kempthorne* and *Cobell v. Norton* and *Cobell v. Babbitt*) *See, Cobell v. Salazar (Cobell XXII),* 573 F.3d 808 (D.C. Cir. 2009).

[20] As citizens of the U.S., as well as being residents of the state they reside in addition to tribal membership, AI/AN individuals are eligible for federal Indian health care through IHS as well as all state and federal programs available to all U.S. citizens. In practice, however, individuals are often denied federal or state program health benefits because enrollment staff wrongly assume that eligibility for federal Indian-only IHS health care is mutually exclusive with other federal or state programs (Shelton, 2001).

[21] For a beautiful, if haunting and disturbing, poetic rendering of the history of Canton AII, see Jennifer Soule's piece entitled "Hiawatha's Asylum for Insane Indians" at: http://sdmines.sdsmt.edu/upload/directory/materials/23249_20101021092150.pdf

proposed a mental hospital exclusively for Indians, conveniently to be built in his home state (Leahy, 2009; Waldram, 2004). Two years later in 1899, Canton Asylum for Insane Indians was born, with its first "patients" admitted in 1902 (Leahy, 2009). Aiming for the "total assimilation of the patient to the 'normal' standards of the dominant society" (Leahy, 2009, p. 40), Canton was open to both adults and children and there were no formal admissions criteria beyond the recommendation of a reservation agent for commitment, nor any legal process in place to challenge confinement (Leahy, 2009). Diagnoses ranged from chronic epileptic dementia and acute melancholia to hysteria, promiscuity, and congenital imbecility (Waldram, 2004). Run by an individual with no medical, psychological or healing training, Canton treatment modalities consisted of labor, sedatives, tonics, gardening and control through physical punishment (Leahy, 2009). Similar to boarding schools of the era, patients at Canton were not allowed to use their native languages, the staff cut their hair and required them to dress in asylum attire (Stawicki, 1997). In a 1929 report written by Dr. Samuel Silk - Clinical Director at St. Elizabeth's psychiatric hospital, Silk describes conditions at Canton as deplorable, writing that:

> Three patients were found padlocked in rooms. One was sick in bed, supposed to be suffering from a brain tumor, being bedridden and helpless...a boy about 10 years of age was in a strait jacket lying in his bed...one patient who had been in the hospital six years was padlocked in a room and, according to the attendant, had been secluded in this room for nearly three years (Stawicki, 1997, citing Silk, 1929).

Though few if any of the hundreds of Indians admitted to the facility ever left Canton, subsequent review of the records indicated that the majority of patients admitted were in fact free of mental disorder (Waldram, 2004). The 1929 Silk report on Canton is clear in this regard, stating:

> Would not the United States, if it could be held liable at all, be liable in these cases for enormous damages? The records of the asylum itself show them to be perfectly sane. They are known to be perfectly sane, to the director of the asylum Dr. Hummer. But he assumed the position that these people were below normal – mentally deficient - and they should only be discharged after they were sterilized, and as he did not have any means of doing this, there was nothing left but to keep them there (cited in Stawicki, 1997).

In his review of Canton, Todd Leahy (2009) writes:

> The mental hospital at Canton provided a new mechanism [for] informal social control…Having turned its attention to assimilating individual Indians, the Bureau of Indian Affairs incorporated aspects of incarceration in the asylum…The Indian Office focused their attention on persons who opposed the assimilation project on their respective reservations. Through the asylum, the Indian Office could 'treat' the insane and remove the recalcitrant (p. 37).

Although Canton took mental health policy and coercive assimilation policies to a new level, the practice of sending the politically uncooperative and unruly to the insane asylum was not wholly new. In fact, reservation agents would threaten to commit parents who refused to send their children to boarding school to general population asylums, and, for those who dared to test those threats, they would be committed and their children

subsequently taken away as "legal orphans," free for adoption to White families[22] (Leahy, 2009; Waldram, 2004 citing Angie Debo, 1940). Thus we see the use of mental health policy to facilitate colonization explicitly to facilitate removal and silence dissent but also implicitly as "appropriate forms of helping" became linked with the exclusive use of Western/Euro-centric approaches in conceptualizing and treating illness (noting of course that in this case, the individuals were not mentally ill to begin with even by Western standards). Canton would remain open for 32 years, closing in 1934 after numerous reports on the barbaric conditions and political abuses there.

Other health care policies developing during this period included the BIA's second attempt at providing general health care services to tribal members, beginning in 1908 (DeJong, 2011). By 1920, the lack of funding and the pitiable state of health care services provided through the BIA drew the attention of Congress. In 1921, Congress passed the Snyder Act (25 U.S.C. § 13), appropriating funds for "the relief of distress and conservation of health" of American Indians as well as to pay for the employment of physicians in tribal areas.

However, by 1928, conditions remained quite poor and, as documented in what would become known as the Meriam Report, a research study conducted to explore the impact of federal Indian policy, the destruction caused by allotment policies, boarding schools and poor health care policies was evident (McCarthy, 2004). The Report concluded that the federal government had failed to meet its obligations to Indian peoples on all fronts: protection of land, health, education and its mission to "civilize" Indian

[22] Although generally not in the context of asylums, the practice of removing Indian children from their parents and placing in the dependency system where they could be freed for adoption into non-Indian homes was so rampant that Congress finally passed the Indian Child Welfare Act in 1978 (25 U.S.C. 1901 et seq.) to provide increased protections for Indian families and children.

peoples, in fact making their living conditions even worse than ever before (McCarthy, 2004). The Report called for massive revamping of federal policies, increased funding for culturally-supportive programming, increased tribal autonomy, and policies for the protection of Indian lands. An outraged Congress responded with 8 years of hearings before it too had to conclude that federal Indian policy had utterly failed in its trust obligations to maintain the health, education, well-being and land protection of Indigenous peoples (Deloria & Lytle, 1983).

1934-1952: Indian Reorganization and Self-Government

The Meriam Report (issued in 1928), along with a change in BIA management, as well as the advent of the Great Depression and President Roosevelt's New Deal politics, ushered in a new era of federal Indian policy. John Collier took over the Commission on Indian Affairs and began to revamp federal policy, pushing to adopt the proposals included in the Meriam report (Pevar, 2004). Whether *Congress'* agreement to reverse course on policies such as boarding schools and other assimilationist programs was born out of concern for Indian well-being and sovereignty or perhaps more likely out of a desire to use tribal self-government-based policies as a means of cutting back on expensive Indian-only programs during the depression era, is unclear, although the desire to terminate federal Indian programs would become explicit in the years to come (DeJong, 2011).

Nevertheless, for American Indians, this New Deal period was profoundly defined by Collier's leadership and in particular by the passage of the Indian Reorganization Act of 1934 (hereinafter "IRA") (25 U.S.C. § 461 et seq.). Although grounded in somewhat paternalistic paradigms, the IRA sought to improve conditions by building on tribal self-

determination and self-government, providing economic stimulus and increasing tribal control over how funs would be used to improve the lives of tribal members (Wilkinson, 1987). Other IRA provisions included ending allotment policies, returning allotted lands or allocating new lands to tribes (upwards of 2 million acres), creating new health facilities and infrastructure projects, and supporting the revival of tribal governments which had faltered under the weight of previous oppressive policies (Pevar, 2004; Wilkinson, 1987).

The IRA afforded opportunities for self-government, the creation of tribal constitutions and by-laws, as well as the revival of culturally appropriate programming. However, many tribes found it difficult to create legal/governmental frames consistent with their tribal traditions after so many years of dislocation, educational and cultural "re-programming," legal prohibitions on practicing traditions of tribal governance and the constraints in governance formation under the IRA (Deloria & Lytle, 1983). The IRA's model for self-governance was inconsistent with traditions held by many tribes. For example, the IRA model of governance was based on a majority-vote, winner takes all approach to governance whereas many tribes had long-standing traditions of consensus-based decision-making (Dixon & Roubideaux, 2001). Moreover, although some tribes had long traditions of Constitutionalism, for many others the experience of self-government through constitutions and election of council members based on farming districts created during the allotment era was wholly foreign, based on "abstract principles of American democracy which viewed people as interchangeable and communities as geographical marks on a map" (Deloria & Lytle, 1983, p. 15). Thus

while the Reorganization period was a significant improvement over prior eras, it was not a panacea for tribes and tribal governance.

Federal Indian health policy in the IRA era (1934-1952).

In terms of federal health policy during the Reorganization era, we see two distinct policy trends, one in 1934-1941 and a far more insidious policy turn following World War II. The commencement of the Reorganization period was characterized by internal debates over whether to transfer the Indian Medical Service ("Indian Service") into the general population federal Public Health Service to achieve increased efficiency and create oversight by the PHS which, Chief Medical Supervisor James Townsend argued, would improve medical services to AI/AN populations (U.S. Code & Admin. News, 1954). As Commissioner of Indian Affairs, Collier fought against the transfer which he believed would functionally strip the Indian Service of its independence (DeJong, 2011). Collier argued that economic efficiency and integration with state services could be achieved through improved rights under New Deal legislation for the Indian Service to contract with states and local providers for services it was currently unable to provide (House Bill No. 7781, 1935). The debate over transfer dominated Indian health care policy, lasting for a number of years until the debate itself became swamped by the prospects of war (DeJong, 2011).

The years following World War II ushered in a new era of conservatism and efforts to create efficiency in federal programming through the merger of general population and AI facilities began to evolve into calls for the outright termination of federal Indian programs, including health care (DeJong, 2011). It was in this context that numerous medical associations, the National Congress of American Indians and the

Association on American Indian Affairs sought to re-ignite the issue of transferring the Indian Service to the Public Health Service (DeJong, 2011). In an era of increasing Indian hospital closures, significant financial abuse by Indian Service bureaucrats, and a turn in the political winds towards termination of federal trust obligations to provide any kind of services to American Indians, the goal of transferring the Indian Service to the general population Public Health Service was to preserve access to care, increase access to funding, and to address gross understaffing of health care professionals and training issues in Indian Country (DeJong, 2011).

However, while some groups saw transfer and consolidation as a possible solution to poor health care in Indian country and a work around to avoid outright termination of AI services, many tribes were extremely wary of the move, arguing that the proposed legislation failed to authorize the PHS to contract with tribes and more ominously, that the merger of the Indian Health Service program and delegating service responsibilities to the states was simply a precursor to efforts to liquidate all federal Indian programs (DeJong, 2011). Their fears were well-founded as we see in the next era of federal Indian policy: the era of termination.

1953-1968: Termination and Urban Relocation

The pro-development and self-government era policies exemplified by the Indian Reorganization Act would last less than 20 years, truncated by a new administration which believed the whole costly "Indian problem" could be addressed simply through termination: termination of tribes, termination of Indian-specific programs and by the complete integration of Indians into the American fabric as simply another racial group (Deloria &Lytle, 1983; Pevar, 2004). In practical terms, termination of the trust

relationship meant the loss of federal recognition as a tribe and tribal government, the dissolution of the reservation and the loss of all federal funding and services, including health care (Pevar, 2004). Termination would "in effect rescind…the federal authority over 'Indian affairs' established in the commerce clause of the Constitution" (Wilkins and Lomawaima, 2001, p. 132) leaving terminated tribes and Indian peoples subject to the whims of State law and abrogating federal trust responsibilities established in hundreds of treaties and in a century of case law. Framing termination as "real independence" for Indian tribes with demonstrated ability to manage their own economic affairs, Congress declared in 1953 that federal benefits and services should end as rapidly as possible - over the subsequent decade, the federal government would end its trust relationship with 109 tribes, ordering them to distribute property and disband (Deloria & Wilkins, 1999).

Another important event during this era was the 1953 Congressional passage of Public Law 83-280 (commonly referred to as PL 280), which extended state jurisdiction over tribal lands for criminal offenses and for limited civil matters involving private persons or property (Pevar, 2004). This extension of jurisdiction was mandatory for 5 states including California (later extended to a 6th) and optional for the remaining states. The legislative rational given for PL 280 was the intention to reduce lawlessness and a lack of access to courts in tribal communities by opening state courts for criminal cases and for settling civil matters between private parties (H.R. Rep. No. 848, 1953). However, other policy options such as funding tribal courts and law enforcement initiatives could have supported the need to improve access to justice without the massive extension of the arm of the state into tribal territory (Pevar, 2004). The choice to extend

state jurisdiction, particularly in criminal matters, was consistent with the federal government's overall agenda of assimilation, diminishment of the primacy of tribal government and with termination era policies. PL-280 continues in effect today and, as will be discussed below, this termination era policy has gained new traction through expansion of the civil jurisdiction portion of the bill via case law, particularly in the areas of civil commitment law and child welfare. This issue is examined in depth in subsequent chapters but it is important to note here the historical roots of modern day policy, particularly when those roots grew from the soil of termination era agendas.

Health policy during termination & relocation (1953-1968).

Termination policy had devastating consequences across the board. For terminated tribes, termination of health care services along with the total withdrawal of economic, social and other basic programming support delivered not only a psychological blow but the material consequences were often dire and contributed to record declines in both physical and mental health. For example, Shelton (2001) writes that for the Klamath Tribe, which was terminated in 1961 (though later restored in 1986), the once healthy Nation saw alarming declines in health and marked increased in early deaths. Infant mortality rates rose to twice the state average and 28% of Klamath tribal members were dying by age 25 (52% of tribal members died before age 40, with 40% of deaths during this period being alcohol related) (Shelton, 2004). These numbers were by no means unique to the Klamath Nation. The average life span for American Indians during the termination period dropped to just 42 years old, "two decades less than the general population" (Wilkinson, 2005, p. 22). Here we see clear links between federal Indian policy, the politics of existence for tribal communities and health outcomes.

Termination policy was further bolstered by relocation efforts which offered job training and housing assistance to encourage Indians to relocate to urban centers where federal policy-makers argued they would assimilate into the American fabric as simply another ethnic minority (Aragon, 2006). The promises of jobs and housing often proved to be empty and roughly a third of people returned home (Aragon, 2006). Of those who remained, alienation, poverty, trauma and a profound sense of dislocation resulted in dramatic increases in behavioral health issues for urban Indians, including substance abuse and suicide (Saylors & Daliparthy, 2004; Wilkinson, 2005).

For American Indians who did not have their tribal status terminated during this period, the Public Health Service and the Indian Health Service (IHS) (following the transfer of the Indian Service in 1954) provided health services to AI individuals (DeJong, 2011; Shelton, 2004). Congress significantly underfunded health services and health status indicators were still markedly below the general population even for tribes that maintained federal recognition. Moreover, beyond neglect and poor care, there were rumors of outright malfeasance. After a decade or more of complaints, these rumors were revealed as truths when it came to light that IHS doctors were covertly sterilizing Native women as a matter of routine practice – women would go in to receive basic health care such as a C-section or other procedure and wake up to find they had been sterilized by IHS doctors without their knowledge or consent (Kuschell-Haworth, 1999). It is important to note that in similar cases with Latino and African American women, the doctors responsible for these procedures consistently reported feeling as though they did nothing wrong and that their actions were in fact wholly ethical as they conceptualized their patients to be ignorant, impoverished "baby-makers" who, but for the doctors'

intervention, would continue to have more children than they could care for (see *Madrigal v. Quilligan*, 1981). Despite the outright genocidal nature of these ideas and practices, the courts found the doctors were not liable for the unwanted sterilizations.

1968-Present: Tribal Self-determination

In the wake of the civil rights movement and significant activism within American Indian communities against the draconian and unethical practices of the 1950's and early sixties, federal Indian policy once again shifted dramatically, with President Johnson repudiating termination policies and announcing a new era of federal support for Indian rights, self-determination and preservation of culture (Pevar, 2004). Congress passed legislation limiting judicial and state law intrusions into Indian country, restored federal tribal recognition to many of the tribes terminated during the earlier period and created new legal frameworks for programs to improve conditions on reservations that afforded significantly more control over program administration and development to tribal governments (Wilkinson, 2005).[23]

Of particular relevance to health and mental health law were two key laws: The Indian Self-determination and Education Assistance Act of 1975 (25 U.S.C. § 450 et seq.); and The Indian Health Care Improvement Act of 1976 (permanently reauthorized in 2010) (25 U.S.C. §§ 1601-1680o). The Indian Self-determination and Education Assistance Act of 1975 (amended in 1988 and 1994) requires federal agencies to allow tribal administration of a range of programs, including health care. This made it possible

[23] Other important laws passed during this period include the Indian Child Welfare Act (1978); Indian gaming laws and tax reforms; the Indian Civil Rights Act of 1968; laws pertaining to natural resource protections and extraction rights; protection of sacred sites and Indian artifacts, education laws including No Child Left Behind (2003) and other reforms to support Indigenous centered education (see e.g. Getches, Wilkinson, Williams, & Fletcher, 2011; Goldberg, Washburn & Frickey. 2011; Pevar, 2004; Wilkins & Lomawaima, 2001).

for tribes to take over many IHS programs and, in the case of substance abuse, to apply for federal block grants directly to the Substance Abuse and Mental Health Services Administration (SAMSHA) (Shelton, 2001). In 1994, amendments to the Indian Self-determination Act further improved the contractual mechanisms for tribal control of health (and other) programs and increased tribal input into IHS-run programs through mandated negotiated rule-making provisions between the Department of Health and Human Services and tribal governments. The 1994 amendments also made self-governance a permanent part of federal policy, while also acknowledging the full force of the federal trust responsibilities. However, tribal administration of health care programs is still constrained by the funding and regulatory requirements governing IHS, limiting the degree to which tribes can design programs deviating from federal/Western-centric notions of best practice in health care services.

The Indian Health Care Improvement Act: 1976-2009.

Passed originally in 1976, the Indian Health Care Improvement Act (25 U.S.C. §§ 1601-1680o) became the cornerstone legislation for the provision of health care services to AI/AN populations, with special provisions for Indians in urban areas. In enacting the IHCIA and its amendments, Congress has declared that it "is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians…provid[ing] all resources necessary to effect that policy" (IHCIA, 1976, 25 U.S.C. 1602a). While the stated goals, funding and increased possibility for tribal participation and control over health programs were steps in a more promising direction, the IHCIA prior to 2010 failed to deliver on many of its promises (Kuschell-Haworth,

1999; Shelton, 2001; Somers, 2010). Access to care remained limited by budgetary constraints, lack of personnel, convoluted reimbursement and payment schemes, and payer of last resort formulas that often impeded access to care and adequate referrals to non-IHS service providers or specialists (Kuschell Haworth, 1999). Health outcomes for AI/AN populations, while improved over those during the termination era, remained disproportionately poor as compared to the general population, particularly with regards to preventable, chronic illnesses and behavioral health problems (U.S. Department of Health and Human Services, 2001; 2006).

Moreover, the pre-2010 IHCIA limited reimbursement for contract services to only those services IHS was authorized to provide or to "health care providers" as defined in the regulations – this functionally excluded all traditional healers from inclusion in the formal health care delivery system, although many programs worked around this by employing traditional healers as "consultants" or "social work technicians" (Kuschell-Haworth, 1999). This was in stark contrast to legislation passed in 1988 (re-authorized in 1992) for Native Hawaiian health care which included language explicitly authorizing funding for traditional healers as designated by the Native Hawaiian government (42 U.S.C. 11701 et seq.). In addition, after 2000, funding under the IHCIA was appropriated on an annual basis, leaving the entire system subject to uncertainty and swings in budgets based on the political climate on Capitol Hill from year to year (Somers, 2010).

The Indian Health Care Improvement Act: 2010 – Present.

Tribal leaders and Indian community activists worked tirelessly for years to get the IHCIA reformed (see e.g., National Indian Health Board, 2011). In 2010, President

Obama signed into law the 2010 Indian Health Care Improvement Reauthorization and Extension Act, passed as part of the larger health care reform bill, the Patient Protection and Affordable Care Act.[24] Permanently authorizing appropriations for Indian health care, the new and improved IHCIA increases authority for tribes to conduct their own health programs; expands the health care workforce via training, recruitment, and funding for assistants to conduct a broader range of basic services; provides organizational reform to IHS; and provides funding and programs for dental and chronic diseases (including mandatory screening for diabetes when medically indicated) (Somers, 2010). The revised IHCIA also allows dental assistants to provide basic care; mandates long-term care/hospice/home health care programs; reforms the reimbursement process to make it easier for Indian tribes to collect from third party payees or to bill the government for services covered by Medicare, Medicaid, Children's Health Insurance Program; and reforms benefits availability for employees and dependents (U.S. Department of Health and Human Services, 2010; Somers, 2010).

The IHCIA of 2010 also includes for the first time comprehensive behavioral health program "suggestions" covering a wide range of problem areas across the full spectrum of the continuum of care for behavioral health services (e.g., community education, home health, community based counseling, outpatient and inpatient care, as well as prevention, intervention, and aftercare) (IHCIA, 2010; Somers, 2010). Programs are "suggested" in that Section 702b states that "The Secretary, acting through the Service, *shall provide, to the extent feasible and if funding is available*" the behavioral programs listed in the Act (emphasis added). The only actual mandates in this section are for a needs-and-feasibility

[24] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010).

assessment by IHS and the possibility of funding for technical assistance and administration for tribes wishing to develop a community behavioral health plan. Nevertheless, behavioral health programs suggested in the law include the following: youth suicide prevention; youth and adult drug and alcohol education/rehabilitation; sex-specific domestic violence, sexual assault, and sexual violence programs; fetal alcohol spectrum disorder programs; child sexual abuse prevention and treatment; dual diagnosis programs; community outreach/education programs; and mental health assistantships and training programs (IHCIA, 2010 § 702).

Of particular interest in the behavioral health programs portion of the Act is Section 709, which authorizes creation of the first locked psychiatric facility dedicated to American Indians since the Canton Asylum for Insane Indians back at the turn of the 20th century. Section 709 of the IHCIA states that within one year of passage, the IHS "*may* provide, in each area of the Service,[25] *not less than* 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems" (IHCIA, 2010, § 709, emphasis added). The "*may provide not less than*" language is ambiguous, falling short of the mandate implicit in "shall" language but also not wholly permissive in nature and as such, it remains unclear whether any facilities will be developed. To date, the only action taken on the inpatient facility provision appears to be an IHS needs assessment report (which remains unavailable to the public) and IHS Director Roubideaux's comment in a letter to all tribes stating simply that additional actions on inpatient mental health will require appropriations (Roubideaux, 2011). Nevertheless, the prospect of developing inpatient mental health facilities for AI/AN populations raises a host of issues

[25] California would have two facilities, one Northern and one Southern.

including those related to the legal processes by which an individual could be involuntarily confined to such a facility and more broadly the law of civil commitments, to which we now turn.

Chapter 5

Understanding the Law of Involuntary Psychiatric Commitments

This chapter provides an introduction to the law of mental health-based involuntary psychiatric commitments and provides an overview of the relevant Federal Indian laws which impact mental health services for American Indians. The goal here is to provide a roadmap for understanding what the law actually says before we begin the legal analysis.

What is Mental Health Law and Civil Commitment?

In the context of mental health, civil commitment law is a set of legal procedures governing how, when and for how long a person with a mental illness can be placed in a locked psychiatric facility against their will (e.g., involuntary psychiatric commitment). Mental health civil commitment does not imply that the person committed any crime - commitment is for treatment and stabilization rather than punishment (although the person confined may very well experience it as punishment). Individuals can be subject to involuntary civil commitment related to criminal charges, for example civil commitment to a psychiatric facility after being found mentally incompetent to stand trial for a crime,[26] civil commitment of defendants found not guilty by reason of insanity, or post-sentence civil commitment for sexually violent predators.[27] This discussion, however, is limited to the laws governing involuntary commitment of individuals diagnosed with a mental disorder(s) and applies only in the cases where the disorder

[26] For more detail on this see, Disability Rights California at: http://www.disabilityrightsca.org/pubs/507701%20Ch%201.pdf

[27] Welfare and Institutions Code sections 6600 et seq.; see also See *United States v. Comstock,* 560 U. S. (2010), No. 08-1224.

impairs their ability to maintain themselves safely in the community (either because they are a danger to themselves or others or they have become gravely disabled such that, as a result of the mental illness, they are not able to provide for their food, clothing or shelter).

These mental health-based civil commitment laws create legal processes for determining under what conditions a person with a mental illness can be involuntarily admitted to a psychiatric facility and create legal channels to challenge the commitment. Civil commitment laws also limit the length of time a person can be held in the facility and afford various due process protections. These laws also exclude from commitment people with only physical/cognitive disabilities, people who are surviving safely in the community despite mental illness, and people who simply live in ways at odds with dominant social norms. We will examine the laws in more depth below, however, mental health-based civil commitment and conservatorship laws are generally a state matter and the legal frameworks vary to some degree from state to state. As such, this discussion uses one state, California, as an exemplar to give readers a more concrete idea of how the process works generally and how these laws apply in the context of both urban and reservation-based AI populations.

California as an exemplar: California and the case studies.

Among all of the states, California continues to have the largest population of AI/AN persons, with an estimated 440,000 individuals of AI/AN heritage, with that number rising to 739,000 when including individuals of AI/AN heritage in combination with another racial group (as identified in U.S. census data collection) (U.S. Census Bureau, 2008). California has 108 federally recognized tribes representing approximately 20% of all tribes in the United States (Center for Families, Children & the Courts, 2011).

Ten California counties rank among the nation's top fifty U.S. counties with the highest AI/AN populations (U.S. Census Bureau, 2001; 2008). In California, only 3% of the AI population reside on reservation lands, with large numbers of urban Indians often times concentrated in the larger cities or living near Rancherias in more isolated parts of the state (Center for Families, Children & the Courts, 2011). Given these demographics, California makes an excellent exemplar for understanding how mental health laws impact AI populations. This analysis examines California state law as well as using two case study counties, Los Angeles County and Humboldt County, to assist readers in understanding the complex issues governing the civil commitment and conservatorship processes for AI peoples.

Los Angeles County is an urban county with the largest AI/AN population of all California counties (estimated at 98,000) (Center for Families, Children & the Courts, 2011; U.S. Census Bureau, 2008). With such a large American Indian population and no federally recognized reservation lands in the County, Los Angeles provides excellent examples of issues relevant to urban Indian mental health care. In contrast, Humboldt County, located in Northern California, is a largely rural setting with California's largest Indian reservation, the Hoopa Valley Indian Reservation, within its boundaries (Hoopa Valley Indian Tribe, 2003). Humboldt County also encompasses a portion of the Yurok (Oohl) Tribe, the largest tribe per capita in the state (Yurok Tribe, 2006), as well as six additional rancherias/reservations. These include: the Karuk Indian Reservation (partly located in neighboring Siskiyou County and including tribal members of the Karuk, Klamath, and Shasta Tribes), the Big Lagoon Rancheria (including Yurok and Tolowa tribal members), Blue Lake Rancheria (including Yurok, Wiyot, and Hoopa tribal

members), the Cher-Ae-Heights Trinidad Rancheria (including Chetco, Hoppa, Karuk, Tolowa, Wiyot and Yurok tribal members), the Rohnerville Rancheria – Bear River Band (including Mattole and Wiyot tribal members), and the Wiyot Tribe's Table Bluff Rancheria.[28] The large size of the Hoopa reservation and Yurok Nation, plus the additional 6 reservations/rancherias within the county, make Humboldt County an ideal case study to highlight law/policy issues relevant to American Indians residing on reservation lands and the complex relationships between county, state and tribal governments.

Data collected for this project confirm that both counties have AI individuals subject to mental health-based involuntary commitment laws residing in their locked psychiatric facilities, as well as individuals subject to mental health based conservatorships, although the records are incomplete due to changes in technology and recording methods. L.A. County records also indicated that there are AI individuals subject to the laws governing restraints and involuntary administration of psychiatric medications. For both counties, the data also confirm that neither county has any agreements, legal processes or Memoranda of Understanding in place with tribes governing the civil commitment/conservatorship process for AI tribal members nor do they have any contracts with tribally affiliated behavioral service providers to provide treatment for adult inpatient psychiatric care.[29] Humboldt County does contract with a

[28] http://www.epa.gov/region09/air/maps/images/AIR1100040_3g.gif

[29] L.A. County does have one contract with a tribally affiliated service provider for some outpatient services related to parenting and other behavioral health issues. Through various programs, the state also provides some grant support across California, including both L.A. County and Humboldt County, for outpatient AI-run health clinics, many of which provide therapeutic services. Similarly, IHS and federal-state grant programs provide limited support for outpatient health services clinics on reservation lands

tribally-chartered behavioral services provider, Two Feathers Native American Family Services of Big Lagoon Rancheria, for AI *youth* in the County's juvenile detention facility, however there are no Memoranda of Understanding or other policies in place governing placement or facilitating care by tribally affiliated or AI-centered agencies for adults. Neither county had policies outlining a process for facilitating culturally appropriate care for AI individuals in the facilities or for creating access to outside AI-centered treatment agencies. This lack of data supports the argument discussed in greater detail below that it is the silences and lack of action or attention to AI-specific issues in law and policy that evidence modern issues of colonization in mental health practice. Nevertheless, while the lack of data is in many ways data itself, the contrast of how the law functions for urban and reservation based populations as between the two counties provides useful exemplars for explaining complicated legal issues and as such, both Los Angeles County and Humboldt County are used below in the analysis to highlight how the legal issues play out in under the matrix of state, federal and tribal laws.

Mental Health Civil Commitment and Conservatorship Law in California

The body of law governing California's mental health-based commitments can be found in the state's Welfare and Institutions Code (sec. 5000 et seq.) (W.I.C.), commonly known as the Lanterman-Petris-Short Act or LPS.[30] California enacted LPS provisions in order to end "inappropriate, indefinite and involuntary commitment of people who are

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across the state. However, there are no contracts with tribally affiliated behavioral health service providers for inpatient care (e.g. for individuals subject to voluntary or involuntary psychiatric commitment).

[30] In 1994, California voters passed Proposition 63, The Mental Health Services Act, which provided funding, culturally responsive programming and multicultural needs assessment mandates for mental health services. The MHSA does not govern civil commitment but its passage and concomitant funding mandates were significant developments in the overall functioning of California's mental health delivery system.

mentally disordered, developmentally disabled or impaired but not disabled by chronic alcoholism" (W.I.C. § 5001a) and to "provide for prompt evaluation and treatment, safeguarding individual rights through due-process judicial review with the participation of…the public defender…while guaranteeing and protecting public safety" (Gin, 2008, p.1). The LPS act provides a graduated schema for psychiatric holds, with increasingly stringent criteria for allowing involuntary commitments as the length of the commitment increases, as well as increasing levels of procedural due process rights.[31]

Civil commitment: The initial 72-hour hold.

The first level of an LPS involuntary commitment is a 72-hour psychiatric hold, often referred to as "being 5150'd" in reference to the statutory code section authorizing the hold (W.I.C. § 5150). The vast majority of cases begin (and end) with the 72-hour hold (California Department of Mental Health, 2011). A person may be involuntarily held for up to 72 hours in a designated psychiatric facility *for evaluation and treatment* if a *peace officer or other professional* identified in the statute[32] finds there is *probable cause* to believe the person is a *danger to him/herself or others or is gravely disabled* (W.I.C. § 5150, emphasis added). In meeting the danger to self or others provision, the danger must present a *substantial physical danger* to self or others *and* it must be *imminent* in nature (see e.g., *People v. Superior Court*, 1983, emphasis added). Alternatively, a person may

[31] For a very helpful chart outlining the various psychiatric holds and related due process rights, see the County of Santa Clara LPS Holds Chart at: http://www.sccgov.org/SCC/docs%2FMental%20Health%20Services%20(DEP)%2Fattachments%2FFall%2FLPS%20HOLDS-CHART.pdf

[32] Section 5150 identified the following persons as those who may make the initial probable cause determination sufficient to take an individual in for psychiatric evaluation or to have them taken to such a facility: a peace officer; a member of the attending staff…of a mental health evaluation facility designated by the county; designated members of a mobile crisis team…or other professional person designated by the county (such as a social worker or psychiatrist).

qualify as gravely disabled upon a showing that, *as a result of a mental disorder*, the person is *unable to provide* for his or her basic personal needs for *food, clothing, or shelter* or the person cannot survive safely even with the help of friends or family who are both willing and able to provide for those needs (and who have indicated as much in writing) (W.I.C. §§ 5008h1; 5250d1, emphasis added). If the individual is either a danger to him/herself or others *or* is gravely disabled, he/she can be held involuntarily for 72 hours in a locked psychiatric facility for evaluation and treatment.

The 14-Day intensive treatment commitment.

If, during the 72 hour period, the professional staff determine that the person is a danger to self or others or is gravely disabled and the person refuses voluntary treatment, they may certify the individual for involuntary intensive treatment for an additional 14 days if it appears unlikely that the individual will stabilize safely by the end of the 72 hour hold – this 14 day extension is often referred to as a 5250 hold (W.I.C. § 5250). The individual is entitled to a probable cause hearing within four days of the recommendation through an internal administrative review board (W.I.C. §§ 5256).

If the individual loses their argument for release at the administrative certification hearing, they may request a hearing in Superior Court by filing a writ of habeas corpus challenging the 14-day certification (W.I.C. §§ 5275; 5276). Notably, in many counties the process is streamlined by eliminating the administrative board review altogether and treating all challenges to involuntary holds (even challenges to the initial 72-hour hold) as requests to go directly to Superior Court via a writ of habeas corpus.[33] Upon the filing of the writ, the court must hold a hearing within two days to determine if the person is a

[33] This ensures the patient's due process protections and saves the county the cost of the administrative hearings process.

danger to self or others or is gravely disabled or, alternatively, if he/she is entitled to be released. The individual has a right to an attorney, most often the public defender, and the state/county bears the burden of proof at this level.

Involuntary confinement beyond 14 days.

If the judge finds that the person meets the legal criteria and certifies involuntary commitment, he/she may not be held longer than 14 days except under the following conditions:

1) The facility is **recommending conservatorship** through the county Public Guardian (conservatorships are discussed in more detail below). When the facility recommends conservatorship, the initial 14 day hold may be *extended up to 3 days* while the Public Guardian investigates and files for temporary conservatorship if appropriate (with total days of confinement not to exceed 47 prior to decision on the conservatorship petition (W.I.C. § 5270.55));

2) If the person presents an **imminent threat of suicide** and refuses treatment *with a threat or attempt during treatment* or causing them to be brought in for treatment, they may be *certified for an additional 14 days* (subject to the same right of habeas corpus review) (W.I.C. § 5260 et seq.);

3) In counties which have adopted optional provisions for longer term holds, an individual who remains **gravely disabled** may be *certified for an additional 30 days* (subject to the same right of habeas corpus review). However, if it appears during the 14 day hold that an extra 30

days will be insufficient to "reconstitute" the individual, a referral for conservatorship must be submitted during the 14 day period (W.I.C. §§ 5270.15, 5270.55); or

4) In rare instances, an individual may be certified as an **imminent danger to others** and with judicial review, the individual may be *held for up to 180 days* (W.I.C. § 5300).

LPS conservatorships law.

The involuntary civil commitments discussed above are short-term solutions intended for crisis intervention and immediate stabilization. However, for some individuals, short-term psychiatric interventions are insufficient and local officials may file for what is called an LPS conservatorship (a mental health-based conservatorship). A conservatorship is a legal arrangement whereby the court appoints a designated guardian (the "conservator") to take care of the needs of an individual who, it is shown during the hearing process, is unable to care for him or herself. The conservatorship may be of the *person* (e.g., the conservator acts as a guardian over the person's physical needs, general wellbeing and contractual agreements), *the estate* (conservator acts as fiduciary as to the person's finances/assets) or *of both person and estate*. The most common circumstance for the establishment of a conservatorship is through the California Probate Code for a probate conservatorship. These typically occur when families or friends become concerned for elderly or disabled family members, particularly after incidents where they have fallen victim to predatory practices. If there is no family to step in and the individual comes to the attention of Adult Protective Services as a person in need of

protection, it falls to the county's Public Guardian office to apply to become the conservator through a judicial hearing.

Humboldt County can serve as an example here for how probate conservatorships function in real time. Typically, the County's Adult Protective Services (APS) will receive a call from a community member reporting concerns that some unscrupulous individual is taking advantage of an elderly or disabled person and that the elder or disabled individual seems confused or disoriented. Often times the reports are of physical abuse or financial scams, ranging from the scammer accepting unwarranted amounts of money to getting the individual to sign over the deed to his/her home. Such behaviors may not always qualify as criminal acts but certainly necessitate intervention to protect the person. APS investigates and, if no family can be found to intervene (or if it is a family member responsible for the abuse), APS requests that the County Public Guardian file with the court to become the conservator over the person, the estate or both. The individual is appointed an attorney for a hearing wherein the court will decide if a conservatorship is legally appropriate and if so, whether the Public Guardian (P.G.) should have responsibility and control over the person and/or the estate. If appointed as conservator, the P.G. will make decisions about the persons living situation, medical decisions and finances. Any contracts signed by the individual after the conservatorship is established, for example signing away the deed to the house or agreeing to let squatters reside in the home, are not enforceable and the P.G. will pursue all criminal and civil actions necessary to try and protect the person and their assets.

A very similar process applies for individuals with mental illness, although different legal standards must be met before the P.G. can step in to take over decision-

making powers for such an individual (see e.g., W.I.C. §§ 5350-5372). Unlike probate conservatorships, which are intended to prevent victimization of individuals who are unable to protect themselves due to some kind of infirmity, an LPS or mental health-based conservatorship is based on mental health status and the individual's inability to survive without intervention. The court will establish an LPS conservatorship only if the the individual is *gravely disabled* such that, *as a result of mental disorder*, the person is *unable to meet his/her basic personal needs for food, clothing and shelter* and there is *no one else who*, as stated in writing, *can meet these needs and maintain the individual safely in the community*. Note that the inability to provide for food, clothing and shelter must be the result of a mental illness – this requirement precludes the state from involuntarily committing homeless individuals who do not have a mental illness as well as individuals who may have a mental illness but are finding ways to meet their basic personal needs.

The individual for whom the LPS conservatorship is sought has a right to a hearing and a right to no-cost legal representation to contest the need for the conservatorship or to request limitations on the powers afforded to the conservator (W.I.C. § 5350d). LPS conservatorships are most often initiated after an individual presents for emergency psychiatric care and fails to improve within the first extension of the 72-hour hold. If it appears, during this 14 day period extension, that the individual is not going to become safe and able to care for his/her basic needs, the county's Public Guardian will file for a temporary conservatorship which lasts between 30 days to 6 months, pending possible application for a permanent (year long) conservatorship (W.I.C. § 5350). Both the temporary conservatorship (T-Con) and the permanent conservatorship

are subject to judicial review (e.g., the individual has right to a hearing and an attorney for both actions). For a permanent conservatorship, individuals may request a jury trial and the state/county must show beyond a reasonable doubt that the person is gravely disabled as a result of mental disorder (W.I.C. § 5350).

As with individuals subject to shorter-term psychiatric civil commitments, conservatees may be placed in locked facilities as medically indicated upon application to the court (or more typically, if the original conservatorship order authorizes any and all in-state placements in accordance with treatment plans developed by treating professionals, additional application to the court may not be necessary). While individuals retain the right to refuse medical treatment, the Public Guardian may obtain a court order to override the refusal. Conservatorships last for one year and may be renewed upon petition, subject again to the right of the individual to a hearing on the matter.

In accordance with the current training and practice guidelines, mental health practitioners generally seek to maximize their clients' abilities to maintain independently in the community. Accordingly, for clients under conservatorship who are placed in locked facilities, best practice is to develop case plans focused on building skills, connecting resources and engaging in planning that will allow the client to successfully transition out of the locked facility and into appropriate community-based living. The goal is not to keep people locked up in state/county facilities indefinitely but to transition them safely back into the community in a timely fashion. The reality, however, is that the longer one spends in an institutionalized setting, the harder it is to develop and practice the skills needed for independent living or to create a record of success necessary to

demonstrate to a judge that you are ready to leave the structured environment of the facility (Winick, 2005). As a result, clients may find it very difficult to leave institutional settings once they arrive.

Legal Rights for Those Subject to Involuntary Psychiatric Confinement

Individuals in locked psychiatric facilities have the same legal rights and responsibilities guaranteed all other persons under Federal and State law, with some obvious exceptions related to their freedom of movement and particular rights delineated by statute (W.I.C. § 5325.1). Whether the individual is there on a short-term psychiatric hold (voluntarily or involuntarily) or through a long-term placement related to their conservatorship, the individual is presumed to be legally competent (W.I.C. § 5331) and has the right to make informed decisions about his/her treatment.[34] Individuals also have the right to be informed of their rights in a language accessible to them along with the provision of a patient's rights handbook (W.I.C. § 5325). Confined individuals have an absolute right to timely judicial review, including the right to an attorney, for involuntary commitments beyond 72-hours (W.I.C. §§ 5275-5278; 5350d). Individuals also have the right to have their attorney or other designated persons be notified of any rights they are denied while in the facility (including rights under LPS as well as general applicability laws and protections) (W.I.C. § 5326.1).

With regards to involuntary administration of medication, the patient has the legal right to refuse treatment, including refusing psychotropic medications, even where he/she has been involuntarily committed (W.I.C. §§ 5325.2; 5332). However, this right is not absolute. A client's decision to refuse medication can be over-ridden under two

[34] For detailed requirements regarding the definition and process for obtaining informed consent for individuals with mental illness, see W.I.C. §§ 5326.2.-5326.5.

circumstances: first, in the case of emergency (and then only to the extent necessary to resolve the immediate safety issue); or second, by court order obtained after a hearing to determine if the person lacks the capacity to make his/her own medical decisions. In California, the capacity hearing, often referred to as a *Riese* hearing,[35] must be held within 24 hours after the psychiatric facility files the petition seeking a court order for forcible medication (W.I.C. §§ 5332-5336).

In addition to rights related to medications, individuals in psychiatric facilities have a number of additional rights, including the following (all rights listed here are under W.I.C. § 5325.1 unless otherwise noted):

- A right to treatment services in the least restrictive environment which promote the potential of the person to function independently;
- A right to culturally competent care (W.I.C. § 14684);
- A right to dignity, privacy, and humane care;
- A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect;
- A right to proper use of medication, e.g., medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program;
- A right to prompt medical care and treatment;
- A right to religious freedom and practice;
- A right to participate in appropriate programs of publicly supported education;

[35] The court in *Riese v. St. Mary's Hospital and Medical Center*, 209 Cal.App.3d 1303 (1987) found a presumption of capacity to make medical decisions for persons subject to involuntary civil commitment under LPS and required a judicial determination of incapacity in order to over-rule the patient's refusal of treatment.

- A right to social interaction and participation in community activities;
- A right to physical exercise and recreational opportunities;
- A right to be free from hazardous procedures;
- A right to refuse psychosurgery (W.I.C. § 5325; additional restrictions at W.I.C. § 5326.6);
- A right to refuse convulsive treatment (additional restrictive regulations and restrictions are found under W.I.C. §§ 5326.7- 5326.85, 5326.91);
- A right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services (W.I.C. § 5325);
- A right to have mental health records kept confidential (although records are subject to release in part or in whole for specified purposes related to law enforcement, protective services, treatment needs, and insurance – see W.I.C. § 5328);
- Upon request, families or other designees have the right to information related to the patient's diagnosis, treatment and prognosis but only upon consent of the patient. If the patient does not consent, family or designees requesting information shall be informed only of the person's presence in the facility (exceptions apply in the case of patients who disappear from the facility, see W.I.C. § 5328.3) (W.I.C. § 5328.1).

Under Welfare and Institutions Code section 5326, there are additional rights which may be (and often are) denied upon a showing of good cause (e.g., they present a danger to self or others; they substantially infringe on the rights of others; or they would result in

serious damage to facility property). These non-absolute rights include the individual's right to:

- Wear his or her own clothes;
- Keep and use his or her own personal possessions including his or her toilet articles;
- Keep and be allowed to spend a reasonable sum of his or her own money for "canteen" expenses and small purchases;
- Have access to individual storage space for his or her private use;
- See visitors each day;
- Have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them;
- Have ready access to letter-writing materials, including stamps, and to mail and receive unopened correspondence.

Federal Indian Law Intersections with Civil Commitment Law

AI individuals subject to psychiatric commitment retain all of the same due process and treatment rights described above, as would any other individual. However, unlike the non-AI population, while an American Indian person's right to access care *voluntarily* does not change regardless of location within the territorial boundaries of the United States, the state's ability to force *involuntary* psychiatric treatment *varies*. It varies by residency status, by quasi-legal tribal agreements with the state to transfer jurisdiction, and by variations on how and when a state court may assert authority over an AI individual. Whether the individual may be involuntarily committed may also depend on whether the one federal case relating to mental health-based psychiatric civil

commitments of reservation residents is controlling in the jurisdiction of the state/county filing for commitment (see *White v. Califano*, 1977).

In addition, there are three main laws governing Indian health care and behavioral/mental health that are relevant here: the Snyder Act (1921), which authorized initial federal appropriations for Indian health care services; the Indian Self-determination and Educational Assistance Act (1975), which in part created negotiated rule-making and contractual procedures to increase tribal self-governance and control over health care administration; and the Indian Health Care Improvement Act (IHCIA) (2010). Federal Indian mental health services are largely governed by behavioral health legislation within the IHCIA, including counseling, rehabilitative services, suicide prevention programs, outpatient psychiatric care and now inpatient care as well (Gone, 2004; IHCIA, 2010). Service delivery is made of a patchwork of service providers: programs may be run by Indian tribes directly, through the Indian Health Service, by contract with non-tribal public or private institutions, non-profit health centers, or through a variety of state and federal programs, including Medicare/Medicaid and the Children's Health Insurance Program (CHIP) (LaFramboise, 1988; Somers, 2010).

The patchwork of service delivery systems has important legal consequences, particularly in the context of mental health civil commitment law as the diversity of service providers results in a number of pathways through which an AI individual may or may not land in a state/county run psychiatric facility. Moreover, as we will discuss in the section on jurisdiction, there are number of complicating factors specific to federal Indian law which make it difficult to know whether an AI individual can legally be subject to involuntary commitment and if so, to which facilities and under which laws. In

the context of emergency psychiatric care, *where* the individual happens to be standing (or otherwise configured) when they become in need of mental health services, *whether* they are a resident of a reservation or not and *which* governmental agency they receive the services from can mean the difference between confinement and freedom, state control or tribal protection.

We will review the legal issues of federal state and tribal mental health law in depth in subsequent chapters but for now, it is sufficient to know that for urban Indians who come into contact with emergency mental health, state laws governing psychiatric commitments similar to the ones described above for California will apply. For AI individuals residing on tribal lands, the process is more complicated, at least from a purely legal perspective. Reducing the complexity to its most basic elements, reservation residents may enter state/county run facilities on an involuntary basis primarily in one of three ways: by transfer of tribal jurisdiction over the individual into state/county care; by coming into contact with police or mental health professionals off reservation lands during a mental health crisis, with subsequent admission to a psychiatric facility; or, in some states, through an extension of state authority onto tribal lands to effectuate a civil commitment. [36] With multiple pathways through which AI individuals may find themselves in state/county run psychiatric facilities where they will be subject to state psychiatric commitment laws, it is critically important to understand issues of colonization within the framework of state mental health law. To that end, the final

[36] Generally tribal jurisdiction transfers are accomplished extra-legally via Memorandum of Understanding or tribal court orders. This process is not common in California, which lacks tribal MOU's for LPS transfers and because California is a one of six states with expanded civil jurisdiction related to a federal law passed during the termination era, Public Law 83-280 ("PL-280"). These approaches each raise complex legal issues and as such, are discussed in greater detail in subsequent chapters.

section of this chapter will outline the basic framework of what a mental health-based civil commitment case looks like in practical terms before moving into the legal analysis.

Anatomy of a Mental Health Case

Now that you have a working understanding of the legal rights and standards applied in psychiatric civil commitment and conservatorship cases, as well an overview of how these laws intersect with federal Indian law, the task is to put these laws into the larger context of how mental health cases work from start to finish. Understanding this overall anatomy of a mental health case is important as each step of the process implicates colonization in unique ways.

As discussed above, there are a number of ways individuals may enter the emergency mental health system: for example, on a 72 hour emergency psychiatric hold, through a transfer from tribal court, or from a referral from Adult Protective Services for conservatorship. Regardless of how the individual enters the system or at what stage he/she is in the process, if state control over the individual is against his/her wishes, the individual has the legal right to contest the action. This legal right extends to every point at which the state seeks to assert control and as a result, one individual may have multiple hearings related to his/her confinement(s).

For example, an individual contesting a 14-day hold may also have a separate case contesting involuntary administration of psychotropic medications. The same individual may later file a new objection if the state/county applies for a temporary conservatorship of the individual and again if the state/county moves for a full permanent conservatorship. The individual may also file multiple writs contesting medication, placements, or denials of rights while under a psychiatric hold as well as during the

temporary and permanent conservatorship. While each of these cases have their own legal issues and standards, they all follow the same general procedural pattern, which we will detail here.

For individuals contesting a psychiatric hold, medications or conservatorship, they are assigned a public defender (if they cannot afford an attorney) and their legal objection is filed with the court (technically, for confinements, the filing is called a writ of habeas corpus rather than an objection or motion). Court staff set a date for a bench trial/hearing (or jury trial if requested) within the legally allotted timeframe. It is important to note here that, as with all legal cases, mental health cases need to be filed in a court with authority over the issues in the case (mental health) and over the parties (jurisdiction). Generally this means filing in the municipal court where the psychiatric facility holding the individual is located or alternatively for conservatorship, in the municipal court located in the area where the individual resides.

For American Indians, issues of jurisdiction are complicated by federal Indian law and implicate tribal sovereignty to the extent that state/county courts are taking jurisdiction over tribal members and/or reservation residents. These issues are explored in greater depth in the jurisdiction chapter but for now, it is sufficient to know that mental health cases can be adjudicated only by courts with authority over the issues and the parties which generally means the local municipal court where the individual is located or resides.

Assuming that the case is filed in the appropriate venue and the court takes jurisdiction, the case will go to either a bench trial/hearing or to jury trial. The county attorney will present the case and carries the burden of meeting the standards of proof.

Evidence in support of the county's case usually entails expert testimony by the treating psychiatrist with regards to initial presentation, diagnosis, symptomology, psycho-social assessment, and various other items relevant to the legal standards for the particular type of hearing. This testimony is subject to cross-examination. Then the individual, in consultation with the public defender, may choose to testify and/or to call relevant witnesses, most often family members willing to testify that they are willing and able to care for the individual and/or ensure medication compliance should the individual return home. The county attorney will cross-examine each of the respondent's witness and after closing arguments, the court enters its judgment for or against commitment, forcible medication, or conservatorship depending on the case.

If the court finds the county did not prove the individual meets the legal requirements for commitment/conservatorship and orders release from the psychiatric facility or denies the conservatorship, the individual is free to go. If the court approves commitment, the individual returns to the locked psychiatric facility but only for the time prescribed by law for the type of commitment contested in court. For example, if the facility sought to hold the individual for 14 days and the court approved the hold, the facility may hold the individual no longer than the 14 days. If the facility wishes to hold them longer, the facility would likely file a petition for temporary conservatorship and the individual would be entitled to another hearing. In essence, the individual retains the right to judicial review whenever the state/county seeks to add time to the commitment, to forcibly medicate, to conserve, or to place a conservatee in a locked facility.

Each of these hearings follow a similar course as that described above and each step of the hearing process, from the corpus of mental health laws to culturally embedded

notions of what constitutes mental illness and who counts as an expert, implicate issues of colonization for AI peoples. The following chapters provide an in depth look at how colonization functions both implicitly and explicitly in the law, hearing processes and treatment during involuntary psychiatric commitments.

Chapter 6

Framing the Legal Analysis: A TribalCrit Approach to Involuntary Psychiatric Commitment Law

As we see above, the law of involuntary psychiatric commitment is itself a complicated matter, made only more so when adding in the overlays of federal Indian law and state mental health policy to the discussion. In matters of complexity, it behooves us to start by laying out a framework for understanding the relevant legal issues. Tribal Critical Race Theory (TribalCrit) will act as our guide here, framing the discussion and allowing us to highlight several main themes or meta-issues that will recur throughout the legal/policy analysis below, which explores more specifically how colonization is codified, enacted and maintained through the law of psychiatric commitments.

TribalCrit as a Frame for the Legal Discussion on Mental Health Law

As an analytical frame, TribalCrit functionally grounds analysis of social issues within an American-Indian/Indigene-centric, anti-colonialist paradigm. This focuses the analysis on issues of central import to AI/AN communities, as defined by those communities, and embeds the analysis in political, historical, ethical, and methodological foundations of critical relevance to Indigenous peoples and tribal nations. Analysis within a TribalCrit frame begins from and constantly returns to the central tenets of the theory, namely: the endemic nature of colonization, assimilationist policies, imperialism, liminality, sovereignty/self-determination, centrality of Indigenous epistemologies, varied Indigenous traditions, stories as theory and research/praxis protocols. As suggested by Brayboy (2005), TribalCrit can be appropriately applied beyond the context of education to guide analysis of a wide array of issues of import to AI/AN communities. In so doing,

scholars/communities can use TribalCrit as a tool to excavate critical issues embedded in imperialist, colonizing structures in ways consistent with and driven by the commonalities between Indigenous worldviews.

The historical-political approach taken by TribalCrit reminds us that health care policy, and in particular mental health policy, is a pathological political beast with colonizing tendencies. This is not said in jest or hyperbole – as discussed in the historical section above, in the context of American Indians, health care policies have been used explicitly as part of larger political agendas of extermination (for example, the practice of forced sterilization of AI women) and assimilation (from criminalization of traditional healing and extra-legal civil commitment of the political unruly in the Canton insane asylum, to the normalization of Western medicine as the exclusive gold standard of "civilized" medicine), among others (see Shelton, 2001). Colonization, health policy and politics are intimates - TribalCrit encourages us not to forget the consequences of this reality.

Moreover, by placing emphasis on the endemic nature of colonization, TribalCrit lends itself to examining not only the ways in which mental health law becomes a tool for coercive land acquisitions and assimilationist projects but, particularly in the modern age, how mental health frameworks grounded in Western-centric notions of jurisprudence, justice, health and helping enact colonization through the marginalization and exclusion of Indigenous worldviews. For Indigenous peoples, abstracted ideas about jurisprudence, health and worldview have real and tangible consequences including how psycho-social difficulties are defined in both law and social services and the possibility of long-term psychiatric confinement, among many others. Given the serious consequences and the

fact that mental health policy has formed within the Euro-centric colonial context, TribalCrit is both appropriate *and* necessary in the analysis of mental health law for AI/AN populations and tribes.

Epistemological considerations.

In addition to highlighting the centrality of colonization to social policy outcomes, TribalCrit reminds us that Western knowledge systems are not the only, nor necessarily the best suited, frames for developing meaningful mental health law and policy. This advisement is multifold. First, we must be aware that the law comes from somewhere and represents a particular epistemological frame. American jurisprudence finds its roots in English common law, which developed in the context of a powerful Christian church and the transition from feudal systems of government to a more centralized nation-state system based on laws (in particular laws related to settling disputes, taxation and war) (Johnson, 2005). The English paradigm of justice is based on adversarial practice, punishment, individual liberties, property ownership, and culturally-based notions of what constitutes good evidence or good scientific proof.[37] The enculturated epistemological underpinnings of the law become normalized as natural – not a product of culture but as the way things are, have always been – as the best, most advanced, most just.

Second, beyond the letter of the law, the dominant and legally codified understandings of mental health are also enculturated projects, reflecting their own epistemological and ontological roots. How psychologists and social workers educated in

[37] The English common law system continued developing through the Enlightenment period, where many ideas were borrowed, without acknowledgement or credit, from other societies with their own unique worldviews including knowledge taken from societies in Northern Africa, Egypt and the Middle East (see e.g., Robinson, 1983).

Western-centric notions of health define mental illness, how judges and lawyers schooled in English-common law and Western science understand what constitutes best evidence, how policy makers decide that putting madness on trial is the best way to protect civil liberties, public safety and well-being, or how AI community members present testimony when a family member's health, safety and liberty are all at stake – these are all dependent on epistemological frames and historical memory.

Even the language used herein, e.g., "mental health policy" reflects a non-neutral cultural point of view codified in law and policy. The term itself adopts a Euro-centric Cartesian splitting of self into mind versus body: mental health as distinct from the physical and absenting spirituality altogether. Duran and Duran (1995) explain:

> Another crucial worldview difference…is the non-compartmentalization of experience. In Western experience it is common to separate the mind from the body and spirit and the spirit from the mind and body. Within the Native American worldview this is a foreign idea. Most Native American people experience their being in the world as a totality of personality and not as separate systems within the person…Native American [worldviews are ones] in which the individual is part of all creation, living life as one system and not separate units that are objectively relating with each other (pg. 15).

Thus the phrases "mental illness" or "mental health policy" reflect divisions of mind, body and being which are not in fact universal. The terminology of "mental health" also generally assumes a culturally located focus on *individual* pathology or individual health: "mental health" in the dominant discourse of the helping professions is generally understood as an individual matter, albeit one that is situated within the context

of the social environment. To wit, social work programs frequently divide courses of study along the lines of individual versus community, some going as far as having distinct educational tracks for students interested in mental health *or* communities. The construction of mental health, the language choices and the law and policy which flow from those constructions, are enculturated projects, and to the extent that they operate to the exclusion of Indigenous viewpoints on well-being or by absenting them from conscious thought altogether, they function as tools of colonization. That this discussion unfolds using the terminology of "mental health law and policy" undeniably reflects both the domination of Western-centric health heuristics and reflects the struggle to find alternative language more appropriate to the task. As the author, I take responsibility for my own limitations in this regard. I ask the readers for patience as I offer these observations as preliminary contributions to the discussion of decolonizing law, healing and justice.

Despite these linguistic limitations, this project asserts that questioning the hegemony and colonizing tendencies of a Western-centric frame for mental health law and policy is critical. Without so doing, understanding and alternative policy options are, at best, limited and, at worst, deadly. This was certainly the case for the hundreds of American Indians who, having been found unruly on their reservations, were falsely diagnosed with conditions such as "congenital imbecility" or "chronic mania" and were sent for "help," dying behind the walls of the Canton-Hiawatha Asylum for Insane Indians (Leahy, 2009).

Legal neutrality and colonization.

Another theme that frames the legal analysis discussion below is the issue of legal neutrality. Within the realm of health law, the discussion to date has focused almost exclusively on the *disparate impacts* of health policy along race, class and gender lines without questioning the assertion that what is often deemed facially neutral law is not in fact neutral. For example, as discussed below, civil commitment and conservatorship laws are said to be facially neutral because they do not make reference to any particular group or protected class. However, for a nation born on the backs of Indigenous sovereign nations, nations which continue to exist today and operate within unique legal confines, the lack of any mention of tribal sovereignty in the law must be understood as a political choice. It simply is not politically or legally neutral to exclude language recognizing the dual system of sovereigns that exist in this country. Whether this choice is born out of ignorance of history, an historical amnesia of sorts, or reflects more of an active choice to maintain one, hegemonic Western-centric legal frame is unclear.

Nevertheless, the lack of recognition of tribes and tribal sovereignty permeates mental health laws from the beginning of a mental health case to the end. Despite being replete with multiple choice points where sovereignty could be recognized, the law is silent on these issues and, because no protected classes are differentiated for special or different treatment, there is a tendency to assume the law is neutral and therefore provides equality under the law. Legal neutrality, or the failure to recognize tribal sovereignty and Indigenous approaches to jurisprudence in the language of the law or in the system of laws more broadly, makes the political nature of the law invisible and allows those who benefit from Western-centric legal systems to maintain them even as

they exclude, marginalize and undermine both Indigenous worldviews and tribal sovereignty. This disjoining of the political from mental health further encourages the tendency for non-Indigenous service professionals to assume that best practice in behavioral health care for AI populations is met simply through culturally competent care, conceptualized in terms of race or cultural difference *alone* rather than in terms which challenge the basic assumptions of Western legal, psychological, and political thought. Ultimately, this myth of legal neutrality is a dangerous tool of colonization and it is a theme we will return to again and again as we discuss mental health law as applied to AI peoples.

Mental health law, state power and tribal sovereignty.

TribalCrit also calls on us to question the meta-epistemological frameworks and political ideologies used to legitimize the state's authority over AI bodies and minds, particularly given the state's relationship to a variety of political (e.g., racialized, colonizing, class-based) projects. Examining colonialism in the mental health law/policy context highlights the role of the state in pathologizing AI peoples, subjecting them to state control and relegating them to marginal spaces defined by Eurocentric norms of illness/health. Involuntary psychiatric commitment law thus demands examination of the role of the state in exercising state power over the citizenry. State power is not the only issue, however. For AI peoples, the power of the state and, more broadly, of governments to exercise authority over AI bodies and minds occurs within a broader context of doctrines of tribal sovereignty and the scope of state, federal and tribal powers over tribal members generally. Thus as we begin thinking about the law and colonization, it is

important to contextualize the particulars of the legal analysis within the larger frame of sovereignty.

TribalCrit seems to embrace two lines of thinking with regards to tribal sovereignty: one based in the dominant legal discourse wherein Indian tribes seek federal legal recognition and protection of the rights and interests of Indian peoples – a nation-state based sovereignty conceptualized within the current Western-centric jurisprudence – and a second line of thinking which conceptualizes sovereignty from an Indigenous frame. Let us begin with nation-state based conceptions of tribal sovereignty. In American jurisprudence, unlike foreign powers such as France, Uganda or China, American Indian tribal nations are not recognized as wholly independent, sovereign entities. Rather, Supreme Court case law recognizes tribal sovereignty as both clearly existing and yet limited in scope by tribal status as "domestic dependent nations" (*Cherokee Nation v. Georgia*, 1831) with tribal powers subject to revocation or sublimation by Congress (Canby, 2009; Wilkinson, 1987). Imposed on tribes by force, American jurisprudence recognizes itself as the sole arbiter of claims arising from actions within its boundaries.

For tribes wishing to challenge the legitimacy of the legal system or to oppose actions taken under its authority, their primary recourse, outside of international appeals, is to engage with the U.S. legal frame – to play by its rules and seek justice or relief from it, by it. Conceived as such, the import of securing sovereign, nation-based rights within the paradigm of American jurisprudence should not be understated: these rights, codified either in treaties or in federal Indian law more broadly, have served as one of the few tools tribes have been able to use to protect tribal nations - that is, to require that the

government follow at least and at a minimum its own laws with regards to the treatment of AI peoples and tribal nations (Deloria & Wilkins, 1999). Notably it is these same laws – laws based in notions of tribal sovereignty defined by Western jurisprudence - that come under direct attack during periods when the federal government becomes actively aggressive towards tribal nations. Rights secured through the American jurisprudential system have been challenged during war, removal, termination eras; when the government espouses a goal of "helping" tribes while making not so subtle incursions into Indian territory and tribal social policy (e.g., allotment, schooling policies); and when it asserts federal plenary powers to acquire land or assets (e.g., Indian gaming) (Page, 2003). Given the import of U.S. federal Indian law for the fate of tribal existence, independence and general well-being, tribal nations have fought hard to create, preserve and enhance tribal rights and sovereignty within the frame of American/Western jurisprudence.

Operating from within the U.S. legal frame, however, has a cost. In fighting to obtain/preserve rights within the American jurisprudential frame, tribes implicitly, if reluctantly, legitimate U.S. law as the dominant and ultimately exclusive frame for which issues of justice can be resolved (Williams, 1986). This is problematic for a number of reasons. At its most basic level, it creates a fox-guarding-the- hen house system of justice where the fox (represented by the courts and U.S. legal system) is the only one with enforceable, recognized authority to decide on the legitimacy of his own actions vis-à-vis the hen-house. In such a situation, the fox is hardly to be trusted.

Moreover, having to use the U.S. legal system to secure enforceable rights is problematic in that it requires tribes at a practical level to ascribe to or at least function

within the confines of Western notions of sovereignty that are in many ways incompatible with Indigenous concepts of inherent tribal sovereignty. Sovereignty in Western jurisprudence is based in notions of dominion and individual rights (see Alfred, 2005). Sovereignty in Western thought is also designed for "exclusive jurisdiction, territorial integrity, and nonintervention in domestic affairs" (Coffey & Tsosie, 2001, citing Anaya, 1996). This statist construction of sovereignty is highly problematic. It requires serious thought about the implications of engaging in legal *reform* as a policy solution when such a strategy implicitly legitimates the state, its authority and its legal structure thereby perpetuating the violence inherent to Western/Euro-centric conceptions of the nation state which are based on authority (power enforced through the use or threat of punishment/force) and territoriality (the manufactured right to take, defend, and occupy lands for socially constructed 'citizens') (see e.g., Alfred, 2005; Coffey & Tsosie, 2001; Giddens, 1987; Williams, 2005). The statist-based conception of sovereignty also necessitates addressing the ways in which justice and sovereignty interplay, including the ways in which our current legal frame falls short of the kinds of fiduciary duties inherent to the trust relationship and the absence of law and policy that honor Indigenous jurisprudence as an equal rather than maintaining U.S. law as the final arbiter of "justice" (see e.g., Williams, 1986; Williams, 2005).

In addition, framed as it is within Federal Indian law, tribal sovereignty in Western jurisprudential parlance promotes "the idea that Native peoples' legal rights depend upon recognition by the very government that has attempted to divest Indian nations of their sovereignty" (Coffey & Tsosie, 2001). Writing to this, Alfred (2005) explains:

> State sovereignty can only exist in the fabrication of a truth that excludes the indigenous voice. It is in fact antihistoric to claim that the state's legitimacy is based on the rule of law. From the indigenous perspective, there was no conquest and there is no moral justification for state sovereignty, only the gradual triumph of germs and numbers…Recognizing the power of the indigenous challenge and unable to deny it a voice, the state…has created an incentive for integration into its own sovereignty framework…Those indigenous communities that co-operate are the beneficiaries of a patronizing faux altruism. They are viewed sympathetically as the anachronistic remnants of nations…By agreeing to live as artifacts, such co-opted communities guarantee themselves a mythological role and thereby hope to secure a limited but perpetual set of rights (pp. 44-45).

Recognizing the limitations inherent to grounding tribal sovereignty exclusively in the hegemonic frame of Western jurisprudence, TribalCrit and Indigenous scholars suggest a second conceptualization of sovereignty, one that speaks to the inherent sovereignty of Tribal peoples that pre-dates and survives in spite of a Western jurisprudence that neither speaks the same language nor cares particularly to understand Native alternative paradigmatic views of justice, land, rights, and law (see e.g., Wilkins & Lomawaima, 2001; Coffey & Tsosie, 2001). From Indigenous perspectives, and perhaps from a justice perspective more broadly defined, tribal sovereignty is inherent to the peoples, their moral visions as a people, their cultural traditions, their lands and their varied forms of governance, existing whether the U.S. Congress chooses to recognize it or not. Sovereignty as thus conceived goes beyond the limited definitions of sovereignty as nation-state within the Western jurisprudential frame to include evolving notions of

sovereignty based in "regimes of respect" (Alfred, 2005, pg. 46), adapting traditional notions of tribal governance to meet modern day challenges (Coffey & Tsosie, 2001) and developing *relationally based legal frames* which respect "diverse identities and spheres of autonomy" (Anaya, 1996, pg. 79).

Alfred (2005) adds that "the inter/counterplay of state sovereignty doctrines – rooted in notions of dominion- with and against indigenous concepts of political relations – rooted in notions of freedom, respect and autonomy – frames the discourse on indigenous sovereignty at its broadest level" (pp. 33). The working-within versus working-outside of the hegemonic Western legal frame with regards to the promotion and development of tribal sovereignty is a constant struggle. In the context of mental health law and policy, it raises questions of whether and on what terms to engage the U.S. legal system to secure community well-being and how to create a vision of the future that is wholly self-determined, particularly when the fox is walking right outside your front door. TribalCrit begins, however, from the starting point that whatever the approach, sovereignty matters and that tribal autonomy and self-determination are intimately tied to notions of survivance and sovereignty, as variously defined by AI peoples.

The Catch 22 of Sovereignty, Services and Demanding Social Change

From a TribalCrit perspective, challenging the endemic nature of colonization in mental health law and policy is an essential step in social justice praxis. There are, however, some practical implications to such an endeavor. Among them is the reality that in arguing for the primacy of decolonization within the context of mental health, AI communities may find themselves boxed into a lose-lose paradigm where sovereignty and access to services are constructed as mutually exclusive realities – a deadly game of

zero sum trade offs where the government's trust obligation to provide for the well-being of AI peoples is met on Western-centric terms or not at all. In this all or nothing paradigm, critiquing the epistemological/ontological underpinnings of the law and policy of mental health or making demands for policy approaches that honor tribal sovereignty and self-determination may be wrongfully leveraged as justifications to scale back provision of care under the pretense of honoring tribal sovereignty.

While the system has increasingly made room for culturally appropriate care or tribally administered health care programs, these all occur within the confines of Western jurisprudence, Western conceptualizations of program evaluation and evidence-based practice, and Western notions of the relationship between sovereignty, federalism and federal plenary powers over tribal nations. Tribally run health programs are encouraged, so long as they conceptualize problems in accordance with Western disease-health heuristics and Western paradigms for measuring objective program effectiveness. Minimal requests for 'culturally appropriate care' can be tolerated but demands for full self-determination, demands which question the meta-frames of law and Western-jurisprudence, will not.

In this context, AI communities already facing a lack of access to care, coupled with serious issues affecting morbidity and well-being, may find it risky to argue for more nuanced approaches to care which honor federal trust obligations *and* tribal autonomy over the design, delivery and evaluation of those services. Tribes may find it a strategic necessity to expend precious political capital arguing simply for more access to more care, irrespective of whether that care, or the jurisprudence behind it, is in line with Indigenous worldviews on health, healing, and justice.

So long as the discussion over Indigenous health care is framed as a mutually exclusive contest between access to care grounded nearly exclusively in Western paradigms of law and health versus tribal sovereignty and Indigenous worldviews, the need for care, any care, will tend to trump decolonization efforts and regimes of care will continue to have an intimate, enmeshed relationship with colonization efforts, intentional or otherwise. Moreover, activists pursuing decolonization as members or allies of Indigenous communities must be mindful that there are costs to communities for seeking such changes and to move ahead, with communities, carefully and cognizant of possible ramifications.

Moving From a TribalCrit Mental Health Framework to Legal Analysis

In this chapter, we have laid out TribalCrit as a framework for mental health law, highlighting several over-arching themes which will guide our legal analysis. The following chapters explore the ways in which colonization functions both implicitly and explicitly within the specifics of involuntary psychiatric commitment law and related judicial process. The analysis will follow the structure of a mental health hearing, from the court's initial assertion of jurisdiction to notice, the hearing, the commitment, and treatment. As we walk through each step, the themes identified here relating to legal neutrality, epistemology, sovereignty, and the risks of justice advocacy are ever present, forming a background narrative for particularized issues.

Chapter 7

Colonization and the Law: Jurisdiction and Tribal Sovereignty

Every involuntary mental health legal case begins by the filing of a petition in a court with the legal authority to hear the case, or jurisdiction. In psychiatric civil commitment cases for American Indians, the issue of which court, federal, state or tribal, has jurisdiction over the case is both a complex and critically important issue. Jurisdictional issues deeply implicate tribal sovereignty to the extent that states, through their local county municipal courts, are asserting authority over AI tribal members or, in some cases, reaching the long arm of the state onto tribal lands and asserting jurisdiction over reservation residents. In this section, we begin by defining jurisdiction and then explore the ways in which colonization, through impingement on tribal sovereignty, is implicated in the jurisdictional stage of a mental health case. In particular, this section will examine issues of federal pre-emption with regards to state and tribal mental health law and the unique issues of colonization and jurisdiction for urban Indians, for reservation residents generally, and for reservation residents in states such as California which have limited extensions of civil jurisdiction through a Congressional grant of authority referred to as Public Law 83-280 ("PL 280").

What is "Jurisdiction"?

Jurisdiction refers to whether or not a court has the legal authority to hear a particular case and to enter a valid, enforceable judgment (Legal Information Institute, 2012). Jurisdiction is comprised of two parts: subject matter jurisdiction and personal jurisdiction. *Subject matter jurisdiction* refers to the court's authority to adjudicate particular types of cases. For example, under Article 1 of the U.S. Constitution, federal

district courts have original and exclusive jurisdiction over bankruptcy cases. By law, Article 1 courts are the only courts with authority to adjudicate bankruptcy cases – the only ones with subject matter jurisdiction. Subject matter jurisdiction is a non-waiveable requirement, meaning that if you file your case in a court that lacks authority over your particular issue (e.g., lacks subject matter jurisdiction), the court will dismiss the case sua sponte (of its own accord) (Legal Information Institute, 2012). In the case of mental health hearings, local municipal courts, which are courts of general jurisdiction (Ames, 1933), have subject matter jurisdiction over a wide range of issues, including county mental health and psychiatric commitments/conservatorships making it generally appropriate to file mental health cases in a county municipal court.

However, for a court to adjudicate a case, it must have subject matter jurisdiction *and* also personal jurisdiction, or *power over the parties* to the case. Establishing *personal jurisdiction* generally requires a showing that the parties have sufficient contacts in the state or country to ensure that it will be fair to hear the case in that locale and that the party has notice of the proceedings. Personal jurisdiction may be established in a variety of ways: (1) by showing that the defendant or respondent to the case maintains a domicile/residency in the state where the petition is filed; (2) defendant/respondent's presence in the state while being served with a copy of the summons and complaint or petition; (3) by consent of the parties; (4) by showing that the respondent has sufficient minimum contacts with the state (such as having a business there); [38] or (5) as defined by statute (Legal Information Institute, 2012).

[38] The four-pronged test for establishing minimum contacts is found in *International Shoe Co v. Washington*, 326 U.S. 310 (1945). Sufficient minimum contacts require a showing of continuous and systematic activities in the forum and that the cause of action arose out of those activities. If the activities

The requirement for personal jurisdiction is intended to ensure that you cannot be sued or have litigation against you someplace with which you have no connection and would likely never even know that legal proceedings had been initiated against you. For example, if the Internal Revenue Service wanted to sue a California resident for back taxes and the individual had no significant personal or business contacts outside of California, it would not be fair for the government to file the proceedings in some random state like Florida, for example, as the individual is not a resident, has no significant ties or contact with Florida, and would likely never know that proceedings had been initiated there or be able to be present in the state to defend him/her-self. Instead, the government would need to sue the California resident in a federal district court with jurisdiction in California (and it would have to be a court with subject matter jurisdiction over tax matters). While this example uses the federal government, the same logic applies for lawsuits involving private parties. In essence, personal jurisdiction is about fair notice and authority of the court over the parties in question based on a reasonable connection to the state.

While a court must have personal jurisdiction over the parties in order to adjudicate a case, personal jurisdiction is a waive-able requirement (unlike subject matter jurisdiction). Failure to argue that the court lacks personal jurisdiction in the case constitutes a waiver of the requirement. For example, if the California resident above did get sued by the I.R.S. and the government filed incorrectly in Florida, if the California respondent failed to raise the objection that the Florida court lacked personal jurisdiction,

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are unrelated to the cause of action, parties must show that there are continuous and substantial contacts in the forum warranting the extension of jurisdiction. Alternatively, a forum may have personal jurisdiction for sporadic or even a singular incident of contact if and only if the cause of action arises out of that specific contact in the locale.

this otherwise dispositive argument would be waived and the case would proceed. If the case went up to a higher court on appeal, counsel could not raise the issue of the lower court's lack of personal jurisdiction because the party is said to have waived the argument at the lower court level by failing to raise it in a timely fashion.

Personal jurisdiction and waive-ability are important issues in the law of mental health for AI individuals, although the issues are rarely litigated.[39] Establishing personal jurisdiction in mental health cases generally requires that the state/county file petitions in the municipal court where the psychiatric facility holding the individual is located. For example, in Humboldt County, the locked psychiatric facility, Sempervirens, is located in the city of Eureka within the county boundaries. To involuntarily hold a patient beyond the 72-hour emergency window at the Sempervirens facility, Humboldt County Mental Health files a petition in the municipal court, also located in Eureka. As a court of general jurisdiction, the Eureka municipal court has subject matter jurisdiction to adjudicate a mental health case *and* it has personal jurisdiction because the person against whom the petition is filed is physically present in Humboldt County. For out of state residents held at Sempervirens, the court still has personal jurisdiction because the individual is physically present and, although their legal residence may be in another state, they are aware of the proceedings as they receive notice of the county's intent to commitment them.[40]

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[39] The lack of litigation is likely a result of the fact that mental health cases often involve quick and tumultuous changes and people's lives simply carry on, focused on the realities of every day living. Moreover, there are few resources to litigate such issues and clients generally lack the political or financial capital to garner the necessary attention needed to carry on years of litigation.

[40] In many counties, it is standard practice to stabilize out of county or out of state clients and then arrange for transfer to a mental health facility in the individual's home county/state. Transfer back to the home

However, for AI clients the issue of personal jurisdiction is more complicated, particularly for reservation residents. We will address this in more depth below, but for the purposes of understanding personal jurisdiction and waiver, we will briefly address some key issues here. In most, but importantly not all states, AI *reservation residents* who find themselves in a state or county emergency psychiatric facility against their will may be able to assert that the state/county court lacks personal jurisdiction to hear the case because, even thought they are physically present in the state/county, as a reservation resident, the tribe maintains exclusive jurisdiction over the individual. Absent Congressional action authorizing the state to take jurisdiction over reservation residents, tribal civil jurisdiction over reservation residents trumps the state's authority - as sovereign nations, tribal nations are a step above states in the hierarchy of legal authority. In this case, the individual's status as a reservation resident and the county's concomitant lack of personal jurisdiction over the individual, would preclude the court from hearing the case and prevent *involuntary* psychiatric commitment by the state/county (such individuals retain the right to receive services from the state/county on a voluntary basis, but the state/county would not be able to force the individual to accept involuntary commitment).

This is where the issue of waiver becomes important. The lack of state civil jurisdiction over reservation residents for civil commitments is a dispositive argument – it can put an immediate end to state/county attempts at involuntary commitment. However, often times in cases involving AI clients, defense counsel are not aware of the

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state may benefit the client in that it allows the client to be closer to potential support systems. However, many have criticized such practices, characterizing them instead as a maneuvers not intended for the client's best interest but instead as attempts to shift the cost of care for the individual back to the home county/state.

jurisdictional issues related to tribal sovereignty and state-federal law and they may fail to raise the issue at trial.[41] In so doing, they waive an otherwise dispositive argument, a position which could end the case and set the client free (they also waive the client's right to appeal confinement on the basis of a lack of personal jurisdiction to a higher court). In this case, the lack of training for attorneys related to tribal sovereignty and jurisdiction issues leaves AI clients without the full protection of the law.

There are a number of additional complications related to how courts take jurisdiction in AI mental health cases based on residency status, state relationships to the tribes under federal law and other factors which are addressed in detail below. For now, it is important to know two things: first, that in order for a court to properly adjudicate a mental health case, that court must have jurisdiction over both the subject matter (e.g., over mental health cases) *and* the court must have jurisdiction over the individual person (e.g., personal jurisdiction). Second, whether a court has jurisdiction over the individual person and thereby the authority to involuntarily commitment the individual will vary based on which governmental entity - state, tribe or federal - has legal authority over that person. As we move ahead, the following sections will address some of the more problematic aspects of jurisdiction and address the following questions: first, which courts have jurisdiction over AI mental health cases; second, under what circumstances do they have jurisdiction; and third, how do the differences in how and when particular courts take jurisdiction over AI mental health cases implicate issues of tribal sovereignty?

[41] The client would likely have a cause of action for professional negligence against the attorney. This, however, would not necessarily end the confinement and in most cases, clients themselves are not aware of the oversight nor are they in any state to pursue civil tort actions against their attorney.

Establishing Jurisdiction: Does Federal, Tribal or State Law Control?

The question of which government's laws will apply to particular citizens is an inherently political issue. So too, the question of which governments, federal, state or tribal, have legal authority through their respective courts to take jurisdiction over AI tribal members in mental health cases, is also political in nature, grounded in issues of sovereignty, colonization and the legal relationships between the federal government and tribal nations. Under the frame of federal Indian law, the federal government claims plenary, or nearly absolute, legal authority over AI tribes (Canby, 2009). The federal government justifies its imposition of exclusive and pre-emptive power over tribes as a right of conquest, a right of "discovery," and under Constitutional clauses establishing the exclusive right of the federal government to engage with Indian tribes with regards to commerce and treaties[42] (Pevar, 2012). The imposition of U.S. federal law *over* tribes is, of course, a political construction, backed by U.S. military power, whereby settler-colonizers imposed by fiat and force an English system of laws in which tribes, once understood by the newly formed U.S. government as foreign, sovereign nations, became in the eyes of the colonizing legal system, domestic-dependent, quasi-sovereign nations – sublimated *subjects* within the U.S. legal system. While Congressional fiat can never erase the inherent sovereignty of tribal nations, tribal sovereignty as a practical matter is constrained by Congressional authority, allowing Congress to regulate a wide range of matters implicating AI nations and, as we saw in the 1950's termination era, the right to even terminate federal recognition of tribes *as tribes*. In the context of federal Indian

[42] Congress declared it would no longer enter into treaties with tribes in 1871. However, the Supreme Court continues to treat the Treaties Clause as a source of power *over* Indian tribes (see Pevar, 2012).

law, this rather sinister dynamic is blandly referred to simply as the plenary power doctrine.

Under the plenary power doctrine, the federal government claims exclusive, pre-emptive and nearly absolute[43] power over the affairs of Indian tribes. This means that federal laws will generally preempt both state and tribal laws to the extent that the laws conflict with federal legislation or where the federal government is said to 'occupy the field,' thus precluding state or tribal governments from passing significant legislation in that area. However, tribes retain the right to regulate their internal affairs, although in larger policy matters, federal law will generally trump tribal law in the American judicial system (Pevar, 2012; see also *Worcester v. Georgia,* 1832). Federal plenary power and tribal sovereignty doctrines also generally limit *state* assertions of jurisdiction over tribal lands or reservation residents without express grants of authority to the states from Congress. [44] Although, notably, the Supreme Court has increasingly allowed state intervention where federal law does not *explicitly* pre-empt the states and where (the court finds that) state action does not substantially infringe on tribal matters, including, for example, state authority over non-Indians living on reservation lands (see e.g., *Strate v. A-1 Contractors,* 1997; *Nevada v. Hicks*, 2001; *Williams v. Lee*, 1958, and *Worcester v. Georgia,* 1832). Nevertheless, state intervention into tribal matters is generally precluded under federal Indian law. While state extensions of regulatory and adjudicatory power

[43] Federal power over Indian tribes is limited by the Due Process Clause, the Just Compensation Clause and by case law affording quasi-sovereign status to tribes which are in fact, if not in law, inherently sovereign nations (Pevar, 2012).

[44] In addition to federal pre-emption and plenary power doctrines, for many Western states, the federal government required the inclusion of clauses expressly disclaiming jurisdiction over tribal affairs into state-formation documents (enabling acts, constitutions, and territorial acts) (see Wilkins & Lomawaima, 2001).

are limited under federal law, under the Equal Protection Clause of the 14th Amendment, states do have an affirmative obligation to provide tribal residents with the same access to services as any other resident of the state (see e.g., *Apache County v. United States*, 1976). For our purposes, this means that states have an obligation to provide reservation residents with equal access to mental health services available to state residents generally. This leads us to the question of how federal pre-emption and state obligations impact jurisdictional issues in involuntary AI mental health cases?

Under the rubric of federal pre-emption and plenary powers doctrines, any federal laws governing mental health for American Indians would trump state law and potentially tribal law as well. For example, under federal health care privacy laws enacted through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have a number of federally guaranteed privacy rights with regards to their records and medical information. Federal law pre-empts state or tribal laws which would undercut or create less protection for patient privacy than that established under federal HIPPA regulations. However, in the case of non-criminal mental health law, there are very few federal laws governing psychiatric civil commitment processes, with primary federal legislation largely limited to regulations governing federal reimbursement and eligibility for services rather than substantive laws governing the admissions and treatment process (see e.g., Code of Federal Regulations Title 38 and 42; see also Quinn, 2005; Winick, 2005). In fact, with a few limited exceptions, [45] there are no federal laws specifically governing the

[45] Federal laws related to mental health typically focus on broader issues including: authorization of IHS to contract for behavioral health services; federal reimbursement for mental health services under Medi-Caid/Medi-Care; defining mental illness for Veterans or for Social Security disability benefits; regulating the care of individuals under 21 in psychiatric facilities; and regulating insurance/parity issues related to mental health care.

legal standards or rights for mental health-based psychiatric commitments beyond the requirement, born out of Supreme Court case rulings, that states provide constitutionally sufficient due process protections in their frameworks for mental health-based civil commitments.[46] The absence of federal legislation governing psychiatric commitments is important because without federal law occupying the field, there is no direct federal preemption of state or tribal laws governing mental health-based psychiatric commitments, creating a legal vacuum in the field. This vacuum creates a number of complicated legal scenarios regarding the applicability of state or tribal jurisdiction.

However, before we move on to explore these jurisdictional dilemmas, there is one possible exception to the lack of federal legislation over psychiatric commitments with the potential to fill this vacuum, at least in part, which should be addressed here. This exception lies in recent changes to federal Indian law under the 2010 version of the Indian Health Care Improvement Act (IHCIA). Section 709 of the IHCIA authorized American Indian inpatient psychiatric/mental health facilities which could be used by tribes or American Indian individuals as treatment sites. In that instance, federal mental health law and Bureau of Indian Affairs (BIA) regulations would have pre-emptive governance regarding the legal process of commitment and the care provided. However, the general lack of federal mental health laws in this arena might leave space for tribal laws to operate here, with jurisdiction of the tribal court over committed individuals

[46] The Supreme Court has consistently ruled that civil commitment constitutes a severe intrusion on personal liberty requiring that state mental health laws include procedural due process protections (see e.g., *Addington v. Texas , 441 U.S. 418, (1979), Jackson* v. *Indiana*, 406 U.S. 715 (1972); *Humphrey* v. *Cady*, 405 U.S. 504 (1972); *In re Gault*, 387 U.S. 1 (1967); *Specht* v. *Patterson*, 386 U.S. 605 (1967).

determined by location of the facility or some alternative process, such as tribal membership.

However, the jurisdictional dilemmas posed by the lack of federal law governing mental health commitments will likely continue to be at issue for American Indians despite the IHCIA reforms. First and foremost, the provision for developing such facilities appears to be voluntary (e.g. the language states the Service *may* provide not less than 1 inpatient mental health care facility per service area),[47] suggesting such facilities may not be developed, particularly so given the lack of funding for this provision. Moreover, in the case that IHS inpatient mental health facilities become a reality, there will be only one per service area (except in California which will have 2), translating into 13 facilities across the entire United States. With large distances between individuals and the facility sites, it seems much more likely that in an emergency mental health situation, American Indian peoples will be sent to local county or state facilities.

This brings us back to the original issue of the legal vacuum and what laws apply when AI individuals are involuntarily held in state/county psychiatric facilities. Given the lack of federal mental health legislation, combined with very little in the way of tribal legislation in this area, the vacuum is often filled by state law or by a myriad of quasi-legal approaches by families, lawyers, judges and mental health professionals to obtain involuntary psychiatric care in state/county facilities when reservation residency status

[47] In the American Indian-lead steering committee proposed drafts of the legislation, this language read "*shall* provide" Indian dedicated inpatient facilities but Congress opted not to include the mandatory language suggesting it is indeed intended as an optional "requirement." Steering committee drafts are available online at the following web address (see section 706 which would eventually become section 709):
http://webcache.googleusercontent.com/search?q=cache:7s058akulC4J:www.ihs.gov/adminmngrresources/ihcia/documents/b-title7.doc+www.ihs.gov/adminmngrresources/ihcia/documents/b-title7.doc&hl=en&gl=us

might otherwise preclude involuntary commitment. In practical terms, this means that if AI individuals find themselves in a state or county psychiatric facility which seeks to hold them on an involuntary basis, they are likely to be subject to state laws governing involuntary psychiatric holds and for those who continue to have trouble beyond the crisis care period, they may be subject to state mental health conservatorship laws if the person is shown to be gravely disabled such that they cannot safely meet their basic needs for food, clothing and shelter as a result of mental disorder.

There are, however, significant differences in whether the state can *legally* assert jurisdiction over AI individuals, each of which implicate and impact tribal sovereignty in unique ways. These differences are based on: residency status of the individual (on or off reservation lands), whether a particular tribe has its own facilities and laws for managing acute mental health issues, quasi-legal practices by practitioners (sometimes with the support of families) to obtain involuntary services regardless of the law, and state relationships to tribes resulting from grants of jurisdiction by Congress[48] or by compacts with the tribes. Due to the complexity of the various scenarios, we will address jurisdiction and sovereignty issues in three steps: first, jurisdiction for urban Indians; second, jurisdiction for AI reservation residents generally; and third, jurisdiction for AI reservation residents in states such as California which have limited extensions of civil jurisdiction under a law known as PL 280.

Jurisdiction for Urban Indians

As discussed above, the lack of federal legislation governing psychiatric commitments for mental health creates a legal vacuum in that there is no federal

[48] These states are mandatory states under a federal law known as "PL 280," which will be discussed in greater detail below.

exclusive authority nor any pre-emption and the field is open for regulation by tribes and/or states. In the case of AI individuals living off the reservation, these individuals are not covered by tribal mental health laws (to the extent that they exist) by virtue of the fact that the individuals reside on state lands outside of tribal jurisdiction. For these individuals, state law governing psychiatric commitments will apply. In legal parlance, under a seeming reversal of pre-emption law, state jurisdiction will be presumed to apply for urban Indians irrespective of tribal authorization or Congressional legislation (Wilkinson, 1987). This means that state/county courts may legally assert personal jurisdiction over AI urban Indians and adjudicate the case. It also means that all state laws governing due process and treatment rights while in the locked facility will also apply to that individual and tribal nations will have no authority to intervene.

The applicability of state civil commitment law for urban Indians is particularly salient given the large number of American Indians living off reservations in urban areas (Nebelkopf and King, 2004). In California, for the 97% of AI peoples living off reservation lands, if emergent psychiatric care becomes an issue, state law governing civil commitment under the Lanterman-Petris-Short Act (LPS) will apply. For example, Los Angeles County has the largest urban Indian population in the United States (Ong & Houston, 2002). Los Angeles County data indicate there are AI clients in County psychiatric facilities subject to involuntary confinement. Even though some or all of these individuals may be enrolled tribal members, because the individuals reside off reservation lands, Los Angeles municipal courts have jurisdiction over all legal proceedings associated with their confinement – tribes have no right of intervention into the case, both by law and in practice, given the absence of any agreements between the

State or County and tribal nations. Although many tribes have long argued that the protections of tribal sovereignty should extend to tribal members wherever they go, the absolute right for states to assert state jurisdiction over urban Indians within state boundaries is, from a legal standpoint, firmly established in American jurisprudence (Pevar, 2004). Urban Indians who enter state/county psychiatric facilities involuntarily will, therefore, be subject to state laws governing the legal case and patient rights issues while in confinement.[49] Thus, the legal issues for urban Indians lie in the linkages between colonization and the state civil commitment hearing process, as well as in the implications for involuntarily confining and treating tribal members in a psychiatric system evidencing its own historical amnesia of the relationship between the helping professions and political agendas of cultural assimilation, termination, and genocide (Waldram, 2004).

Jurisdiction for AI Reservation Residents in the Majority of States

Unlike urban Indians, AI reservation residents have increased protection against state assertions of jurisdiction. With regards to mental health based civil commitment, the majority of states follow the holdings under *White v. Califano*, a 1977 8th Circuit federal court case, which found that absent express Congressional consent, the state may not involuntarily commit reservation-based Indians because, as sovereign entities, tribal governments retain jurisdiction over their own residents preventing the state from extending its reach onto tribal lands (see also, Pevar, 2012). Under *Califano*, the state/county court, lacking personal jurisdiction over reservation residents, cannot legally authorize a state/county facility to involuntary hold AI reservation residents and the

[49] Federal law regarding privacy and due process rights will also apply and this is the case both for urban Indians and reservation residents who find themselves in state/county facilities.

individual will functionally be excluded from state-county based *involuntary* psychiatric services (or from another viewpoint, spared from unwanted services and intrusions into tribal sovereignty).

While limitations on state authority over reservation Indians protects tribal sovereignty, there are some complicating factors to consider. First, "protecting tribal sovereignty" can be, and has been, used as a cover by financially strapped states to avoid providing necessary, if culturally suspect, care, placing people's lives at risk if the individual really is an immediate danger to self/others. Moreover, the decision not to involuntarily confine the individual on the basis of respecting tribal sovereignty may run counter to what the family and tribal community members feel is best. There are often limited options available to keep family members safe, particularly for smaller tribes without their own resources to manage the crisis or where there is a lack of traditional approaches that would otherwise have been sufficient – such traditions may have waned as a result of long-standing federal policies which denied funding or criminalized traditional healer activities, boarding schools which interrupted knowledge transmission or other forms of disruption that have impacted the larger social fabric of community life (Kuschell-Haworth, 1999; Manson, Bloom, Rogers, & Neligh, 1987; Shelton, 2001).

In a somewhat bizarre twist on the law undergirding the sovereignty doctrine, even if a tribe wanted to authorize a limited extension of state authority to secure involuntary commitment because they felt it was the best option available to protect the individual's life or the lives of others, under federal law, there is no mechanism for tribes to legally transfer jurisdiction of reservation Indians to the state, at least not over the individual's objection which would violate individually based federal Indian civil rights laws

(Henderson, 1982). Thus, in the case of involuntary treatment, families and tribes may find that when their loved ones need services as a matter of life or death, even if those services are colonizing and questionable in nature, they may be left without any viable options, state or otherwise.

Part of the dilemma here is that *access to care* and *Indigenous-knowledge-driven health approaches to care that are respectful of sovereignty* are often framed as mutually exclusive options e.g., you can have Western-centric, state/county-based care *or* you have no access to involuntary care but you can maintain limits on state intrusions into tribal sovereignty. Ultimately, in many states this tug-of-war between care and sovereignty, and the related jurisdictional issues, become a barrier to addressing the pressing needs of individuals, families and communities.

So how have these legal barriers played out in real time with regards to mental health cases and involuntary services? In some cases, court and counsel simply elect to ignore the lack of personal jurisdiction in order to ensure access to mental health services they genuinely believe the individual needs (Henderson, 1982). This quasi-legal/not legal process may occur under a variety of circumstances such as when reservation residents come to the attention of police or health workers while off reservation lands and are taken into state/county emergency psychiatric facilities. Alternatively, in cases involving AI reservation residents who evidence a need for care but refuse to get any, Tribal police, lacking viable options on the reservation, may deposit an individual in need of involuntary psychiatric services off reservation lands, notifying local police who will then wait until they see behaviors suggesting the individual is a danger to him/herself or others and then take the individual into emergency psychiatric care (Henderson, 1982). At that

point, state civil commitment procedures are initiated wherein the judge and defense counsel simply remain silent about issues of residency and jurisdiction so as to avoid the jurisdictional issues. However, because defense counsel never raises the issue of jurisdiction, the matter is waived and the court can proceed, "legally" (Henderson, 1982). This wink and a nod system of civil commitment reflects the binary logic of a system where the only other alternative is to no care – a potentially life threatening decision. For families in need of assistance managing a loved one's out of control behavior related to mental health or imbalance, Western-centric care may be better than no care at all, particularly when the behaviors are seriously dangerous and there are no tribal resources in place to address the issue. Irrespective of that fact, these kinds of jurisdictional dilemmas reflect a nuanced and complicated relationship between colonization, sovereignty and mental health law and policy.

Many states and tribes have tried to address this dilemma of jurisdiction and service preclusion extra-legally through Memoranda of Understanding (MOUs) or state executive orders for cooperation and recognition of tribal court orders (see e.g., Henderson, 1982; see e.g., Arizona Department of Health Services, 2013). Here, the tribes delineate procedures for civil commitment and either sanction state jurisdiction over residents for the purpose of receiving state psychiatric services or establish procedures for state recognition of Tribal Court civil commitment orders (Manson, et al., 1987). These MOU-type practices recognize a degree of tribal sovereignty and attempt to remove barriers to access to care. From a practical perspective, this approach can be done in a way that maximizes tribal input and, particularly in cases where the tribes have their own legal procedures in place, MOUs can be useful in marrying tribal jurisprudence

with the resources of the state. However, such practices can also prove problematic.

Within the current frame of federal Indian law, MOUs or state executive orders transferring jurisdiction over involuntary reservation residents are political solutions, not legal ones as they have no real legal effect absent Congressional legislation authorizing such a transfer of authority from the tribes to the states (see *Kennerly v. Dist. Ct.*, 1971). The MOU solution may also be more form than function when it comes to self-determination and decolonization, particularly when the MOU simply authorizes the state to take jurisdiction but does not require any substantive changes to the actual legal process or treatment approach to ensure those elements are more consistent with local tribal values regarding justice, health or relationality more generally. In the case of MOUs structured as a mere stamp of approval of Western-centric power structures rather than as a truly self-determined or at least collaboratively designed process, while practical and providing some recognition of tribal sovereignty/tribal council input, these do not ultimately change or substantively challenge the colonial nature of the legal, political or health-care relationships between American governmental entities and tribal nations. Nevertheless, carefully crafted MOUs can create a vehicle for collaborative engagement between the states and tribes to address the access versus sovereignty dilemma in involuntary psychiatric commitment and emergency mental health cases.

Jurisdiction for AI Reservation Residents –California & PL 280 States

In most states, tribal sovereignty doctrine and case law precludes states from involuntarily committing an AI reservation resident to a psychiatric facility absent either an agreement between the state and the tribe or by the individual's "consent" to the state's assertion of personal jurisdiction (often obtained in an uniformed manner through

waiver or through an intentional act on the part of judges and counsel to simply ignore the issue of jurisdiction so as to ensure the individual receives what is perceived as deeply needed treatment for a serious mental condition). Despite the realities of common practice, the general legal rule is that states may not *involuntarily* commit AI reservation residents to psychiatric facilities. However, this is not necessarily the case for all AI reservation residents.

There are 6 states, California, Minnesota, Nebraska, Oregon, Wisconsin and Alaska, which have somewhat unique relationships to tribes under federal law – relationships that potentially impact how these states take jurisdiction in civil matters such as involuntary commitments. We will use California as an exemplar here. The issue of jurisdiction by state/county courts over AI reservation residents for involuntary commitment is largely an open question in California, as it is in the other 5 states. This is particularly true for two reasons: first, the one and only case finding state jurisdiction does not reach onto tribal lands for the purpose of involuntary psychiatric commitment (*White v. Califano*, 1978) is not controlling outside of the 8th circuit – it is persuasive authority only and so California courts are not bound by that decision; second, California lacks any MOU-type agreements with tribes to delineate an agreed upon practice for involuntary psychiatric commitment of AI reservation residents.[50] The question then is how does California take jurisdiction over AI reservation residents for psychiatric civil commitment and conservatorship hearings?

There appear to be three possible answers to this question: first, it is possible that, as with many of the states above, jurisdiction is not appropriate but attorneys uneducated

[50] Craig Parker, Legal Counsel to California Department of Mental Health, personal communication, October 20, 2011.

in issues of sovereignty never raise the issue of jurisdiction, unknowingly waiving the matter and everyone simply proceeds as if it is a non-issue. Second, the state, through its courts, may be asserting personal jurisdiction under the 'presence in the state' test (e.g., on the basis that the state served the individual notice and a copy of the complaint while the individual was present in the state in the psychiatric facility). However, this notion of personal jurisdiction based on 'presence in the state' runs counter to federal Indian law which generally precludes state assumptions of jurisdiction over Indian lands or AI reservation residents absent explicit Congressional authorization – if the states needed merely to wait until AI individuals stepped off the reservation to assert proper jurisdiction over them or their lands and property, they could enforce any manner of state laws which would be and in fact are prohibited under federal case law (e.g., regulation of lands, taxation, tort claims, etc.).

The third avenue through which California may be asserting jurisdiction over reservation residents is through the peculiarities of a federal law known as Public Law 83-280 (often referred to simply as "PL 280"). Enacted in 1953 during the termination era, PL 280 extends state jurisdiction onto tribal lands for criminal offenses and limited extensions of civil jurisdiction for matters between private parties (for example, if a reservation resident wants to sue another resident for damaging personal property, he/she can go to state/county court to litigate the issue – this may be the only option if the tribe lacks a tribal court or laws governing the issue) (Pevar, 2004). Notably, PL 280 does not divest tribes of the right to regulate or adjudicate criminal or civil cases – rather it creates concurrent jurisdiction for the states over criminal and some civil actions (Pevar, 2012). Congress made the extension of jurisdiction mandatory for 5 states, including California,

Minnesota, Nebraska, Oregon, Wisconsin (later adding Alaska as a 6th state), and optional for the remaining states (in subsequent amendments, Congress required tribal consent for states to exercise this option) (Pecos-Melton & Gardner, 2004). Congress passed PL 280 ostensibly to reduce lawlessness and a lack of access to courts in tribal communities (Goldberg, 1975). Many have speculated, however, an ulterior motive in that by allowing states to take over criminal prosecutions for incidents on tribal lands, the federal government could shift the burden of investigative and litigation costs to the states. In fairness, it should be noted that tribes did often lack the infrastructure to address criminal conduct and PL 280's extension of jurisdiction to the states provided an avenue to redress criminality and litigate private disputes (of course increasing funding to tribes to develop *their own* infrastructure in a manner reflecting local values was/is an equally viable solution to this problem but instead the federal government opted to boost state authority over tribes) (see, e.g., Pevar, 2004).

In any case, for the 6 states with PL 280 authority, they have both criminal jurisdiction and limited civil jurisdiction over tribal reservations located in their respective state boundaries. It is the extension of civil jurisdiction to the states under PL 280, and in particular the scope of that extension, that is of particular interest to us here as civil matters include mental health civil commitments. The extent to which the state can extend its reach onto tribal lands in particular types of civil matters depends on how the courts interpret the limiting language of PL 280 civil jurisdiction. For example, the impetus for creating PL 280 civil jurisdiction was to create a venue for private parties on reservations to litigate civil disputes. However, the limiting language in PL 280 and the legislative history are somewhat vague on the actual scope of the law. This leads us to

ask, does extending state civil jurisdiction simply mean that state courts are authorized to adjudicate cases between private AI individuals residing on reservations or does it allow the *state* to become a *party* to the action *against* AI reservation? How the courts interpret the scope of PL 280 thus has important ramifications not only for individual families and communities but for tribal sovereignty as well.

In interpreting PL 280 civil jurisdiction, the Supreme Court in *Bryan v. Itasca County* (1976), initially limited the scope of PL 280 civil jurisdiction to civil disputes *between private parities*. The underlying facts of *Bryan* centered on whether Minnesota, a PL 280 mandatory state, had the right under PL 280's grant of limited civil authority to impose a property tax on a Chippewa tribal member's mobile home which was located on lands held in trust for the tribe. The state argued that PL 280 civil jurisdiction authorized state courts to act as venues for civil litigation *and* extended state civil law over tribal lands, including state taxation laws over reservation lands, or property located thereon. The Court soundly rejected this argument. In its decision, the Court wrote that the legislative history on the extension of civil jurisdiction was "primarily intended to redress the lack of adequate Indian forums for resolving private legal disputes *between reservation Indians and between Indians and other private citizens*" (*Bryan*, 1976, at 384, emphasis added). The Court went on to write that:

> The legislative history virtually compels our conclusion that the primary intent of [civil jurisdiction] under section 4 was to grant jurisdiction over *private civil* litigation involving reservation Indians in state court. Furthermore, certain tribal reservations were completely exempted from the provisions of PL 280 precisely because each had a 'tribal law and order organization that functions in a

reasonably satisfactory manner.' Congress plainly meant only to allow state courts to decide criminal and civil matters arising on reservations not so organized…Rather than an expansive reading…the construction we give [is that PL 280 created an] extension of state jurisdiction over civil causes of action by or against Indians arising in Indian country (*Bryan,* 1976, at 385-386, emphasis added).

The Court wrote also noted that interpretations of PL 280's scope directly implicated issues of assimilation and colonization. The Court wrote:

Today's congressional policy toward reservation Indians may less clearly than in 1953 favor their assimilation, but PL 280 was plainly not meant to effect total assimilation…And nothing in its legislative history remotely suggests that Congress meant the Act's extension of civil jurisdiction to the States should result in the undermining or destruction of such tribal governments as did exist and a conversion of the affected tribes into little more than 'private voluntary organizations'…a possible result if tribal governments and reservation Indians were subordinated to the full panoply of civil regulatory powers…of state and local governments…Moreover, the same Congress that enacted PL 280 also enacted several termination Acts – legislation which is cogent proof that Congress knew well how to express its intent directly when that intent was to subject reservation Indians to the full sweep of state laws and state taxation…Indeed, section 4, [the civil jurisdiction section of PL 280], in its entirety may be read as simply a reaffirmation of the existing reservation Indian-Federal Government relationships in all respects save the conferral of state-court jurisdiction to

adjudicate *private* civil causes of action involving Indians (*Bryan*, 1976, at 387-391, emphasis added).

The *Bryan* Court raised two important issues here: first, the Court limited scope of PL 280 civil jurisdiction to state jurisdiction over private civil litigation involving AI individuals on Indian lands and excluded more general state civil regulatory authority; and second, the Court recognized the assimilative and colonizing potential of PL 280 if it were to be given more expansive interpretations. Subsequent case law echoed *Bryan*, noting expressly that PL 280 civil grants of authority did not include state regulatory activities (such as regulation of Indian gaming) but was limited to criminal/prohibitory statutes (*California v. Cabazon Band of Mission Indians*, 1987). Under the original PL 280 interpretations, absent Tribal consent, states would not have the power under PL 280 to extend state mental health civil commitment laws onto tribal lands or to use state civil laws to commence commitment proceedings for American Indians residing on reservations because state civil proceedings against tribal residents would be beyond the scope of "civil litigation between private parties" under *Bryan* and would not fall under the rubric of prohibitory/criminal laws permitted under *Cabazon*.

However, subsequent case law evidences a significant creep in the definitions of "private parties" and "state regulatory civil jurisdiction," bifurcating civil jurisdiction into *regulatory*, which remains impermissible under *Cabazon*, and permissible *adjudicatory* actions whereby state laws reach right into the heart of Indian country (see e.g., *Burgess v. Watters*, 2006, Cert denied 2007; *Doe v. Mann*, 2005, Cert denied 2006). This doctrinal creep allowing state extensions of laws that are "adjudicatory" in nature has been particularly noticeable in the areas of civil commitment law related to the post-sentence

civil commitment of AI reservation residents defined by statute as sexually violent predators (see e.g., *Burgess v. Watters*, 2006, Cert denied 2007; see also *In re Civil Commitment of Johnson*, 2011).[51] The expansion of PL 280 civil jurisdiction has also occurred in child welfare law, where the courts have sanctioned extension of state child welfare laws onto tribal lands and over tribal communities on the basis that the state laws are adjudicatory in nature rather than regulatory laws (see e.g., *Doe v. Mann*, 2005, Cert denied 2006). Moreover, beginning with *Cabazon*, the courts have also increasingly strayed from the limiting rationale of *Bryan*, which guarded against expansive interpretations of PL 280 as a check against assimilationist policies which would undercut tribal sovereignty, to include a balancing test approach whereby the court now weighs federal/tribal pre-emption and tribal sovereignty interests against the legitimacy of state interests in addressing the particular issue (see *California v. Cabazon Band of Mission Indians*, 1987; *Doe v. Mann*, 2005, Cert denied 2006). Under these new interpretations of PL 280, extending state civil laws governing involuntary psychiatric commitments over AI reservation residents would also be permissible as adjudicatory extensions of authority over tribal lands and persons.

The Supreme Court has consistently denied certification of cases contesting this regulatory-adjudicatory distinction, and in so doing, tacitly approves the expansion of PL 280 civil jurisdiction well beyond the original intent of the law to provide a venue for

[51] See also *Beaulieu v. Minnesota*, 583 F.3d 570 (8th Cir., 2009) (cert. denied, 132 S. Ct. 1907 (2012)). *Beaulieu* involved the civil commitment of an AI individual residing on tribal territory as a sexually violent predator under PL 280 and state civil commitment law for post-sentence sex offenders. The party requested certification for hearing by the Supreme Court on the issue of whether the state could legitimately assert PL 280 authority for civil commitment of sexually violent predators post-release. However, counsel failed to raise the PL 280 jurisdiction issue in the lower level courts resulting in waiver and as such, the Supreme Court denied certification.

private litigants from reservations. It also goes well beyond the scope of *Bryan,* which limited PL 280 civil jurisdiction to state authority to adjudicate civil litigation between private parties. This is a troubling development. The new rubric of regulatory versus adjudicatory powers, which was never permissible under *Bryan,* greatly expands state power vis-à-vis tribes, both to be a party to actions against AI reservation residents and to extend state law onto tribal lands. This is particularly dangerous as there is no brightline distinction between regulatory and adjudicatory law, leaving a great deal of room for the state to extend its reach. As the Court itself noted in 1976, PL 280 is an assimilationist policy at its heart - expansive interpretations of state civil jurisdiction under PL 280 undercut tribal sovereignty and promote colonization through transformation of what originally was a limited law creating a venue for private disputes into a giant octopus of state power over Indian lands and tribal members. In this respect, jurisdictional law related to issues of civil commitment directly implicates colonization. In the chapter that follows, we will explore additional ways in which colonization is woven into the fabric of mental health law and policy by examining the mental health hearing process and treatment rights.

Chapter 8

Colonization and the Law: From Mental Health Hearings to Confinement

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> The ideas [Westerners] export to other cultures often have at their heart a particularly American brand of hyperintrospection and hyperindividualism… What is certain is that…other cultural conceptions of the mind remain more intertwined with a variety of religious and cultural beliefs as well as the ecological and social world. With little appreciation of these differences, [Westerners] continue…efforts to convince the rest of the world to think like [them]. Given the level of contentment and psychological health [Western] cultural beliefs about the mind have brought, perhaps it's time that [they] rethink [that] generosity.
>
> Ethan Watters, 2010[52]

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Involuntary psychiatric commitment cases often involve multiple hearings and within each of those hearings, AI individuals will be subject to both the form and function of the applicable laws. As we learned above, those laws are generally state-based mental health laws, rather than tribally developed frameworks of care. Understanding the letter of the law and the process of the hearing, from notice provisions to how we understand what constitutes legitimate evidence and "culturally appropriate care," all implicate colonization in different ways. This section explores colonization throughout psychiatric commitment cases, including critical steps in the hearing process,

[52] Watters, 2010, pg 254-255.

treatment, and far-reaching consequences of confinement for both individual AI families and tribal nations in order to better understand how colonization is at play both explicitly and implicitly in involuntary psychiatric commitment law.

Beginning the Hearing: Notice, Rights of Intervention & ICWA

One of the first steps in the hearing process is the requirement that parties to the action receive notice of the hearing. As with most states, California law includes a number of provisions relating to notification for psychiatric commitment and conservatorship cases. The National Alliance on Mental Illness, San Mateo County Branch (2013), summarizes the notification requirements for individuals held beyond the initial 72-hour assessment period as follows:

> A *notice of certification* is required for all persons certified for intensive treatment *and* must be signed by the professional person or designee in charge of the facility providing evaluation and by a physician or psychologist who participated in the evaluation. A copy of the certification notice shall be personally delivered to the person certified, and the person's attorney or advocate as designated in Section 5252. The person certified shall also be asked to designate any person who is to be sent a copy of the certification notice. If the person certified is incapable of making this designation at the time of certification, s/he shall be asked to designate a person as soon as s/he is capable. The person may choose not to have any other person notified. (NAMI-SMC, 2013)

In addition to the certification notice requirements, there are a number of other rights which protect against individuals from simply being disappeared into locked facilities. Individuals may enforce these rights through mental health hearings, with each

hearing requiring proper notice to all parties. For example, each of the rights listed below may be enforced through petitions to the court. These may include:

- The right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services (W.I.C. § 5325);
- The right to be informed of one's rights (in a language accessible to the individual) along with the provision of a patient's rights handbook (W.I.C. § 5325);
- The right to timely judicial review for confinements beyond 72 hours and for involuntary medication issues, as well as the right to a publicly appointed attorney if the individual cannot afford one (W.I.C. §§ 5275-5278; 5350d);
- The right to make/receive phone calls and to access letter writing/mailing materials (these rights are subject to revocation for good cause) (W.I.C. § 5326);
- For conservatees, placement in a locked facility is permissible only if it is part of the treatment plan or upon application to the court, with proper notice of the hearing to all involved parties.

For every hearing held in relation to these rights, proper notice is required according to the local rules of civil procedure, which will require notice to all involved parties within a set timeframe prior to the hearing date. Collectively, these laws do provide some measure of protection for individuals against abusive practices and diminish the probability that individuals will be locked away wrongfully or without access to outside supports, including tribally affiliated resources and friends/family.

However, notice requirements and rights of contact do not guarantee that individuals will be able to obtain help for wrongful confinement, particularly as they may be estranged from loved ones, struggling with mental illness, and may be under heavy sedation. For example, Rita Quintero, the Tarahumara Indian discussed in the introduction, spent 12 years wrongfully confined to a locked psychiatric facility under heavy medication and out of contact with family members who were actively looking for her. In her case, notice of the state's intent to confine her never reached any family nor was she able to advocate for herself to enforce the full panoply of rights accorded to her under the law. Nevertheless, while notice provisions are certainly not a fail-safe against wrong-doing, notice requirements do serve a protective function.

The question then is how do these otherwise protective laws – laws which are seemingly benign - enact colonization? The answer lies in what is *missing* from the statutory notice requirements: namely the absence of any legal requirement or specific consent-based mechanism for notifying tribes that a tribal member is in state psychiatric custody or that a state/county court is taking jurisdiction over the case. This silence stands in contrast to federal statutory notice requirements in dependency/foster care cases for AI minors under the federal Indian Child Welfare Act, or "ICWA" (1978). While dependency cases involve children and thus perhaps warrant more aggressive protective notice requirements, individuals struggling with mental illness and subject to serious medication-related impairments, are also a highly vulnerable population, yet the notice provisions in adult mental health are not nearly as stringent as those under ICWA, nor do they reflect a recognition of the connection between mental health and colonization. This difference warrants some exploration.

Congress passed ICWA to address the extremely high rates of AI children being removed from their homes by the state and placed in non-Indian families for adoption or placed in institutional settings far from family or tribal life – practices which were not only harmful to the individual families and children but also harmful to AI communities as a practice of cultural genocide (Pevar, 2012). Through consultation with many Indian community leaders, Congress designed ICWA provisions, including notice and various other rights such as rights of intervention by the tribe into the case, as well as evidentiary requirements for Indian expert testimony, to protect children as a vulnerable population, unable to fend against the power of the state and/or against the significant racial and socio-economic bias by social workers and judges prevalent in the late 1970's (and which may persist today given the continuing disproportionate representation of AI children in the foster care system) (H.R. Rep., 1978; Pevar, 2012).

ICWA notice provisions require that once a child welfare case is opened and the child is determined to be an "Indian child,"[53] the county must notify any tribes in which the child is a member or in which the child may be eligible for membership based on family history (ICWA, 1978). In emergency cases where the child's life is in imminent danger, social workers may remove the child without prior notice to the tribe but ICWA requires that notice be given shortly thereafter. Notice requirements, along with other provisions within the statute, afford tribes the opportunity to exercise some measure of control over child dependency cases in two ways: first, requiring notice ensures tribes are aware of the state action against member-children/families, allowing the tribe to pull in

[53] Regulations governing the process for determining if the child is "an Indian child" very from state to state but generally include ICWA interviews of parents, children and available family members to assess if the family has any American Indian ancestry. In California, even vague and equivocal references to possible AI heritage result in mass notifications going out to all possibly relevant tribes.

potentially supportive extended family in a supportive role; second, receiving notice is a critical step in facilitating tribal authority, under ICWA, to legally intervene in the case – referred to as a right of intervention.

The right of intervention under ICWA creates a mechanism for tribes to become parties to the case with the same rights as any other party to the case, e.g., to receive notice, to receive copies of all court document filings, to present evidence, and to file motions for judicial determination. The right of intervention also creates concurrent jurisdiction for tribal courts over children living off the reservation[54] and a right to either intervene in the dependency case or alternatively, tribes may choose under ICWA to take sole jurisdiction over the case, removing it from the county/state dependency system and into tribal court (Clifford-Stoltenberg, Kupcho, Mills, & Simmons, 2013). While ICWA's success in protecting AI families is open to debate,[55] it is clear that the notice provisions

[54] ICWA provides that for children on reservation lands, the tribe retains exclusive jurisdiction, absent federal law conferring civil jurisdiction to the state to adjudicate child dependency cases. As discussed above, because PL 280 confers limited civil jurisdiction to California, recent case law suggests that PL 280 is now being used to assert state civil jurisdiction over child welfare cases for children residing on reservation lands (see e.g., *Doe v. Mann*, 2005, U.S. Supreme Court cert denied 2006). Where the state asserts jurisdiction over reservation youth, the tribes retain the same rights under federal ICWA laws to intervene or assert sole jurisdiction over the case in tribal court.

[55] Some of the difficulties in ICWA solvency include uneven implementation, lack of infrastructure to facilitate implementation, lack of training on ICWA, lack of education/awareness of AI cultures/norms, misidentification of Indian children, state-based attempts to limit the scope of ICWA and persistent inadequate funding for tribes and state based agencies (Evans-Campbell, 2006). In addition, major difficulties continue under ICWA legislation in adoption cases related to improperly reported parentage information for Indian children resulting in failures to place children in Indian homes at the outset of the case or inappropriate application of state parentage laws in place of ICWA, denying biological parents (usually unwed biological fathers) contesting the adoption status as a parent under state law. These kinds of errors result in children being placed with non-Indian prospective adoptive parents where the children may live for many years before Indian parents or relatives are able to complete the appeals process. These cases create heart-breaking situations in which one set parents or the other is going to lose their child and for the child, it may mean leaving the home of the only parents the child has ever known. Cases similar to this are currently set to appear before the Supreme Court (see *Adoptive Couple v. Baby Girl, Father and Cherokee Nation*, Docket No. 12-399 S. Ct., cert. granted, Jan. 4, 2013).

play an important role in protecting vulnerable populations and in preserving tribal cultures and sovereignty.

Notably, many of the same rationales for adding notice and intervention provisions under ICWA, as well as additional provisions related to Indian expert testimony discussed below, are relevant to involuntary psychiatric hearings: both systems interface with vulnerable populations (children vs. mentally ill or disenfranchised adults); both have histories of abusive practices for facilitating active colonization efforts (e.g., wrongful removal of Indian children and adoption to white families vs. removal and assimilation era-policies such as the Canton Asylum for Insane Indians); and both systems evidence difficulties with professional bias impacting critical decisions (e.g., bias or lack of cultural understanding influencing social work risk assessments; lawyers and judges proceeding with court hearings without any understanding of Indigenous worldviews on child rearing or mental health, etc.). Moreover, tribal sovereignty and self-determination are relevant to both child welfare and mental health in terms of direct impacts on individuals/families as well as in how the law recognizes (or fails to recognize) tribal authority/competency in these arenas.

However, while ICWA and mental health law share many fundamental attributes, involuntary psychiatric commitment laws and LPS conservatorship laws do not contain any of the same notification or other protections – in fact they are silent on tribes all together. Mental health-based civil commitment laws contain no requirement to contact tribes (upon client consent),[56] nor do they contain any provisions for a tribal right of intervention into the proceedings or concurrent jurisdiction. While individuals do have

[56] Client consent would be required due to federal health privacy laws as well as state confidentiality requirements.

the right to contact anyone they wish to notify them of the potential confinement, including family or tribal governments, clients in emergency mental health proceedings are frequently heavily medicated and disoriented, making it less likely that they will reach out for help from the tribe on their own. Moreover, as Winick (2005) explains, defense attorneys in mental health cases often "relax their advocacy role and adopt what has been termed a 'paternalistic' or 'best interests' approach in which they seek to effectuate what they may perceive their client's best interests to be" (pg. 142). Taking the role of the paternalistic/maternalistic guardian biased towards the client receiving services rather than that of a zealous advocate makes the attorney less likely to ensure the client understands all of his/her legal options or to capitalize on legal loopholes that could set the client free.

The problematic aspects of this assumed 'best interests' approach are amplified for AI clients. Attorneys unfamiliar with Indigenous practices and worldviews may mis-judge client or familial conduct or wishes, supplanting the client's directives with his/her own judgment about the individual's mental health and best interests. As a result, the attorney may fail to assert or even do the research to become aware of potential legal arguments based in tribal sovereignty or potential challenges, arising from the client's tribe's worldviews, to the Western-centric DSM IV diagnosis. Moreover, defense attorneys are unlikely to have any specialized knowledge of federal Indian law, issues of sovereignty or familiarity with AI culture and may under-estimate or may be totally unaware of the potential relevance of advising clients of their right to personally notify their tribe of the proceedings.

Furthermore, even if the tribes become aware of the hearing, the lack of any legal right of intervention in mental health cases precludes tribes from asserting jurisdiction over the individual or to otherwise join the case as a party to the action. Without this right of intervention, tribes lack standing and therefore have no legal rights in the case, at least for urban tribal members and in some states, even for their own members residing on reservation lands.[57] This is furthered in the state of California, by the fact that neither the state nor the two counties studied herein have Memorandum of Understanding with tribes to manage or coordinate communication or jurisdictional issues between county mental health and tribal governments.[58]

Ultimately, the lack of notice provisions or legal rights of intervention in California mental health cases evidences traces of colonization: first, by functionally excluding tribes from the process, and doing so in favor of individual privacy rights which reflect the primacy of the individual in Western jurisprudence; and second, the silence in the law as to the rights of tribal nations facilitates historical amnesia and promotes the notion that racially/AI neutral laws are in fact neutral despite the colonial-political nature of American jurisprudence. Whether adding notice and rights of intervention or wholesale revision of the law to recognize the duality of sovereigns in this country remediates colonization (or even has any real and practical benefit for AI communities) is unclear. Nevertheless, the total silence of involuntary psychiatric

[57] In non-PL 280 states, tribes retain exclusive jurisdiction in mental health cases for reservation residents irrespective of state law. However, for non-reservation residents, the lack of a right of intervention in state mental health laws precludes tribes from intervening for urban Indian tribal members.

[58] As per Craig Parker, Legal Counsel to California Department of Mental Health, personal communication, October 20, 2011, and as per Public Records Act Request responses from Humboldt and Los Angeles Counties, 2012-2013.

commitment and LPS conservatorship law on tribes or Indigenous justice functions as yet another mechanism for enabling colonization.

Evidence, Stories, and Culturally Embedded Notions of Madness

Every trial is based on stories. Stories of what happened, stories of accountability, stories of what was, what is and what will be. Some stories are understood as legitimate, as evidence of truths, and others are so different from the stories usually given in American courtrooms that they are shunned, laughed at or never told at all. Every trial also has a set of storytellers – but we don't call them all storytellers: some are seen as Truth sayers, not storytellers at all – we call them experts and what they say is not called a story, it is called expert testimony. Others are called witnesses and they may tell truths or lies or stories in between and we call this evidence. Still others are called mad and maybe there is something to this or maybe it is the listener who is mad, unable to follow a narrative so different than what he has ever heard before that he cannot hear it and in arrogance, he declares this story strange and the storyteller mad.

In the American courtroom, whose stories are legitimate, which tellers command the title of expert, of credible or sane, these things are all influenced by our cosmologies and cultural contexts. So too are our understandings of who is mentally ill, of who has the qualifications to assess sanity, and of what we believe should be done about it. As Winick (1995) states, "The concept of mental illness is socially constructed, more normative in character than descriptive" (pg. 48). Holstein (1993) adds, that behaviors categorized as mental illness involve norm violations implicating "expectations so fundamental and taken for granted that they are assumed to be standards of natural, decent, and understandable behavior" (pg. 4, citing Scheff, 1966). These expectations are

grounded in culture, worldviews and history, including the past and present ramifications of colonization for AI peoples and because they have become naturalized, they are often unquestioned by members of the dominant cultural groups who, so often, are in positions of power as psychiatrists, social workers, expert witnesses, judges and lawyers. Moreover, mental health law does not have any analogue to ICWA's requirement for an *Indian expert* to testify in cases involving AI clients and, because most judges, attorneys, and mental health experts are not raised in or familiar with Indigenous perspectives on well-being, it is the colonized Western-centric understandings of mental illness that tend to permeate the hearing process. In this section we explore the process itself, rather than the law, in order to understand how colonization is present from an interactional standpoint.

That the power brokers - the ones who provide and evaluate evidence of mental illness in the courtroom - understand notions of mind, etiology and treatment modalities within the blindfolds of Western-centric thought is particularly important with regards to expert testimony. Winick (2005) writes that "in practice, commitment hearings tend to be brief and non-adversarial episodes in which judges appear to 'rubber stamp' the recommendation of clinical expert witnesses" (pg. 143). "Clinical expertise" in mental health cases is established by particular benchmarks – professional education at an institution accredited by the state or national accrediting board, degrees, licensure, familiarity with the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition TR* (DSM-IV, text revision), board certifications, and clinical rotations. These are benchmarks of expertise under the law, benchmarks which are grounded in evidence of successful mastery of professional knowledge in psychiatry and social work, disciplines

driven almost exclusively by Euro-centric/Western knowledge systems, despite the wealth of healing knowledge in non-European, non-Western cultures and knowledge systems.

The professions of mental health, and the curriculum used to educate practitioners who will ultimately be the clinical experts in these cases, have a long history of marginalizing and pathologizing Indigenous approaches to wellness. For example, if we look back to the seminal works of Sigmund Freud, among others, we see the roots of psychological diagnosis linked to Western/European Judeo-Christian cultural norms as the standard for 'natural' or 'normal' behavior and racist, colonialist depictions of AI peoples. In his highly influential 1950 book, "*Totem and taboo: Resemblances between the psychic lives of savages and neurotics,*" Freud writes detailed descriptions attempting to establish what he sees as parallels between "primitive" peoples in the Americas and mentally ill Westerners (Waldram, 2004, pg. 27). Freud was not alone in trying to create a link between depravity and the supposed inherent nature of AI peoples. Depictions of a "true" and often singular AI identity in psychoanalytic anthropology ranged from racist, reductionist and romanticized notions of the American Indian mind as a "primitive state of uncontaminated aboriginality" (Hallowell, 1976, pg. 10), and the exotic/dangerous other whose "belief in spirits and magic" constituted prima facie evidence of psychosis (Waldram, 2004, citing the work of anthropologist A.L. Kroeber), to base assumptions that the behavioral and emotional consequences of forced acculturation constitute some unique form of Indigenous schizophrenia (LaFramboise, Trimble & Mohatt, 1990, citing the work of analysts Spindler and Spindler, 1972).

Moving head in time, we see that such concepts of mental illness which, notably, have evolved to less overtly dehumanizing accounts of AI identity, continue to develop and do so in the context of colonization, mired in its enabling mechanisms of racism, impoverishment, displacement and ideological hegemony (Gone, 2008; Yellow Bird & Gray, 2010). These modern day incarnations of Western-centric mental health continue to discount Indigenous worldviews – worldviews which for many AI individuals and communities deeply inform conceptualizations of the etiology, definition and treatment of behavioral health issues. This is evident in both the curriculum of the helping professions and in the base assumptions that drive mental health theories. For example, social work programs routinely mark the beginning of the helping professions in the United States by dating back to the English Poor Laws and Jane Addam's Hull House.[59] Michael Yellow Bird and Mel Gray (2010) explain that "this colonial narrative, like that of many of the 'discovery' narratives of colonizing peoples, weaves the myth that social work – as a discipline that employs specific strategies and laws to help the less fortunate in society – is a white European innovation and 'proof' of this is offered in textbook after textbook" (pg. 63).

The omission of the long and impressive history of Indigenous helping practices from social work and psychiatry curricula is part of a larger narrative of omission and exclusion "which is not benign and, in fact, contributes to the notion of white supremacy and Indigenous inferiority" (Yellow Bird & Gray, 2010, pg. 63). This is but one example of how students in mental health are acculturated into professional knowledge systems

[59] Hull House was a Chicago-based settlement house for poor and working class individuals, primarily European immigrants. It was co-founded in 1889 by Jane Addams, an English-American woman born to a politically prominent family in Illinois (see e.g., Schneider, 2000).

which are Western-centric, hegemonic, and marginalizing even as these students are told that they are learning to be culturally competent and aware of the importance of cultural difference. This shapes how future mental health professionals understand the substantive content of their field as truth - with some post-modern cultural relativism sprinkled in to be sure – but those "truths," those foundational principles of the profession are Western-centric in nature, though they are not acknowledged as such, and are instead taught as simply good science. To be clear, this is not to say that Western knowledge is bad and Indigenous knowledges are some vision of utopian perfection. Both Western and Indigenous knowledge systems have strengths and weaknesses. Moreover, they do not exist in exclusive opposition to one another – to wit, none of these systems exist in a vacuum and all are influenced by diverse cultures, each with their own intellectual roots (see e.g., Sefa Dei, 2002). Nevertheless, Western-centric knowledge tends to function in a hegemonic and marginalizing manner with regards to other knowledge systems. As Doxtater (2004) explains,

> Western knowledge rests itself on a foundation of *reason* to understand the true nature of the world yet it also privileges itself as the fiduciary of all knowledge with authority to authenticate or invalidate other knowledge (when it gets around to it)…Colonial knowledge communicates particular cultural presuppositions that elevate Western knowledge as real knowledge while ignoring other knowledge. (pg 618-619).

In the context of mental health, this myopic understanding of knowledge relevant to health and well-being results not only in ignorance of Indigenous healing practices, relationality and worldviews, but also results in a projection of Western-centric models of

mind and being onto AI clients. As Gray and Coates (2010) explain, this impacts AI communities and individuals who enter supposedly therapeutic encounters to find that the helping professions may actually make things worse. They write, the "dominant modern foundation, [based on] individual rights, individualism, and materialism, cannot adequately deal with the responsibilities that membership in a particular community and place, [as well as] relationship patterns and/or longstanding cultural traditions require. For Indigenous Peoples – for whom the relationship to community is experienced as part of the fabric of their identity – this denial of history and place has been immensely damaging and disempowering (Gray & Coates, 2010, pg. 15). Writing on the relationship between the rich histories/present realities of Indigenous helping ways and colonization, Lewis Mehl-Madrona (2007) adds to this discussion yet another way in which Indigenous approaches to wellness are transmogrified and marginalized in hegemonic conceptions of mental health/illness. He writes:

> Indigenous healing systems stress susceptibility and resilience, concepts that refer back to disharmony and imbalance….The Elders say 'when you step off the good red road, then comes sickness and disease'…This concept that disease arises from disharmony and imbalance leads us to realize that health and diseases are inseparable from culture, geography, geology, and spirituality…In our healing practices, we begin by acknowledging the spirits of the land…ask[ing] their permission to proceed. We address the mountains and the valleys. These are bona fide entities that must be acknowledged. Their permission is crucial…[but] modern psychiatry and its *Diagnostic and Statistical Manual of Mental Disorders* (DSM) calls this magical thinking, a potential sign of psychosis" (pg. 46-47).

Mehl-Madrona raises two issues here: first that Western mental health approaches notions of health and illness from a different set of relational coordinates than many Indigenous approaches; and second, that Western approaches tend to cannibalize knowledge systems of the "other," spitting out the bones and using them as evidence of the "other's" insanity. As mental health professionals enter the courtrooms in civil commitment and conservatorship hearings, these damaging beliefs and Western-centric, hegemonic conceptualizations of illness are offered as expert testimony, as truths that will largely form the basis for whether individual patients are committed or conserved.

In the context of mental health hearings for AI individuals, mental health practitioners called on to testify as to the sanity of AI clients do so in the colonial context, where they, along with the judges, are often unaware of how their own worldview and the colonizing, hegemonic knowledge systems of Western thought influence their perception of the issues. This also occurs in the context of the colonial legal system, which requires expert testimony and which, as a result of hundreds of years of colonized legal practice, measures that expertise by Western-centric benchmarks of Western-centric knowledge acquisition and professional skill. Mental health law does not recognize Elders, traditional healers, or shamans as experts – it does not preclude them per se but in practical terms, it is the psychiatrist or the licensed mental health social worker who will be called to testify. Training for these professions occurs within a Western-centric frame, making it less likely that they will be able to bring a decolonized approach to the bar.

Beyond the issue of expert clinical witness, colonization and worldview differences may influence outcomes in other ways. For example the lack of understanding of AI cultures and conceptualizations of mental health may lead judges to

misinterpret testimony offered by AI clients or their families. Judges coming from Western traditions may mistake or dismiss non-linear, spiritual or story-based testimonial responses as nonsensical evidence of mental illness. Judges and juries may mistake differences in affect or in the protocols for communication as evidence of dishonesty. For example, take individuals who come from traditions where listening is highly valued and proper communication requires both deep listening and reflection before responding – a commonly held cultural value for many Indigenous communities (see e.g., Macias, 1989). While individual styles will vary significantly, individuals coming from listening-oriented cultures may take longer to respond to questions or be silent for a brief period before answering as they fully listen to the question, pause to reflect and then purposively answer (see e.g. Meister & Burnett, 2004). Listening respectfully and pausing to think about the response before answering may be misinterpreted by non-Indigenous judges and juries as signs of deceit or otherwise undermine credibility (Meister & Burnett, 2004).

Differences in mental health conceptualization may also impact the delivery and evaluation of testimony by AI family members. Under the grave disability standard, the state/county must show that the individual cannot maintain safely in the community. Individuals may opt to have family or other potential caregivers testify at the hearing that he/she is willing and able to keep the individual safe at home, making psychiatric commitment unnecessary. In assessing the family/caretaker's ability to keep the patient safe, attorneys will generally ask the family member or caregiver a series of questions including what he/she knows about the patient's psychiatric diagnosis, whether he/she believes the patient really does have that mental illness, whether he/she supports the use

of psychotropic medications and whether and how he/she will ensure the patient takes the medications as prescribed. How they answer these questions can make the difference between a finding that the patient would be safe in the community or not, between release or commitment. And of course all of these questions implicate enculturated notions of health, illness, etiology and treatment.

Family members/caregivers who do not believe in Western-centric diagnosis and treatment regimens face a difficult dilemma: you can lie and say you believe the psychiatrist's account of your loved one's state of mind in order to convince the court to let him/her go despite the fact that this requires you to participate in the marginalization of your people, your beliefs, your community's long-held knowledge; or you can say you do not believe the mental illness diagnosis or in pharmaceuticals and try explaining to a room full of lawyers, who as a general matter tend to always think they are right and have no understanding of Indigenous worldviews, how you conceptualize what is going on with your loved one, in which case you take the very poor odds that they will not understand and that they will, as a result of *your* testimony, commit your loved one to a locked facility. Either way, colonization wins.

One last note on the hearing process is in order here with regards to the *experience* of AI clients in the courtroom. Across the board, defense attorneys may spend little time with clients prior to the hearing (Winnick, 2005). Many clients, whether Indigenous or not, report feeling that the procedural protections and hearing process were largely hollow dramaturgies, "empty rituals" that left clients feeling betrayed and distrustful of professionals who were supposedly there to help them (Winick, 2005, pg. 146). For AI clients, these feelings may be amplified by long histories of abuse and

betrayal by public officials, by alienation from a legal process which excludes Indigenous approaches to law and understandings of who in the community would actually be qualified to speak to the person's well-being, and by the practical implications of cultural knowledge gaps that may exist, large or small, between the attorney and the AI client. Colonization is not merely a theoretical construct – it is lived and resisted on a daily basis. So too, in the hearing process where AI clients find themselves caught in the odd coupling of colonization and stories of madness.

Legal Standards and Legal Neutrality: Implications for Colonization

We now turn to a larger issue, present both in the procedural silences in notice and expert testimony requirements detailed above as well as in the legal standards governing judicial determinations regarding mental illness and confinement: namely, the issue of supposed legal neutrality in the law. If we look to the plain language of the commitment/conservatorship statutes, the law appears to be facially neutral in that it does not single out any protected class or group for special treatment under the law. For example, in the case of LPS civil commitments, the law states that a person may be certified for treatment in a locked mental health facility if the person is an imminent and substantial danger to him/herself or others or if the person is gravely disabled such that, as a result of a mental disorder, the person is unable to provide for his or her basic personal needs for food, clothing, or shelter and cannot survive safely in the community even with the help of friends or family willing and able to provide for the individual (W.I.C. §§ 5008h1; 5250d1). "Grave disability" is also the standard in LPS conservatorship cases (see W.I.C. § 5350). Similarly, with other types of mental health-related hearings such as hearings contesting non-consensual administration of

psychotropic medications or temporary conservatorships, the legal language does not identify any protected or special groups within the language of the statute - there is no mention of any race, class, gender, disability, sexual orientation, age, or other axes of oppression or privilege. Nor does the statutory language reference tribes, tribal sovereignty or any special considerations for AI tribal members in the mental health system.

In legal parlance, this lack of any specific identifiers in the plain language of the text renders the statute facially neutral. Neutrality is an important concept in American jurisprudence, particularly in light of our long history of discriminatory laws in voting, housing, education and other critical areas. Laws which are not facially neutral as to groups in protected classes – such as groups based on race, sex, alienage, religion, national origin - face heightened levels of scrutiny in order to pass constitutional muster (either intermediate scrutiny for classifications such as gender or strict scrutiny for categories such as race, which qualify under the law as a "suspect class" based on a number of factors).[60] If the law fails to meet the heightened scrutiny requirements, the law will be struck down on the basis that it violates the equal protection clause. Heightened/strict scrutiny is an extremely difficult test to pass and most laws singling out particular groups are found unconstitutional. In recent years, non-neutral laws passed

[60] For **intermediate scrutiny**, the government must show that the different treatment of the class is substantially related to important governmental objectives and is substantially related to the achievement of those objectives. *Mississippi University for Women v. Hogan*, 458 U.S. 718 (1982). To meet the **strict scrutiny** test, the government must show a compelling governmental interest independent of discrimination; the law must be narrowly tailored to achieve those ends and must be the least restrictive means for achieving those compelling interests. See e.g., *Adarand Constructors v. Peña*, 515 U.S. 200 (1995). A classification is generally considered a "**suspect class**" (and therefore will be reviewed under strict scrutiny) if there is a definable group (definable based on immutable, obvious characteristics) with a history of discrimination and political powerlessness and the defining characteristic of the group does not impact the group's ability to contribute to society (*Adarand Constructors v. Peña*, 1995). Race, sex, alienage, religion, and national origin are all considered suspect classifications.

under affirmative action policies to advance particular groups such as racial minorities or women have fallen prey to strict scrutiny reviews despite the fact that the original context for heightened review was to ameliorate discrimination. Writing on the development of equal protection laws, Williams (2012) explains:

> It has long been clear, of course, that any government law or action that discriminates against certain classes of people (e.g., racial minorities) is subject to the strictest judicial scrutiny. In judicial shorthand, such discrimination is valid only if it is very narrowly tailored to fulfill a compelling government interest. But a series of decisions by the Rehnquist Court are important for applying the same exacting standards to the flip side of the discrimination coin. Thus, the Court has frequently invalidated even so-called affirmative discrimination — laws and other actions intended to benefit the victims of past discrimination — where the government has not been able to show both narrow tailoring and a compelling interest (pg. 1).

For AI/AN populations and Native Hawaiians, non-neutral laws protecting Indigenous peoples have, in the past, avoided strict scrutiny review and survived constitutional challenges by positioning the group-specific benefit in the law as a permissible *political* classification rather than a racial one, asserting that the nature of the special group status is based on the unique political relationships of sovereign peoples to the U.S. government. Explaining this political classification, Wilkins (2007) writes, Indian peoples are Nations, not minorities. The argument for classifying non-neutral laws with "Indian preferences and benefits" as based on political status, rather than on legally impermissible race-based categories, is well grounded in the law: from the earliest

dealings between tribes and the federal government, the political nature of identity has been paramount in legal drafting of treaties and Supreme Court case decisions, both of which consistently recognize Indigenous peoples and their governments as inherently sovereign and therefore as political entities. That these groups happen to also be racialized under the peculiarities of American race politics and racial projects[61] does not abrogate political identity or the reality that AI/AN and Native Hawaiian identity is a *legal reality based in sovereignty*, not simply a political movement of a racialized people. However, these non-neutral, politically explicit policies affording protections for AI/AN and Native Hawaiians have increasingly come under attack as unconstitutional, particularly for Native Hawaiians. In a series of cases, the Court has claimed that in the case of politically oriented policies for Indigenous peoples, "ancestry can be a proxy" for unconstitutional racial discrimination (against non-Indigenous peoples) requiring strict scrutiny review, where the laws are frequently struck down (*Rice v. Cayetano*, 2000; for additional discussion, see *John Doe v. Kamehameha Schools/Bishop Estate*, 2003, 2005, & 2006). These decisions against Indigenous peoples mirror larger trends in American jurisprudence eschewing the recognition or protection of groups with histories (past and present) of endemic discrimination, as described by Williams (2012) above.

Looking outside of the realm of federal Indian laws designed specifically to address AI/AN needs, we find that laws of general applicability, including mental health laws, often do not reference tribes or tribal sovereign at all - a clearly political decision. Whether the law is struck down by re-positioning AI political identity as an impermissible racial classification, or whether it is a failure to recognize tribal sovereign

[61] For more on racial projects and race formation in the U.S., see Omi and Winant (1994).

within the frame of general applicability laws, facially neutral language is now the in-thing. From a pragmatic perspective, the use of facially neutral legal language in these situations, which are inherently political and in fact non-neutral, serves several functions: first it normalizes the absence of Indigenous jurisprudence in American law, solidifying historical amnesia into political reality and creating yet another institutional methodology for marginalizing Indigenous worldviews. Second, the "color-blind" and in the case of Indigenous peoples, the "politically blind" approach to law-making inherent to "facially neutral" laws allows power-brokers to champion the discourse of equal protection and non-discrimination even as their "blindness" results in a failure to account for pre-existing structural inequities and individual bias impacting decision-making which, notably, consistently result in disproportionately poor outcomes for minoritized populations consistent with discriminatory practices (see e.g., Freeman, 1995). There is an implicit assumption in this preference for color-blindness that equal treatment under the law is synonymous with equality or equitable outcomes, which we know is not the case. Third, in the specific case of AI peoples and nations, the use of "facially neutral" legal language in a politically non-neutral situation, fortifies the hegemonic nature of U.S. law as the only legitimate legal frame. In so doing, sovereignty becomes sublimated, transformed from a powerful, embodied form, one that is inherent to the land and peoples who first served as its stewards, to a sovereignty that is, in the dominant imagination, a mere legal term of art or simply erased from memory all together.

This is a legal system which often asserts its own neutrality, as if choosing not to mention race or political status is really neutral, and when it does mention these things, earns accolades for being pro-Indian self-determination, in large measure because it

simply no longer calls for the outright termination of AI/AN nations. Williams (1986) explains the dangers inherent in a legal system, rooted in hegemonic power structures, which assumes its own neutrality, writing:

> Particularly with respect to colonized people, the conqueror's law and legal doctrine permit him [*sic*] to peacefully and in good conscience pursue the same goals that he formerly accomplished by the sword with imperialistic fury…The conqueror's law quite often achieves a highly efficient, hegemonic function. The territorial, social, economic, ideological and other forms of colonization facilitated by that law come to appear as inevitable historical necessities, rather than deliberate acts of genocide, to the subjugated peoples (Williams, 1986, p. 225).

The conqueror's law remains ever present in the context of mental health law. While mental health professionals are trained to adapt Western-centric care to include more "culturally appropriate care" for Indigenous clients, a questionable approach in and of itself as complex Indigenous knowledge systems and cultures are reduced to mere additive ingredients in a half-baked Western-epistemological pie, mental health law and legal training programs have not taken pro-active steps towards decolonizing the legal frame itself. In fact, *mental health law* has what one might diagnose as a pathological lack of focus on colonization with regards to sovereignty, assimilationism, imperialism and liminality, as well as a failure to recognize or remedy the exclusions of Indigenous epistemologies and stories as evidence/theory in both law and policy. As Williams (1986) points out, these silences function to obfuscate the colonial nature of U.S. law and push the realities of genocidal pasts and marginalizing presents to the edge of memory, at

least for those privileged under the dominant jurisprudential discourse.

The failure to account for these issues in the law and policy of mental health obfuscates or erases a number of complex issues. If sovereignty and colonization are non-issues in the law of civil commitment, then the links between civil commitment of AI peoples and assimilationist or genocidal policies – both past and present incarnations - are made largely invisible, felt deeply by the people subject to the trials and treatment regimens foreign to their worldviews, but remaining completely irrelevant to the non-Indigenous attorneys, judges, policymakers, and service providers who serve in the name of "helping" others. When mental health law fails to even be in conversation with Indigenous philosophies of law and health, it will not have AI sovereignty and self-determination on the radar. It will not recognize the import of colonization and its relationship to the law, nor the mythology of Western-legal neutrality. Moreover, this lack of legal recognition of tribes in the law creates a disjuncture between (re)emerging AI traditional healing approaches in mental health, where identity is complex and colonization is central, and the evolution of civil commitment law and treatment approaches where colonization is treated, if at all, as historical anathema long since resolved and better off forgotten.

The story of mental health law is also more complex than this might suggest, representing a tug of war between these destructive policies and a federal trust obligation to provide more, to do more for the health and wellbeing of Indian tribes. This is often interpreted simply as a call for more care, more access, without much consideration of what it really means to support health in the context of Tribal autonomy, sovereignty, self-determination, and the vast array of Indigenous epistemological approaches to health

and wellbeing. While the recent authorization of the Indian Health Care Improvement Act[62] arguably represents steps in a positive direction in terms of supporting tribal self-determination and sovereignty, fundamental questions remain over how to develop (and who is developing) health and mental health policy that meets the practical needs of AI peoples, as defined by AI peoples, in line with federal trust obligations, without further legitimating the colonizing proclivities of a law and policy system which fundamentally conceptualizes self-determination and sovereignty within the confines of U.S. law and the legacy of the "domestic dependent nation" doctrine. In many ways, involuntary psychiatric commitment law mirrors Western-centric legal constructions of tribal relationships to the federal government, defined as ward and guardian. As long as legal options for care reflect this unjust hierarchy and remain locked in a binary battle between *services shrouded in Western-centric notions of neutral law and Western-centric healing or program design/evaluation* on the one hand or *sovereignty and self-determination without federal funding and services* on the other, mental health law remains a tool of colonization.

After the Hearing: Colonization & Confinement

At the conclusion of a mental health psychiatric commitment or conservatorship hearing, one of two outcomes is possible: the client wins and is released or the court enters a judgment in favor of the state/county authorizing the mental-health based civil commitment or conservatorship, and the client may be detained for evaluation and treatment in a locked facility. At this stage in the evolution of a mental health case, issues of colonization are present in the context of confinement and treatment. Writing on the

[62] 25 U.S.C. §§ 1601-1680o (2010).

connections between Western-based notions of mental health treatment and the experience of colonization for AI individuals, Gone (2008) writes:

> At the outset of the 21st century, indigenous communities in North America continue to pursue autonomy and self-determination in the aftermath of centuries of European colonization. The sweeping transformations of Native [lives] and livelihood[s] that resulted from European invasion of the "New World" have included rampant disease, dislocation, demoralization, and disintegration for indigenous communities, even as many…First Peoples have met these challenges with creativity, fortitude, resilience and humor. Nevertheless, alarming numbers of Native Americans still contend with the social and psychological sequelae of marginality, poverty, tragedy, and discrimination…Arising from this historical conjuncture is a cottage industry devoted to the surveillance and management of the "mental health" problems of North America's indigenous peoples…In the arena of mental health…it may be that the missionary, military, and anthropological vanguard of the "White-Indian" encounter has been displaced of late by the professional psychotherapists or credentialed counselors of the "behavioral health" clinics who, armed with their therapeutic discourse and their professional legitimacy, are using [something more] surreptitious than bullets to resolve the age old "Indian problem"…In other words…Native American[s]…recognize clinical intervention as a form of cultural prescription that harbors the ideological danger of an implicit Western cultural proselytization (Gone, 2008, p. 310-312).

Powerfully highlighting the relationship between mental health treatment and colonization, Gone writes from the perspective of *less* restrictive forms of community based or clinic-based treatment than those considered here. In the context of involuntary psychiatric commitments, treatment modalities are literally cut off from community and traditional approaches to healing. Treatment in locked psychiatric facilities is largely founded on Euro-centric worldviews of assessment, diagnosis, and relationships, as well as linear, compartmentalized, and individualistic notions of being, the etiology of illness, and the relevance of historical trauma. This is not to say that Western or Euro-centric treatment modalities have nothing to offer individuals from non-dominant cultures or AI individuals in particular. However, it is common practice to engage in approaches to treatment holding the Euro-centric frame as the reference point against which all other approaches are tested. This is a highly problematic paradigm as practitioners believe they are serving clients through culturally appropriate care but in reality, they may simply be giving a multi-cultural nod within a hegemonic Western-based frame which marginalizes Indigenous worldviews and, when it fails to help AI clients, tends to pathologize the individual rather than question the validity of the frame itself. Put more simply, culturally appropriate care and treatment is a complicated matter implicating colonization even as it tries to be progressive and accommodating – after all, accommodation of intellectual and ontological traditions is not the same thing as meeting as equals. It is to the difficulties inherent to the "culturally appropriate care" approach in mental health treatment that we now turn.

Problematizing the notion of 'culturally competent care'

California law requires that mental health providers (receiving state or federal

funding) shall provide for "culturally competent and age-appropriate services, to the extent feasible" in locked inpatient settings and in community based care (W.I.C. §14684(h)). Mental health providers contracting with the California Department of Mental Health (DHS) must submit a cultural competence plan to DHS for review and, to ensure delivery of culturally appropriate care in the client's language, service providers must provide oral interpreter services "to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact" (CCR 9 §§ 1810.410, 1810.410(2)).[63] The right to culturally competent services is defined under the California Code of Regulations, Title 9, Section 810.211 (CCR 9 § 810.211), as follows: "*Cultural Competence* means a set of congruent practice skills, behaviors, attitudes and policies in a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross cultural situations."

There are several important things to note here the first of which is to acknowledge that the legal requirement to provide appropriate services across cultural contexts is in many ways an improvement from previous mental health laws which either failed to recognize that culture was in any way important or sought, through coercive

[63] The cultural competence plan must include:
1. Objectives and strategies for improving the Mental Health Provider's (MHP) cultural competence;
2. A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability;
3. A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services;
4. A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries (CCR 9 §§ 1810.410 et seq.).

measures, to destroy cultural difference in the name of assimilation. The reduction in active attempts to colonize the minds of AI individuals is important and should be legitimately recognized as change. However, the requirement for culturally appropriate care is not without its problems. As is the case with many types of progressive legislation, such as that found in civil rights law or school desegregation, prohibiting legal forms of facially discriminatory behavior does not mean an end to discriminatory practices in the real world. No longer sanctioned by the law, discriminatory behaviors may may become less obviously violent but they may also become more pernicious for having transformed from something explicit, easy to spot and easy to name, to something less tangible, taken out of the law and infused into micro-aggressions at both the inter-personal and structural level, woven into images, rhetoric, and distortions of "otherness" subsequently internalized to the detriment of both individual and community. Moreover, because discrimination becomes encoded into the history of economies, institutions, and structures of social life, the choice-sets individuals and communities have in exercising individual responsibility, autonomy and life choices become fundamentally limited by the present day realities of past and present discrimination. Thus, oppressive practices continue, often in ways that are hard to identify, and yet those in power can claim that the problem has been resolved because the law now bans explicit acts of discrimination.

This dynamic is also evident in mental health law where codifying the right to culturally appropriate care is at once both a positive change away from explicit attempts to colonize or assimilate non-white clients and also a problematic concept in that it lulls service providers into a false sense that colonization is not happening because providers are legally obliged to provide culturally competent services. The inclusion of cultural

competence in the law and practice of mental health suggests that culturally competent care is itself *the* solution to colonization or other forms of cultural oppression and intervention ineffectiveness when in fact cultural competency rarely includes consideration of structural, historical and present day forms of colonization.

Moreover, one has to ask what it really means to provide 'culturally competent care' when the state locks an AI individual into a psychiatric facility which, by its very nature and the nature of the legal process which put the person there, is not culturally consonant with most if not all Indigenous approaches to well-being? The concept of culturally competent care can also be problematized in a number of other ways. Writing on the difficulties of culturally appropriate care in mental health for AI clients, Gone (2006) writes:

> Conventional approaches to cultural competency in mental health service delivery have been both limited and limiting. The typical means to cultural sensitivity in clinical contexts have included (a) cursory familiarity with respective ethnic group characterizations (usually dependent on the abstract description of ethnic prototypes or cultural generalities), (b) offhand generalizations from firsthand professional experience with clients of color, (c) reflexive awareness by majority-culture clinicians regarding the assumptions and privileges inherent to socialization into the dominant culture vis-à-vis the cultural experiences of people of color, and (d) obliged inclusion of people of color in clinically relevant research protocols (often using self-identified race or ethnicity as proxies for presumed cultural participation). In fact, none of these methods adequately prepares the mental health professional or practitioner to flexibly and dynamically

> engage any particular American Indian client who may bring a host of distinctive cultural practices- thereby constituting and embodying cultural identity- into the therapeutic or consultative relationship (pg. 72).

In addition to the lack of deep training to enable meaningful attempts at culturally competent care, the concept itself is problematic in that it does not question the larger frame of mental health in terms of its Western epistemological and ontological roots. Along this vein, Duran and Duran (1995) write that:

> The past five hundred years have been devastating to [Indigenous] communities…The effects of genocide are quickly personalized and pathologized by [mental health professionals] via the diagnosing and labeling tools designed for this purpose. If the labeling and diagnosing process is to have any historical truth, it should incorporate a…diagnosis [of] acute and/or chronic reaction to colonialism…[However, mental health] as discipline prefers to think that psychological thought exists in an a-contextual form, emerging as the immaculate conception of the past century. In reality, psychology as an offshoot of medicine has been gestating since the Middle Ages and continues to be implicated in an ongoing system of social control as it was during the heyday of the papacy. These notions are sure to disrupt the linear thinking of most of our objective scientific brothers and sisters…A…diagnosis for such objective [providers and researchers] would perhaps be, ‘ chronic and/or acute Cartesian anxiety disorder (Duran & Duran, 1995, pg. 6-7).

As Duran and Duran explain, mental health practice reflects particular epistemological traditions and in the context of Western social work, these traditions

have often proved to operate in an exclusive, hegemonic fashion, centering Western worldviews as the orienting gold standard of care. Additionally, in the context of culturally appropriate care and cross-cultural mental health treatment, "*cross-cultural* implies that there is a relative platform from which all observations are to be made, and the platform which remains in place in our neocolonial discipline is that of Western subjectivity" (Duran & Duran, 1995, pg. 8). The idea that mental health professionals can meet the needs of AI peoples by simply including cultural concepts into the frame of Western-centric mental health has proven to be largely ineffective and functionally perpetuates colonization both in that it maintains Western-centric worldviews as the anchoring tenet of good care and by requiring Indigenous peoples to fit into that frame in order to receive assistance.

Moreover, an approach based solely on culturally competent care and codified as a base legal right in the law without reference to tribes, sovereignty or Indigenous presence functionally absents political aspects of identity from appropriate care frameworks. For those unfamiliar with AI politics, the absence of the political in mental health law and specifically in treatment rights validates colonial legal/policy structures without even *suggesting* that professionals might question the ways in which these frameworks exclude and marginalize Indigenous epistemological and ontological approaches to health and justice (see Gray, Yellow Bird, & Coates, 2010; see also Youngblood Henderson & McCaslin, 2005). When mental health and legal practitioners fail to see the law and treatment philosophies as enculturated and historically rooted entities with logic that is not naturally ordained but constructed - and done so with the tools of Western/Euro-centric political and scientific thought - when practitioners

evidence this historical amnesia as to the source and nature of law and treatment ideologies, they become active, if unwitting, participants in colonization.

Women and children: Mental health and TribalCrit

The historical relationship between mental health treatment and women as a gendered subclass is long and generally disturbing, grounded in misogynistic renderings of the female psyche and treatments ranging from the truly bizarre to the outright torturous (see e.g., Moussaieff-Mason, 1998). This unfortunately is also the case for Native women, although their story is further complicated by the politics of race, the realities of a genocidal colonization, the internalization of patriarchical norms resulting in violence and a well-warranted distrust of mental health/social service practitioners (see e.g., Witko, 2006). In the context of involuntary psychiatric commitments, Native women have faced harms uniquely based on their status – not just as Indigenous peoples and not just as women, but as *Indigenous women*.

The Canton Asylum for Insane Indians (1899-1943) provides a plethora of examples here. There was Edith Schroder (Chippewa) who was declared feebleminded and detained for roughly ten years on the basis that her near annual birthing of children made her a menace and nuisance to society for her "lack of self-control" (Leahy, 2009). There was the case of a young woman named Wah-Bish-Ay-She-Quay (Chippewa) who was involuntarily committed for more than 20 years on the basis of a "lack of sexual restraint" evidencing, they said, congenital imbecility requiring her hospitalization until she was properly assimilated into proper female behavior; and the case of Nellie Kampeska, age 17 at admission, committed for being a "psychopathic nymphomaniac" who was subsequently sexually assaulted on numerous occasions by the asylum's

engineer (Leahy, 2009). There were also the numerous women committed to Canton while pregnant or who became pregnant during their "treatment" whose children, born inside the facility, were considered de facto "defective" by virtue of their mothers' status as committed individuals, with many of those children either dying from tuberculosis contracted at Canton or who were kept as science projects by the facility director, who wished to see if alleged psychosis was in fact hereditary (Leahy, 2009). It was also not uncommon during this period for reservation agents to declare problematic women insane, sending them to Canton and declaring that their children had been abandoned, facilitating their adoption usually out to White families (Leahy, 2009). Committed during the eras of removal and assimilation, the misogynistic "diagnosis" of these Native women as part of a larger effort to silence dissenters and remove AI peoples from the land evidences a clear link between gender, patriarchy and colonization. While many women, Indigenous and otherwise, have been committed in the past on false claims of sexual deviance, promiscuity, or hysteria, for AI women, the overtone of eugenics as a tool of colonization and coercive assimilative policy aims is pronounced.

Moving ahead in time to modern practice, AI women continue to face unique circumstances implicating their intersectional identities as Indigenous women. For example, take the case of AI women who are involuntarily committed on a long-term basis, usually under conservatorship, who enter the facility pregnant or who become pregnant during confinement (either as a result of abusive practices by facility staff or through consensual relationships with other patients). For pregnant patients involuntarily committed, should they give birth while in the locked facility, they are automatically deemed unfit to care for the infant by reason of them being deemed unable to care for

themselves and child protective services will remove the child, placing him/her with family, with non-related extended family members (NFRMS) or into foster homes.

For AI women, children removed while they are subject to conservatorship or commitment are covered by the Indian Child Welfare Act (ICWA), which does provide extra protections in terms of requiring placement attempts within the AI community. However, such placements are often not available, particularly for urban AI women who may be far from any tribe, let alone their own or for reservation based women, where placements may not be available due to a lack of resources to do home assessments or simply no family or relatives able to take the child in. AI children continue to have disproportionately high representation in the dependency/foster care system, with many children unable to stay in Indian homes (Pevar, 2012). As is well documented, the placement of AI children into non-Indigenous foster care can have extremely detrimental impacts on cultural continuity and of course can be traumatic for the mother and families (see e.g., Pevar, 2012).

This issue of pregnancy, removal and the related implications for tribal cultural continuity is just one example of how AI women face unique experiences as Indigenous women in the context of mental health law and policy. One of the challenges here is to understand that AI women occupy the liminal spaces of identity as racialized, political *and* gendered beings. To date, TribalCrit's focus has been on centering colonization and Indigenous knowledge systems as the primary axes for analysis and has not, in its current form, highlighted women's or more specifically, Native women's, experiences, as distinctly situated at the intersection of colonialism, power and Indigenous identity. AI women scholars using TribalCrit as a theoretical frame to analyze issues specific to AI

women have consistently reached outside of TribalCrit to mainstream feminist theory to capture the gender element (see e.g., Stemmler, 2010). However, mainstream feminism often fails to account for the centrality of issues related to land, sovereignty and colonization for Indigenous women (Guerrero, 1997; Meranto, 2001). Marie Anna Jaimes Guerrero (Juaneño/Yaqui/Opata) (1997) explains the import of framing Indigenous women's experiences within both gender *and* colonization contexts, writing: "Indigenism is thriving as a liberation movement inspired by…Indian cosmologies. It differs markedly from any feminism that limits the scope of [Indigenous women's] experiences and liberation struggles by defining them solely in terms of sexism" (pg. 120). However, she continues that while Indigenous cosmologies and traditional social structures evidence a "long and life-sustaining legacy of respect and empowerment" for Native women with "rich traditions of female power bases," including many matriarchical societies, Indigenous communities struggle with the "trickle down" effects of colonially-linked patriarchy (Jaimes Guerrero, 1997, pg. 102, 115). It should be no surprise that colonization and patriarchy are linked: for example, sexual assault against AI women was an informal strategy used in the conquest of AI lands and the attempted genocide of the people (Smith, 2005). Witko, Martinez, and Milda (2006) write that:

> When Columbus came to the Americas, he brought with him more than diseases; he brought a new way of looking at the world and new way of viewing women. Prior to Columbus, women were valued, respected and honored…With colonization came the breakup of tribal ways, exposure to sexual assault and violence and the beginning of internalized oppression…Women were no longer

safe, not only because they were Native but also because they were women (pg. 103).

Moreover, in addition to the fact that Euro-centric gender relations built on patriarchical foundations permeated every aspect of daily life for anyone living in the United States, and therefore inevitably impacted Indigenous gender relations/norms, federal Indian policy also actively promoted changes in familial structure, land ownership/land transfer, and governance structures which positioned men as the power-brokers (see e.g., Deloria & Lytle, 1983; Pevar, 2012; Suzack, Huhndorf, Perreault, & Barman, 2011). Cole (2006) writes:

> Colonization by a dominant society that was patriarchical and patrilineal and in most cases misogynist created a great amount of damage for American Indian families, especially those from matrilineal tribes. The structures of influence and power in the tribes were not understood and were ignored by the dominant culture. The role of women was not valued, and women were denigrated. There was a reductionism and devaluation in Indian families that was not there prior to colonization (pg. 123-124).

Thus, while every tribe's traditional and current day gender relations will vary, on balance, the struggle for self-determination among AI peoples remains "simultaneously a struggle against patriarchy" *and* colonization (Jaimes Guerrero, 1997, pg. 120). Given the intersectionality of colonialism, power and gender, TribalCrit as a newly articulated and evolving paradigm may benefit from adding to its central tenets a tenet focused on gender explicitly highlighting the experiences of Indigenous women, as Indigenous women, in the context of endemic colonization and to encourage such analysis through the voices of

Indigenous women (see e.g., Leigh, 2009). Developing a gender-based element of TribalCrit has the further benefit of re-centering Indigenous worldviews and traditions regarding male-female relations, allowing for "de-patriarchification" to occur in ways that are contextually appropriate by keeping decolonization as an anchor and by allowing gender relations to normalize according to each tribe's unique traditions vis-à-vis gender relations. This approach may yield unique and important insights not possible if the analysis is framed solely by Western feminism, which excludes the centrality of colonization, sovereignty, self-determination, and Indigenous perspectives on gender relations or, alternatively, if framed by a-gender free version of TribalCrit, which does foster gender based explorations by focusing on non-patriarchical Indigenous ontologies, but does not make such considerations a central part of the analysis regarding (de)colonization.

Moreover, framing patriarchy in Indigenous communities as a legacy of colonization positions addressing gender issues as a positive aspect of decolonization, avoiding the pitfall of simply demonizing Indigenous men, and allows for an approach built on the strengths of reclaiming Indigenous traditions and knowledge rather than focusing on pathology. Adding gender as an additional guiding tenet of TribalCrit also opens new possibilities to discuss decolonization and issues of particular import to communities including domestic violence, sexual assault, child sexual abuse, and the unique experiences of AI women in a variety of social systems, including mental health – all issues that are often not discussed due to the very power imbalances that caused them. Such issues are also silenced due to a more generalized fear that discussing gender-based violence is a betrayal to tribal unity, opening tribal communities up to intrusive,

judgmental, and often uninformed scrutiny by outsiders or otherwise diverting attention from unified calls for sovereignty and self-determination (see e.g., Clark, 2006; Deer, Clairmont, Martell & White Eagle, 2007; Jaimes Guerrero, 1997). TribalCrit certainly is not the only avenue for opening these discussions – to wit, AI women have a long and vocal history of advocacy and activism within communities (see e.g., Applegate-Krause & Howard, 2009; Mann, 2008; Suzack, Huhndorf, Perreault, & Barman, 2011). However, because TribalCrit creates a unique theoretical guide post for conceptualizing law and policy issues of particular import to Indigenous communities and because the experiences of AI women, as AI women, are often unique, adding intersectional notions of gender explicitly into the primary tenets of the theory may prove a useful endeavor. It may also provide unique insights into the ways in which colonization uniquely impacts AI women in mental health law and policy.

Conclusion

Writing on the relationship between law, colonization and the state, scholar/activists James Sa'Ke'j Youngblood Henderson and Wanda McCaslin (2005) write that the justice and therapeutic systems often refuse "to treat [Indigenous peoples] as fully human…[choosing] instead to dehumanize [Indigenous peoples] as deviant organisms or sick minds that need rehabilitation" (p. 4). Implicit in this statement is the idea that justice, health and "treatment" are all intimately connected to issues of dehumanization, marginalization and colonization. Similarly, the law of involuntary psychiatric commitments necessarily implicates issues of state power, rights frameworks, and culturally embedded notions of illness, treatment, and social control. For American Indians, however, these issues become intricately nuanced as they intersect with notions of sovereignty, federal trust obligations and colonizing tendencies within both legal and treatment frameworks. From criminalizing traditional medicine practices to the use of psychiatric facilities as a political weapon to silence those who would oppose policies of cultural genocide, the federal government's use of mental health services and the professionals who fill its ranks goes far beyond political agendas grounded in proselytizing, grossly violating human rights norms and masking destructive policies in the warm robes of the helping professions. Beyond these explicit uses of mental health law and practice as tools of colonization, we find that the law itself purports neutrality while in fact making political and enculturated choices about justice, sovereignty and definitions of madness. From legal encroachment onto tribal lands through PL 280 and the hegemonic exclusion of Indigenous jurisprudence, to Western-centric conceptualizations of expert witness testimony and the definitions of mental illness,

mental health law is intimately intertwined with colonization. While efforts are underway to improve the law and policy of mental health service provision through culturally competent care and increased tribal control over services, the system continues to hold Western-centric notions of care, culture, jurisprudence and evidenced based practice – all embedded within and evolving out of the colonial context - as the exclusive mainframe for conceptualizing mental health law and policy and marginalizing the wealth of Indigenous knowledges related to well-being, social change and justice. These are not simply theoretical gripes – they are realities with deep and significant consequences for AI individuals and for tribal communities, both as communities and as sovereign nations. Despite the import of psychiatric civil commitment law on the lives of these individuals, their families, and their Nations, little research has focused on the ways in which mental health-based civil commitment/conservatorship law and policy implicate issues of colonization. This project has sought to begin laying a foundation for understanding the nuanced ways in which colonization is endemic to the law and policy of mental health for American Indian peoples and tribal Nations in the hope that solutions may emerge and that change is really possible.

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APPENDIX A

PUBLIC RECORDS ACT DOCUMENT REQUESTS A-C:

DATA COLLECTED AUGUST-DECEMBER 2012

A. Sample Public Records Act Request to Mental Health Departments & County

Counsel, Los Angeles and Humboldt Counties:

Date
Name and Title of the official with custody of the records
Name of Agency
Address
RE: Public Records Act Request

Dear _____,

Pursuant to my rights under the California Public Records Act (Government Code Section 6250 et seq.), I ask to obtain a copy of the following records and/or statistical information, which I understand to be held by your agency, including any and all records dating from January, 2005 to the present including:

1. Documents or statistical data listing the numbers of Native American/American Indian/Alaskan Native (hereinafter "AI/AN") identified adults subject to involuntary psychiatric holds by the County (under California Welfare & Institutions Code section 5000, et seq./Lanterman-Petris-Short Act), listed by year from Jan. 2005 to the present, including gender of clients if known;

2. Documents or statistical data listing the numbers of AI/AN identified adults held on voluntary psychiatric holds in the County (per W.I.C. § 5000 et seq./LPS), listed by year from Jan. 2005 to the present, including gender of clients if known;

3. Documents or statistical data listing the numbers AI/AN identified children under 18 subject to involuntary psychiatric holds by the County, listed by year from Jan. 2005 to the present, including gender of clients if known;

4. Any agreements, MOU/MOA's with Tribes or policy papers regarding processes for involuntary psychiatric commitment of AI/AN Tribal members in the County, including any such documents specific to Indian reservation residents, off-reservation/urban Tribal members, or for Tribal members generally;

5. Any agreements, MOU/MOA's with Tribes, or policy papers regarding culturally specific treatment options for AI/AN individuals in County run or County contracted psychiatric facilities;

6. Any contracts between the County and Tribally affiliated behavioral health providers or Tribes to provide culturally specific treatment services for AI/AN individuals under psychiatric commitment or conservatorship in the County;

7. Any policies or regulations regarding access to AI/AN specific treatment modalities and/or traditional healers for AI/AN mental health clients under the County's care.

I ask for a determination on this request within 10 days of your receipt of it. If you determine that some but not all of the information is exempt from disclosure and that you intend to withhold it, I ask that you redact it and make the rest available as requested. Please provide a signed notification citing the legal authorities on which you rely if you determine that any or all of the information is exempt and will not be disclosed. If no documents or statistical data exist for the specific request, please note as such in your reply. If another department may have one or more of the documents, I ask that you please forward the request to that department, indicating in your reply which particular request was forwarded and the contact information for the new department.

If I can provide any clarification that will help expedite your attention to my request, please contact me by phone or e-mail (listed below). I ask that you notify me of any duplication costs exceeding $25 before you duplicate the records so that I may decide which records I want copied. Alternatively, where possible, documents may be sent via e-mail to hgough@asu.edu

I am also sending a copy of this letter to your counsel at the County Counsel's Office to help encourage a speedy determination, and I would likewise be happy to discuss my request with counsel at any time. Thank you for your time and attention to this matter.

Sincerely,

Heather Gough, JD/MSW
Ph.D. Candidate, Justice Studies
Arizona State University

Contact Information
Heather Gough
(Address)
(Address)
(E-mail)
(Phone)

CC: County Counsel's Office

B. Sample Public Records Act Request to Public Guardian's Office & County Counsel, Los Angeles and Humboldt Counties:

Date
Name and Title of the official with custody of the records
Name of Agency
Address
RE: Public Records Act Request

Dear _____,

Pursuant to my rights under the California Public Records Act (Government Code Section 6250 et seq.), I ask to obtain a copy of the following records and/or statistical information, which I understand to be held by your agency, including any and all records dating from January, 2005 to the present including:

1. Documents or statistical data listing the numbers Native American/American Indian/Alaskan Native (hereinafter "AI/AN") identified adults subject to mental health-based (LPS) *temporary* conservatorships by the County pursuant to California Welfare & Institutions Code section 5000 et seq./Lanterman Petris-Short Act, listed by year from Jan. 2005 to the present, including gender of clients if known;

2. Documents or statistical data listing the numbers AI/AN identified adults subject to mental health-based (LPS) conservatorships by the County, listed by year from Jan. 2005 to the present, including gender of clients if known;

3. Any agreements, MOU/MOA's with Tribes and/or policies regarding legal processes for mental health based civil commitment of Tribal members in the County, including any such documents specific to Indian reservation residents, off-reservation/urban Tribal members, or for Tribal members generally;

4. Any agreements, MOU/MOA's with Tribes, and/or policies specific to the provision of culturally specific treatment options for AI/AN individuals under conservatorship by the County;

5. Any contracts between the County and Tribally affiliated behavioral health providers or Tribes to provide culturally specific treatment services for AI/AN individuals under conservatorship by the County;

6. Any policies or regulations regarding access to AI/AN specific treatment modalities and/or traditional healers for AI/AN individuals under conservatorship by the County.

I ask for a determination on this request within 10 days of your receipt of it. If you determine that some but not all of the information is exempt from disclosure and that you intend to withhold it, I ask that you redact it and make the rest available as requested. Please provide a signed notification citing the legal authorities on which you rely if you determine that any or all of the information is exempt and will not be disclosed. If no documents or statistical data exist for the specific request, please note as such in your reply. If another department may have one or more of the documents, I ask that you please forward the request to that department, indicating in your reply which particular request was forwarded and the contact information for the new department.

If I can provide any clarification that will help expedite your attention to my request, please contact me by phone or e-mail (listed below). I ask that you notify me of any duplication costs exceeding $25 before you duplicate the records so that I may decide which records I want copied. Alternatively, where possible, documents may be sent via e-mail to hgough@asu.edu

I am also sending a copy of this letter to your counsel at the County Counsel's Office to help encourage a speedy determination, and I would likewise be happy to discuss my request with counsel at any time. Thank you for your time and attention to this matter.

Sincerely,

Heather Gough, JD/MSW
Ph.D. Candidate, Justice Studies
Arizona State University

Contact Information
Heather Gough
(Address)
(Address)
(E-mail)
(Phone)

CC: County Counsel's Office

C. Sample Public Records Act Request to Juvenile Divisions & County Counsel, Los Angeles and Humboldt Counties:

Date
Name and Title of the official with custody of the records
Name of Agency
Address
RE: Public Records Act Request

Dear _____,

Pursuant to my rights under the California Public Records Act (Government Code Section 6250 et seq.), I ask to obtain a copy of the following records and/or statistical information, which I understand to be held by your agency, including any and all records dating from January, 2005 to the present including:

1. Documents or statistical data listing the numbers of Native American/American Indian/Alaskan Native (hereinafter "AI/AN") identified children under 18 subject to involuntary psychiatric holds by the County, listed by year from Jan. 2005 to the present, including gender of clients if known;

2. Documents or statistical data listing the numbers of AI/AN identified children under 18 held in juvenile detention, delineated by year, from Jan. 2005 to the present, including gender of clients if known;

3. Any contracts between the County and Tribally affiliated behavioral health providers or Tribes to provide culturally specific treatment services for AI/AN identified youth in confinement (including involuntary psychiatric holds and juvenile detention).

I ask for a determination on this request within 10 days of your receipt of it. If you determine that some but not all of the information is exempt from disclosure and that you intend to withhold it, I ask that you redact it and make the rest available as requested. Please provide a signed notification citing the legal authorities on which you rely if you determine that any or all of the information is exempt and will not be disclosed. If no documents or statistical data exist for the specific request, please note as such in your reply. If another department may have one or more of the documents, I ask that you please forward the request to that department, indicating in your reply which particular request was forwarded and the contact information for the new department.

If I can provide any clarification that will help expedite your attention to my request, please contact me by phone or e-mail (listed below). I ask that you notify me of any duplication costs exceeding $25 before you duplicate the records so that I may decide which records I want copied. Alternatively, where possible, documents may be sent via e-mail to hgough@asu.edu

I am also sending a copy of this letter to your counsel at the County Counsel's Office to help encourage a speedy determination, and I would likewise be happy to discuss my request with counsel at any time. Thank you for your time and attention to this matter.

Sincerely,

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(Phone)

CC: County Counsel's Office