

# American Indian Law Review

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Volume 40 | Number 1

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2016

## Federal Statutory Responsibility and the Mental Health Crisis Among American Indians

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### Recommended Citation

Abilene Slaton, *Federal Statutory Responsibility and the Mental Health Crisis Among American Indians*, 40 AM. INDIAN L. REV. 71 (2016),  
<http://digitalcommons.law.ou.edu/ailr/vol40/iss1/3>

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## COMMENTS

### FEDERAL STATUTORY RESPONSIBILITY AND THE MENTAL HEALTH CRISIS AMONG AMERICAN INDIANS

*Abilene Slaton\**

#### *I. Introduction*

Suicides are occurring at an alarming rate among Indian populations. For example, years ago, on a reservation in North Dakota, a young American Indian girl suffered the loss by suicide of both her father and her sister.<sup>1</sup> Soon after, she fell into a severe depression.<sup>2</sup> For the next ninety days she lay in her bed in the fetal position, while no one seemed to worry.<sup>3</sup> Her school did not even call to check on her when she was absent for all that time.<sup>4</sup> After those ninety days passed, she left her bed, and immediately hung herself.<sup>5</sup> This young girl “died of suicide because mental-health treatment [was not] available on that reservation.”<sup>6</sup> Unfortunately, severe mental illness is a daily struggle for many, despite the many statutes in place to protect and serve the American Indian community, and the way the United States deals with mental health care can cause major issues for citizens. Some of these include high cost, inadequate access to care, and the stigma mental illness can carry with it.<sup>7</sup> These issues, and the incidence of

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1. Sari Horwitz, *The Hard Lives — and High Suicide Rate — of Native American Children on Reservations*, WASH. POST (Mar. 9, 2014), [http://www.washingtonpost.com/world/national-security/the-hard-lives--and-high-suicide-rate--of-native-american-children/2014/03/09/6e0ad9b2-9f03-11e3-b8d8-94577ff66b28\\_story.html](http://www.washingtonpost.com/world/national-security/the-hard-lives--and-high-suicide-rate--of-native-american-children/2014/03/09/6e0ad9b2-9f03-11e3-b8d8-94577ff66b28_story.html).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Horwitz, *supra* note 1.

7. OFFICE OF INSPECTOR GEN., DEP’T OF HEALTH & HUMAN SERV., ACCESS TO MENTAL HEALTH SERVICES AT INDIAN HEALTH SERVICE AND TRIBAL FACILITIES 18-19 (No. OEI-09-08-00580, 2011), <http://oig.hhs.gov/oei/reports/oei-09-08-00580.pdf> [hereinafter ACCESS TO MENTAL HEALTH SERVICES]; OFFICE OF THE GEN. COUNSEL, U.S. COMM’N ON CIVIL RIGHTS, NATIVE AMERICAN HEALTH CARE DISPARITIES BRIEFING: EXECUTIVE SUMMARY 9 (2004), <https://www.law.umaryland.edu/marshall/usccr/documents/nativeamericanhealthcaredis.pdf> [hereinafter NATIVE AMERICAN HEALTH CARE DISPARITIES BRIEFING]; Samantha Artiga et al., *Health Coverage and Care for American Indians and Alaska Natives*, HENRY J. KAISER

mental illness generally, are especially prevalent among American Indian communities.<sup>8</sup>

These problems often go unnoticed outside of native communities, perhaps owing to a difference in community and identity. Namely, native communities demonstrate a strong distrust of the federal government; this, unfortunately, somewhat separates non-Indian Americans from the problems occurring on Indian reservations.<sup>9</sup> Native communities are particularly skeptical of the federal government's Indian Health Service (IHS),<sup>10</sup> perhaps because they feel "unheard and trapped in a system of care over which they have no control."<sup>11</sup> This is unacceptable for this population in desperate need of assistance.

Native populations' disproportionately large rates of mental illness compared to other U.S. demographics seem to result from the federal government's disregard of the importance and power of its own statutes, or perhaps the statutes were merely ineffective to begin with. Even worse, both could be occurring in tandem. Attention must be given to this issue, including, among other things, the improvement of access to mental health care among American Indians. This comment argues that the issue cannot be ignored.

Thus, in Part I, this comment will consider the problems mental illness poses for American Indians before demonstrating that the legislature, the courts, and the federal government must take action to minimize the troubling effects posed by native communities' lacking mental health care infrastructure. Part II will discuss the history and background of mental illness in American Indian populations and how it is currently being handled, including an analysis of what government action has been taken and whether it has been successful. Part III explores current laws set in place to address mental health in native populations, how those laws have

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FAMILY FOUND. (Oct. 7, 2013), <http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives/>.

8. Artiga et al., *supra* note 7.

9. Andrew Boxer, *Native Americans and the Federal Government*, HIST. TODAY (Sept. 2009), <http://www.historytoday.com/andrew-boxer/native-americans-and-federal-government> ("In 1831, the Chief Justice of the Supreme Court, John Marshall . . . was, in effect, recognising that America's Indians are unique in that, unlike any other minority, they are both separate nations and part of the United States. This helps to explain why relations between the federal government and the Native Americans have been so troubled.").

10. JAMIE GRANT & TERESA BROWN, NAMI, AMERICAN INDIAN & ALASKA NATIVE RESOURCE MANUAL 15 (June 2003), <http://www.nrc4tribes.org/files/Cultural%20Diversity%20Resource%20Manual.pdf>.

11. *Id.*

been followed, the consequences of current federal governmental action in carrying out the statutes now in place, and the consequences of the statutes themselves. Finally, Part IV will suggest possible approaches for improving mental health care for American Indians and using the current statutes to aid American Indian communities in their mental health needs, along with a proposed revision to the statutory scheme to provide for more effective implementation and enforcement.

## *II. Background: American Indian Mental Health and the Federal Government*

### *A. Mental Illness in American Indian Communities*

#### *1. Mental Illness Prevalence and Severity*

American Indians suffer from most mental disorders in rates similar to the population of the entire United States, despite the fact that recent research indicates that native populations experience much more psychological distress.<sup>12</sup> Furthermore, Indians suffer from certain disorders at a higher rate than the population does generally, for example, American Indian populations have extremely high rates of suicide, unemployment, and poverty.<sup>13</sup> These problems also place native populations at greater risk for certain mental health disorders<sup>14</sup> than the general population.<sup>15</sup> Specifically, American Indians suffer significantly from anxiety, posttraumatic stress disorder (PTSD), substance abuse, and depression.<sup>16</sup> In the general population of the United States, about one in four adults will experience mental illness in any given year.<sup>17</sup> Suicide, in particular, is the tenth leading cause of death, though it ranks third for individuals between

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12. *American Indians-Alaskan Natives*, AM. PSYCHIATRIC ASS'N, <http://web.archive.org/web/20150727151420/http://www.psychiatry.org/mental-health/people/american-indians-> (last visited Jan. 7, 2015) [hereinafter AM. PSYCHIATRIC ASS'N].

13. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at i; Artiga et al., *supra* note 7.

14. Recent usage of the term “behavioral health” suggests it is often used interchangeably with “mental health.” That approach will be adopted for the purposes of this paper. *Behavioral Health Versus Mental Health*, PSYCHOL. TODAY (OCT. 28, 2009), <https://www.psychologytoday.com/blog/promoting-hope-preventing-suicide/200910/behavioral-health-versus-mental-health>.

15. AM. PSYCHIATRIC ASS'N, *supra* note 12.

16. *Id.*

17. NAMI: NAT'L ALLIANCE ON MENTAL ILLNESS, MENTAL ILLNESS FACTS AND NUMBERS 1 (Mar. 2013), [http://www.nami.org/factsheets/mentalillness\\_factsheet.pdf](http://www.nami.org/factsheets/mentalillness_factsheet.pdf) [hereinafter MENTAL ILLNESS FACTS AND NUMBERS].

the ages fifteen and twenty-four years old.<sup>18</sup> Among American Indian populations, however, the numbers are even more alarming. The youth in American Indian communities experience high rates of suicide—over two times the rate of the nation as a whole, and suicide is the second leading cause of death for these youth.<sup>19</sup> In “some tribal communities the rate has reached ten times the national average.”<sup>20</sup>

Though, for the most part, American Indians generally tend to experience behavioral health disorders at a rate similar to that of the general population of the United States, we now know it is clear that American Indians are at much more predisposed toward a much higher risk for suffering from certain mental disorders.<sup>21</sup> Such disorders include depression, anxiety, and substance abuse.<sup>22</sup> Unfortunately, these high rates of mental illness on Indian reservations pose many short-term and long-term problems for American Indians.

This overrepresentation of American Indians among the nation’s mentally ill could be the result of various traumas that are all too common among native populations, including homelessness, incarceration, domestic violence, and substance abuse.<sup>23</sup> Specifically, American Indians are more likely than other U.S. demographics to face substance abuse, exposure to trauma, physical abuse and neglect, poverty, and post-traumatic stress disorder.<sup>24</sup> Notably, among American Indians, the rate of poverty is two times the national average, and the numbers are similar, though even more extreme, for unemployment rates among Indians.<sup>25</sup> In addition to these facts, the rate of violence is twice as high among American Indian communities.<sup>26</sup> Forced relocation, cultural assimilation, and other historical causes of widespread American Indian suffering may be much to blame.<sup>27</sup>

These particular issues with mental health in American Indian communities affect more U.S. citizens than one might think. Approximately

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18. *Id.*

19. CTR. FOR NATIVE AM. YOUTH, SEQUESTRATION: THE IMPACT ON THE MOST AT-RISK POPULATION – NATIVE YOUTH 5 (2013), [http://www.aspeninstitute.org/sites/default/files/content/upload/Sequestration%20Paper\\_FINAL.pdf](http://www.aspeninstitute.org/sites/default/files/content/upload/Sequestration%20Paper_FINAL.pdf) (citation omitted).

20. *Id.*

21. AM. PSYCHIATRIC ASS’N, *supra* note 12.

22. *Id.*

23. NATIVE AMERICAN HEALTH CARE DISPARITIES BRIEFING, *supra* note 7, at 9 (citation omitted).

24. Horwitz, *supra* note 1.

25. AM. PSYCHIATRIC ASS’N, *supra* note 12.

26. *Id.*

27. *Id.*

5.1 million Americans, or roughly 2% of the population, self-identify as being at least part American Indian.<sup>28</sup> Though this is a relatively small number, the American Indian population grew at a rate almost twice as fast as the total United States population between the years 2000 and 2010, increasing by 18% in those ten years according to the U.S. Census Bureau.<sup>29</sup> This suggests a sharp incline in the number of people suffering from mental health disorders as years have progressed, calling for these issues to be addressed sooner rather than later.

### *2. Department of Health and Human Services Study*

In 2011, the Office of Inspector General (OIG), a branch of the Department of Health and Human Services (DHHS), conducted a formal study on the IHS's struggle to meet the mental health needs of American Indian populations in the United States.<sup>30</sup> The findings, unfortunately, were a great eye-opener. They suggest that federal government agencies do not have the resources to handle the great amount of suffering due to mental health issues that is present in American Indian communities. Six hundred thirty medical facilities responded for this report, that number being far under the amount requested to participate, including both IHS and tribal facilities, so the report is not perfectly representative of all such facilities.<sup>31</sup> As part of the study, the OIG surveyed these facilities and did fieldwork at a smaller number of them to observe conditions first hand.<sup>32</sup>

The report concluded that these American Indians had access to few mental health treatment options through IHS and tribal facilities, and where such options were available, they were lacking in quality.<sup>33</sup> Eighty-two percent of the available facilities provide some type of mental health care service<sup>[34]</sup>; however, the range of available services is limited at some.<sup>35</sup> “Some type of mental health service” does not always equate to an adequate *type* or *amount* of mental health service for the population receiving care.

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28. Artiga et al., *supra* note 7.

29. TINA NORRIS, PAULA L. VINES & ELIZABETH M. HOEFFEL, U.S. CENSUS BUREAU, U.S. CENSUS BRIEFS: THE AMERICAN INDIAN AND ALASKA NATIVE POPULATION: 2010, at 3-4 (Jan. 2012), <http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf> (citations omitted).

30. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 1.

31. *Id.* at 9.

32. *Id.*

33. *Id.* at 10-13.

34. For the purpose of this comment and the study discussed, the term “mental health service” “includes, but is not limited to, all psychiatric services, behavioral health services, substance abuse treatment, and traditional healing practices.” *Id.* at 5 (citation omitted).

35. *Id.* at 10.

Inadequacies in variety and amount of services aside, the availability of mental health services in only 82% of facilities is inadequate. This number, in effect, means that the people living near the other 18% of facilities have even more limitations in their access to mental health care. In addition, for those facilities that do provide some type of mental health service for American Indians, there is no proof that the type of care that each facility provides is adequate to provide for the community it serves.

A total of 70% of health care facilities outside of Indian reservations provide some sort of behavioral health services, and 100% will “provide referrals to substance abuse and mental health services.”<sup>36</sup> Though the percent of health care providers offering actual mental health care services is lower by number, there are constant efforts to strengthen this number in an attempt to better provide for the nation’s population.<sup>37</sup> For example, in 2012 and 2013, a “Behavioral Health Integration Learning Community” was started in an effort to address the needs of health care centers that were not yet providing mental health care services.<sup>38</sup> The Administration is placing extra emphasis on the integration of mental health into the facilities and systems lacking mental health care options.<sup>39</sup> In addition, in the United States generally, there are many facilities that focus on mental health, giving hospitals many referral options to potential behavioral health patients. The lack of mental health facilities in Indian communities makes the benefit these other hospitals provide almost impossible for native communities.

Even worse was the finding that of the IHS and tribal facilities that do provide mental health services, only 39% of those offer crisis intervention services around the clock, seven days a week, and 10% of facilities participating in the study did not offer crisis intervention services at all.<sup>40</sup> This study demonstrates the unfortunate reality that American Indian mental health services are not a top priority in this country. This limited availability of crisis intervention services could well explain the high incidence of American Indian suicides. If people do not have anywhere to go when they hit their lowest point of mental illness, many may think they have no other option.

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36. *Clinical Issues: Behavioral Health*, NAT’L ASS’N COMMUNITY HEALTH CTRS., <http://web.archive.org/web/20150928220556/http://www.nachc.com/BehavioralHealth.cfm> (last visited Dec. 21, 2014).

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*; ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 12.

The report also indicated that access to psychiatric facilities is limited because of an extreme lack of licensed mental health providers.<sup>41</sup> “Although 82% of the surveyed facilities reported that they provide mental health services, a variety of staffing issues affect access to services.”<sup>42</sup> Many of these facilities were staffed full time with only unlicensed workers, such as social workers and substance abuse counselors.<sup>43</sup> These available, unlicensed workers are not in a position to provide patients with mental health treatment.<sup>44</sup>

Another major issue is that the vast majority of these facilities, 81%, do not offer inpatient behavioral health services.<sup>45</sup> The only IHS facility that offers such services only admits patients between ages thirteen to seventeen.<sup>46</sup> Overall, this lack of available mental health care is exceedingly unhelpful to individuals in emergency situations. In addition, though people in their teenage years do suffer strongly from mental illness, having only this one facility for this age group leaves out many people below and above that age range, depriving them of the help they need. The age range for suicide stretches far past this five-year age group.

Lastly, many barriers, including physical, personal, social, and economic barriers, limit access to mental health facilities that are available.<sup>47</sup> Noteworthy examples include obtaining transportation, distance, poor roads, weather, lack of childcare, and finances.<sup>48</sup> In addition, most American Indians do not have health insurance,” making the financial barriers even more burdensome.<sup>49</sup>

Although this OIG study brought awareness to numerous issues plaguing the American Indian mental health care system, the issues were neither small nor easily fixable. Other parts of the government would need to become involved in order to even approach solving many of these problems. Because of this, unfortunately, even if the other problem were to be fixed, this one regarding insurance may still linger, making a workable system much harder to reach than it otherwise would be.

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41. *Clinical Issues: Behavioral Health*, *supra* note 36.

42. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at ii.

43. *Id.* at 17.

44. *Id.*

45. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 13.

46. *Id.*

47. *Emtel, Inc. v. Lipidlabs, Inc.*, 583 F. Supp. 2d 811, 817 (2008).

48. *Id.*

49. Artiga et al., *supra* note 7.

This report did not introduce small problems that could be fixed with just some adjustments and/or developments in the system. These findings presented much more than that, making the government's job much harder. Even if a seemingly adequate amount of facilities were to be provided based on population numbers, access to mental healthcare will remain a problem so long as physical and financial barriers remain.

### 3. *Common Stigma of Mental Illness*

Lacking availability of services is not the only reason American Indians may not be getting the mental health treatment they need. The stigma of mental illness, and resulting discrimination, often dissuade the mentally ill from seeking medical treatment for a potential mental illness.<sup>50</sup> For example, “[l]ack of knowledge, fear of disclosure, and rejection of friends . . . are a few reasons why people with mental illness don’t seek help.”<sup>51</sup> This stigma acts as a barrier to both asking for and getting the help these individuals need.<sup>52</sup> Many people suffering from mental illness believe they can solve it on their own, hoping to avoid the stigma that results from disclosure of their mental health issues.<sup>53</sup>

Though only approximately two-thirds of people with mental illnesses actually seek treatment, this negative attitude toward mental health care reaches its peak in American Indian communities.<sup>54</sup> “[W]hile some American Indian tribes do not stigmatize mental illness, some [groups] stigmatize [only] some mental illnesses, and other tribes stigmatize all mental illnesses.”<sup>55</sup> American Indians, specifically, tend to not seek help or not return to a clinic for their mental health care needs if the facilities “do not respect or are incompatible with the cultures of the people they serve.”<sup>56</sup>

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50. *Facts About Stigma and Mental Illness in Diverse Communities*, NAMI MULTICULTURAL ACTION CTR., <http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=5148> (last visited Sept. 18, 2015).

51. *Id.*

52. Sarah Kliff, *Seven Facts About America's Mental Health-care System*, WASH. POST (Dec. 17, 2012), <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/12/17/seven-facts-about-americas-mental-health-care-system/>.

53. *Id.* (“A 2007 study in the journal *Psychiatric Services* looked at 303 mental health patients who had, in the past year, thought about going to the doctor but decided against it. The researchers asked them why . . . Seventy-one percent agreed with the statement ‘I wanted to solve the problem on my own.’”).

54. *Facts About Stigma and Mental Illness in Diverse Communities*, *supra* note 50.

55. *Module 7: Cultural Perspectives on Mental Health*, UNITE FOR SIGHT, <http://www.uniteforsight.org/mental-health/module7> (last visited Dec. 21, 2014).

56. *Facts About Stigma and Mental Illness in Diverse Communities*, *supra* note 50.

Presenting behavioral healthcare services in ways that are sensitive to the culture of the people a facility is serving can be essential to increasing the usage of those facilities.<sup>57</sup>

For example, there is a stereotype of American Indian groups that alcoholism and substance abuse run rampant among those communities.<sup>58</sup> It is true that in some American Indian communities “alcoholism and illicit drug use disorder rates are much higher than U.S. average.”<sup>59</sup> Even so, this does not apply to all American Indian groups, and even for those to which it does apply, most American Indians are not alcoholics.<sup>60</sup> It is extremely important that medical providers are aware of stigmas such as those against often assumed alcoholism in order to ultimately understand and relate to the people they are caring for in a sensitive way. Providing services that follow more traditional methods of healing may be more appealing to those who continue to practice and live by those methods. Practicing with methods used by the community being served is a great way to show respect and understanding of cultural differences that may be present between patients and health care providers.

#### *B. Federal Health Agencies*

##### *1. Indian Health Service*

Both state and federal governments have created organizations to address physical and mental health in Indian communities. The IHS, created in 1955 under what is now the Department of Health and Human Services (DHS), is the primary agency serving the health needs of American Indians.<sup>61</sup> It was created with the intention of providing health care services, both mental and physical, to American Indian tribes.<sup>62</sup> IHS, which is run by the federal government, is responsible for providing federal health services to the members of the 564 federally recognized tribes in the United States.<sup>63</sup> In 2005, IHS formalized a Behavioral Health Initiative that holistically addresses the health, wellness, strength, and resilience of American Indian communities. The major focus areas for the IHS

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57. *Module 7: Cultural Perspectives on Mental Health*, *supra* note 55.

58. AM. PSYCHIATRIC ASS'N, *supra* note 12.

59. *Id.*

60. *Id.*

61. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 2; Alex Dyste, *It's Hard Out Here for an American Indian: Implications of the Patient Protection and Affordable Care Act for the American Indian Population*, 32 LAW & INEQ. 95, 102 (2014).

62. 25 U.S.C. § 1661(a)(1) (2012).

63. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 2.

behavioral health program are substance use disorders, mental health disorders, violence prevention, and increasing the integration of behavioral health into primary care.<sup>64</sup> The initiative's enabling statute provides:

The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare which may include, if feasible and appropriate, systems of care, and shall include—

- A. prevention, through educational intervention, in Indian communities;
- B. acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;
- C. community-based rehabilitation and aftercare;
- D. community education and involvement, including extensive training of health care, educational, and community-based personnel;
- E. specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and
- F. diagnostic services.<sup>65</sup>

Regrettably, the IHS system is plagued by a strong sense of mistrust among the native peoples it is designed to serve, and it has also been criticized for its financial inability to address native populations' mental health needs.<sup>66</sup>

The statute text states that all of these potential inclusions must be carried out, but only if "feasible and appropriate."<sup>67</sup> If none of the listed items are feasible, financially or otherwise, the effort to create a better behavioral health program becomes essentially moot. The agencies responsible for putting this comprehensive behavioral health system into action, including the IHS, require much more funding than they currently

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64. *Behavioral Health*, INDIAN HEALTH SERV., <https://www.ihs.gov/communityhealth/behavioralhealth/> (last visited Sept. 28, 2014).

65. 25 U.S.C. § 1665c(a)(1) (2010).

66. Carol M. Suzuki, *When Something Is Not Quite Right: Considerations for Advising a Client to Seek Mental Health Treatment*, 6 HASTINGS RACE & POVERTY L.J. 209, 236 (2009).

67. 25 U.S.C. § 1665c(a)(1).

receive to put toward these projects because HIS is too underfunded to meet the needs of native populations.<sup>68</sup> Specifically, many cuts have been made recently to the funding for the federal facilities that provide mental health care to American Indian populations.<sup>69</sup> During IHS's 2013 fiscal year alone, funding for IHS was cut by approximately 220 million dollars, and Substance Abuse and Mental Health Services (SAMHSA), a branch of DHHS, funding was cut by approximately 168 million dollars.<sup>70</sup> During a time such as this, when tribal communities are suffering from such a high rate of mental illness and problems with providing needed health care, the impact of these cuts will be great, and will only work toward the prevention of future progress in provided the needed mental health care services.<sup>71</sup>

### *2. Substance Abuse and Mental Health Services Administration*

The SAMHSA Office of Behavioral Health Equity (OBHE) is a product of the 2010 Affordable Care Act (ACA).<sup>72</sup> Established in 2012, this office is the result of the ACA's demand that a certain number of agencies "establish offices of minority health."<sup>73</sup> This is but another office working under the Department of Health and Human Services that has an aim to help minority groups.<sup>74</sup> Unlike IHS, OBHE targets groups outside of the American Indian community, such as the LGBT community. Even so, it still has the potential to help the issues in mental health on Indian reservations today.<sup>75</sup> This is another possible source from which to draw resources as the federal government attempts to help this minority group.

### *C. State and Local Health Agencies and Organizations*

Though the federal government is tasked with providing health care services for American Indians,<sup>76</sup> many states also offer services to aid the Indian communities at a local level.<sup>77</sup> Several states with high American

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68. NATIVE AMERICAN HEALTH CARE DISPARITIES BRIEFING, *supra* note 7, at 33; Artiga et al., *supra* note 7.

69. CTR. FOR NATIVE AM. YOUTH, *supra* note 19, at 2.

70. *Id.*

71. *Id.* at 6.

72. *About the Office of Behavioral Health Equity (OBHE)*, SAMHSA, <http://www.samhsa.gov/behavioral-health-equity/about> (last updated Jun. 1, 2015).

73. *Id.*

74. *Id.*

75. *Id.*

76. 42 U.S.C. § 2001(a) (2012).

77. *See* NATIVE AM. COMMUNITY HEALTH CTR., INC., <http://www.nativehealthphoenix.org/> (last visited Jan. 7, 2015); NATIVE AM. CONNECTIONS, <http://www.nativeconnections.org/>

Indian populations do so through agencies and organizations, and these have made significant strides in the field of American Indian mental illness.<sup>78</sup> A juxtaposition of these state agencies against federal institutions clearly demonstrates how the latter have fallen short in securing the trust of the peoples they serve. Having a comforting presence opens an essential line of communication between the government and the American Indian populations they govern. Many state organizations have this trait, while many American Indians feel that the federal facilities do not.<sup>79</sup>

One similarity between all of the state-level agencies and organizations providing mental health care services for American Indians is that they all pay special attention to specific cultural needs and methods, respecting and using those methods in everyday practice. These cultural factors can have a large impact on a community's perceptions of and willingness to accept mental health treatment.<sup>80</sup> "Often physical concerns and psychological concerns are not separated and emotional distress may be expressed in different ways."<sup>81</sup> Therefore, creating an atmosphere of cultural respect is key in successfully providing mental health care to American Indians. Additionally, these state-level agencies and organizations—unlike the nationwide IHS—are more effective in that they can better meet the idiosyncratic needs of the local populations they serve.

The creation of so many state agencies and nonprofit organizations to target the issues with the availability of mental health care quickly brought to light the great need these facilities face. The importance of the service they provide should not be a last priority in the delegation of government funds.

### 1. Oklahoma

The Oklahoma Department of Mental Health and Substance Abuse (ODMHSA) is a state agency that performs functions similar to IHS and SAMHSA, though ODMHSA serves a smaller community of patients.<sup>82</sup>

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org/ (last visited Jan. 7, 2015); NATIVE AM. HEALTH CTR., <http://www.nativehealth.org/> (last visited Jan 6, 2015); *Tribal State Relations*, OKLA. DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., [http://www.ok.gov/odmhsas/Additional\\_Information/Tribal\\_State\\_Relations/index.html](http://www.ok.gov/odmhsas/Additional_Information/Tribal_State_Relations/index.html) (last visited Sept. 28, 2014).; SACRAMENTO NATIVE AM. HEALTH CTR. INC., <http://www.snahc.org> (last visited Jan. 6, 2015).

78. *States Ranked by American Indian and Alaska Native Population*, U.S. CENSUS BUREAU (July 1, 1999), <https://www.census.gov/population/estimates/state/rank/aiea.txt>.

79. GRANT & BROWN, *supra* note 10, at 15.

80. AM. PSYCHIATRIC ASS'N, *supra* note 12.

81. *Id.*

82. *Tribal State Relations*, *supra* note 77.

ODMHSA is one example of state agencies that aim to work with the tribal governments to work to prevent and treat the symptoms of mental illness among the American Indian community.<sup>83</sup> This state agency serves as an effective bridge between the American Indian community and the federal agencies by providing information at a level closer to American Indian communities. This bridge approach is effective because state agencies demonstrate more familiarity with the needs of local communities than can federal agencies. ODMHSA's website is stocked with information to assist native patients in navigating the complicated American Indian health system.<sup>84</sup> Thus, such state agencies provide easy access to information that assists native patients in identifying their mental health care options.

## 2. California

California, being home to 109 federally recognized tribes, has the largest American Indian population in the United States.<sup>85</sup> In contrast to Oklahoma's state agency approach, California uses non-profit organizations to guide American Indians through the mental health care system.

In California, unlike Oklahoma, many of the organizations set in place to aid American Indians are non-profit organizations. For example, the American Indian Health Center (NAHC), one such non-profit, aims to provide comprehensive health care for the native populations of California.<sup>86</sup> NAHC, along with most state service organizations, stands out because its mission emphasizes respect for cultural differences.<sup>87</sup>

The Sacramento American Indian Health Center (SNAHC) is another non-profit that serves the state's American Indian population.<sup>88</sup> It is a federally qualified, "culturally competent" health center program, meaning it serves a population that has little access to medical care, its fees are adjusted based on the ability of each individual to pay, and meet other federal administrative requirements needed to retain the title.<sup>89</sup>

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83. *Id.*

84. *Id.*

85. *Our Community*, SACRAMENTO NATIVE AM. HEALTH CTR. INC., <http://www.snahc.org/about-2/our-community> (last visited Jan. 7, 2015).

86. *NAHC Mission Statement*, NATIVE AM. HEALTH CTR., <http://www.nativehealth.org/content/nahc-mission-statement> (last visited Jan. 7, 2015).

87. *Id.*

88. *Introduction*, SACRAMENTO NATIVE AM. HEALTH CTR. INC., <http://www.snahc.org/about-2/introduction/> (last visited Jan. 7, 2015).

89. *See* 42 U.S.C. § 254b(a) (2012). There are multiple fundamental qualities that make a facility a "health center" under the Health Center Program. The facility must be located in or serve a high-need community, be governed by a community board, and provide primary

These agencies have become an essential presence and have made significant strides with in the field of American Indian mental illness. A juxtaposition of these state agencies against federal initiatives institutions clearly demonstrates how this exploration is necessary in order to fully understand what the actions of the federal government the latter have been lacking in relation to fallen short in securing the trust of the peoples they serve. Having a comforting presence opens an essential line of communication between the government and the American Indian populations they govern. Many state organizations have this trait, while many American Indians feel that the federal facilities do not.<sup>90</sup>

### 3. Arizona

Arizona, like California and Oklahoma, has a large American Indian population that state agencies support in part.<sup>91</sup> American Indian Connections (NAC) is one example of an Arizona state organization that offers a thorough behavioral health program, including outpatient programs, youth specific services, and substance abuse services.<sup>92</sup> Like many other state organizations, NAC's mental health care services include traditional healing methods, such as talking circles, purification, native crafts, and cultural presentations.<sup>93</sup> Currently, one thousand five hundred people, including both adults and children, benefit from the behavioral health services offered by American Indian Connections.<sup>94</sup>

Another noteworthy Arizona organization, the American Indian Community Health Center (NACHC), was granted its initial funding from the Indian Health Service to be a small community nursing program.<sup>95</sup> The agency has since expanded to include both a behavioral health division and

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health care to all persons, among other performance requirements. *What Is a Health Center?*, U.S. DEP'T HEALTH & HUMAN SERVS., <http://bphc.hrsa.gov/about/what-is-a-health-center/index.html> (last visited Sept. 19, 2015); 42 U.S.C. § 254b(a).

90. GRANT & BROWN, *supra* note 10.

91. *States Ranked by American Indian and Alaska Native Population*, *supra* note 78.

92. *See About*, NATIVE AM. CONNECTIONS, <http://www.nativeconnections.org/about> (last visited Jan. 7, 2015); *Behavioral Health*, NATIVE AM. CONNECTIONS, <http://www.nativeconnections.org/behavioral-health/adult> (last visited Jan. 7, 2015).

93. *Traditional Healing*, NATIVE AM. CONNECTIONS, <http://www.nativeconnections.org/behavioral-health/traditional-healing> (last visited Jan. 7, 2015).

94. *History*, NATIVE AM. CONNECTIONS, <http://www.nativeconnections.org/about/history> (last visited Jan. 7, 2015).

95. *History*, NATIVE AM. COMMUNITY HEALTH CTR., INC., <http://www.nativehealthphoenix.org/history> (last visited Jan. 7, 2015).

a primary care division.<sup>96</sup> Much like the other organizations, the NACHC's behavioral health section aims to provide services "culturally appropriate to the urban American Indian community."<sup>97</sup>

*D. The Potential Effect of the Affordable Care Act*

The ACA may offer new opportunities to American Indian communities, including increased insurance coverage and access to health care.<sup>98</sup> "Moreover, the ACA permanently reauthorizes the Indian Health Care Improvement Act,<sup>[99]</sup> extending and authorizing new programs and services within the IHS."<sup>100</sup> The IHCA was implemented originally with the hopes of strengthening the health of American Indians. The IHCA is not completely comprehensive because it has omitted to provide traditional healing practices often used by American Indians.<sup>101</sup> This lack of care is contrary to the purpose it was intended to further.<sup>102</sup> A large part of the ACA aims to expand Medicaid, for which many American Indians may qualify on the basis of income, depending on their state of residence.<sup>103</sup> Despite this intended expansion of Medicaid, states are not yet required to participate in this portion of the ACA.<sup>104</sup> This means that American Indians living within those states that do not participate will be unable to benefit from the help the Medicaid expansion will provide elsewhere.<sup>105</sup> For example, Oklahoma is one of the states that have refused to expand Medicaid.<sup>106</sup> In the state of Oklahoma alone, this refusal to expand Medicaid will leave 123,000 American Indians uninsured.<sup>107</sup> Altogether, there are twenty-four states that are currently resisting the expansion of Medicaid. According to the White House website, this will result in 5.7

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96. *Id.*

97. *Behavioral Health*, NATIVE AM. COMMUNITY HEALTH CTR., INC., <http://www.nativehealthphoenix.org/behavioral-health> (last visited Jan. 7, 2015).

98. Artiga et al., *supra* note 7.

99. Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.).

100. Artiga et al., *supra* note 7.

101. Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act*, 4 DEPAUL J. HEALTH CARE L. 843, 843-44 (1999).

102. *Id.*

103. Artiga et al., *supra* note 7.

104. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 424 (2010).

105. Artiga et al., *supra* note 7.

106. *22 States Are Not Expanding Medicaid*, WHITE HOUSE, <http://www.whitehouse.gov/share/medicaid-map> (last visited July 1, 2014).

107. *Id.*

million Americans remaining uninsured.<sup>108</sup> American Indians are included in these numbers.

Despite these twenty-four holdout states, the ACA, overall, is a step in the right direction—the direction of providing better mental health care for American Indians. Unfortunately, the ACA is a step toward making a positive change that the federal government cannot further enforce because Medicaid’s expansion is merely permissive.<sup>109</sup> Awareness of the severity and consequences of the extreme lack of available mental health care will be key in convincing states to comply with the federal government’s Medicaid expansion program.

### *III. Analysis of Statutory Law and Policy*

#### *A. Statutory Law*

Current law places upon the federal government the responsibility of providing health care to American Indians.<sup>110</sup> For example, one federal statute provides:

All functions, responsibilities, authorities, and duties of the Department of the Interior, the Bureau of Indian Affairs, Secretary of the Interior, and the Commissioner of Indian Affairs relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of the health of Indians, are transferred to, and shall be administered by, the Surgeon General of the United States Public Health Service, under the supervision and direction of the Secretary of Health and Human Services.<sup>111</sup>

This statute suggests that the federal government is responsible for providing health care facilities for American Indians. This duty is reaffirmed in case law.<sup>112</sup> The government works toward fulfilling its responsibility through multiple avenues, including the IHS and contracts with non-Indian providers.<sup>113</sup> Unfortunately, the federal government’s

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108. *Id.*

109. Patient Protection and Affordable Care Act, 124 Stat. 424.

110. Artiga et al., *supra* note 7.

111. 42 U.S.C. § 2001(a) (2012).

112. *E.g.*, *White v. Califano*, 581 F.2d 697, 698 (1978).

113. Artiga et al., *supra* note 7; 42 U.S.C. § 2001(b) (“In carrying out his functions, responsibilities, authorities, and duties under this subchapter, the Secretary is authorized, with the consent of the Indian people served, to contract with private or other non-Federal

current approach has been insufficient to properly address the high rates of mental illness in Indian communities.

Statutes also provide for the implementation of a behavioral health program within IHS facilities.<sup>114</sup> That statute provides:

**(a) Innovative programs**

The Secretary, acting through the Service, consistent with section 1665a of this title, *may* plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

**(b) Awards; criteria**

The Secretary *may* award a grant for a project under subsection (a) to an Indian tribe or tribal organization and *may* consider the following criteria:

- (1) The project will address significant unmet behavioral health needs among Indians.
- (2) The project will serve a significant number of Indians.
- (3) The project has the potential to deliver services in an efficient and effective manner.
- (4) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.
- (5) The project may deliver services in a manner consistent with traditional health care practices.
- (6) The project is coordinated with, and avoids duplication of, existing services.<sup>115</sup>

The statutory scheme indicates that the option is available to implement programs to better the current behavioral health programs within the Indian Health Service facilities. In order to make the decision, the statute lists criteria that may be considered to help weigh the options as to whether the Secretary of Health and Human Services (HHS) will award a grant. The criteria to be considered cover a broad range of potentially proposed

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health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other similar basis.”)

114. 25 U.S.C. § 1665j (a)-(b) (2012).

115. *Id.* (emphasis added).

projects, therefore, any project to be presented has a good chance of being implemented. A greater effort in thinking of solution could quickly lead to an actual change under this statute.

*B. Federal Responsibilities and Statute Ineffectiveness*

The high incidence of mental illness in native communities seems to have two potential explanations. First, the federal government seems to be shirking its responsibilities under the statutes requiring it to provide health care to American Indians. This duty should be understood to include mental health care, and has been, judging by their creation of IHS. Although IHS behavioral health facilities exist, the federal government appears to fall short of its statutory duty to provide health care for American Indians in that access to these facilities and services is limited, and providers do not allow proper and adequate use of the facilities provided. Given such a lack of access to mental health services, native communities often must operate as if federal services do not exist at all. Therefore, existing services offered are insufficient to meet the federal government's statutory duty. Understanding what level of improvement would be acceptable is difficult. Though any improvement would be beneficial, the goal should be to at least raise the rates of mental illnesses in American Indian communities to equal those for the rest of the U.S. population. If this were to happen, it would dispose of the current imbalance that currently exists.

Second, the drafting of governing statutes leaves much to be desired. Initially, it must be noted that if the federal government is considered by the lawmakers to be following the current written law, then the statutes should require more of the government. Specifically, lawmakers should draft into the statutes a duty to monitor and review the effectiveness of IHS facilities. Looking at the actual numbers, including the changes in rates of mental illness after new facilities are set up, would be extremely helpful in gauging the effectiveness of each community served by an IHS facility, as well as all IHS facilities' effectiveness put together. Judging by what has resulted from past federal action, it is now noticeable that only setting up the facilities themselves is not enough.

In the behavioral health statute, specifically, the Secretary of HHS is provided with only the *option* to take action if it seems needed.<sup>116</sup> This is not enough. The initiative could do great things by providing higher quality mental health care services to American Indians and making them easier to access, but no official is ever forced to take action. The statute, in its

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116. *Id.*

current form, is discretionary. The legislature should rewrite the statute to make it mandatory, and the government should be deemed to have breached its duty where a lack of care is proven. This would also prevent government actors from allowing the stigma and negative stereotypes associated with some of these communities from interfering with the decision to provide better care.

The statutory scheme also falls short in its failure to provide an individual cause of action for breach.<sup>117</sup> If there is no way for individuals to use the court system to enforce these statutes, it is less likely that they will be adequately enforced. Providing an opportunity for individual American Indians to take action when they suffer actual injury owing to the government's failure to meet its statutory duty of care would make the statutes much more effective, and therefore, more likely to lower the incidence of mental illness among American Indians.

The fact that the federal government continues to not provide adequate services for American Indians could be the result of little enforcement of these statutes. The federal government should put forth a good faith effort to uphold the statutory scheme, taking advantage of the powers the statute gives it, and the statute should be rewritten to correct for failures in drafting. If the federal government fails to address either drafting or implementation, it also fails the nation's native communities.

### *C. Consequences of Continuous Violation and/or Ineffectiveness of Statutes*

#### *1. Criminal Justice System*

The government's failure to implement the statutory scheme—and concomitant failure to provide mental health care for American Indians also has constitutional implications with respect to the criminal justice system. Though having a mental illness does not automatically result in incompetence of the defendant, many times a mental illness can satisfy the test for incompetence. The federal standard for competency was first set out in *Dusky v. United States*, when it stated:

[I]t is not enough for the district judge to find that 'the defendant (is) oriented to time and place and (has) some recollection of events,' but [] the 'test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of

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117. See 42 U.S.C. § 2001.

rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.’<sup>118</sup>

If a criminal defendant fails to meet this standard in a competency hearing, the defendant is deemed incompetent to stand trial.<sup>119</sup> A high incidence of mental illness may also lead to higher likelihood that native criminal defendants may testify while incompetent, resulting in derogation of his or her due process rights under the Fifth and Fourteenth Amendments.<sup>120</sup>

Under the federal competency standard, a defendant must show reasonable cause to believe that the defendant may be incompetent for a judge to grant a motion requesting competency hearing.<sup>121</sup> American Indians may have difficulty satisfying this standard, however, where they have no access to mental health care providers for diagnosis and treatment. Access to care is, of course, a prerequisite to documentation of mental illness.

This is especially true for mental illnesses with fewer objectively observable symptoms. Although evidence tends to be more readily available for mental illnesses typified by objectively observable behavioral symptoms, such as with schizophrenia,<sup>122</sup> illnesses more in the vein of anxiety demonstrate few outward symptoms.<sup>123</sup> Mentally ill American Indians that lack patient charts or documented prior incidents of extreme anger or other behavior may thus struggle to meet the burden of proof for a

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118. 362 U.S. 402, 402 (1960).

119. 18 U.S.C. § 4241 (2012).

120. The United States Constitution includes a due process clause in the Bill of Rights—in the Fifth Amendment—which applies directly to the federal government. U.S. CONST. amend. V. Due Process is also incorporated to the states through the Fourteenth Amendment. NW. JUSTICE PROJECT, DUE PROCESS IN INDIAN COUNTRY 1 (2015), <http://www.washingtonlawhelp.org/resource/due-process-in-indian-country?ref=Ysey5>. This clause guarantees that “[n]o person shall be deprived of life, liberty, or property, without due process of law.” U.S. CONST. amend. V. This protection is provided to American Indians on reservations usually through the Indian Civil Rights Act (ICRA), or through tribal codes, constitutions, and customs. NW. JUSTICE PROJECT, *supra*.

121. 18 U.S.C. § 4241(a) (2012).

122. “When schizophrenia is active, symptoms can include delusions, hallucinations, trouble with thinking and concentration, and lack of motivation.” *Help with Schizophrenia*, AM. PSYCHIATRIC ASS’N, <http://www.psychiatry.org/mental-health/schizophrenia> (last visited Jan. 7, 2015).

123. Jim Folk et al., *Anxiety Symptoms (Including Anxiety Attacks, Disorder, and Panic Signs and Symptoms)*, ANXIETY CENTRE, <http://www.anxietycentre.com/anxiety-symptoms.shtml> (last updated Mar. 2016).

finding of incompetence. The court may order a psychiatric or psychological evaluation,<sup>124</sup> but if this is done or offered after a competency hearing took place and the defendant was found competent, then this evaluation may be of little use.

This introduces a potential problem in criminal trials involving American Indian defendants who have no access to getting the care they need for their mental health issues. If these issues with the mental health care system and how it provides American Indians with health care access continue to occur, or possibly worsen, these due process rights that are held so dearly by American citizens will mean very little when it comes to American Indians sitting as defendants in their own criminal trials.

## 2. *Families and Community*

The effects of American Indian mental illness extend beyond the individual. Families and communities must also learn to cope. The negative effects on families will occur both where the federal government is violating the current statutes, and when the statutes need to be rewritten to have more control over the effect of mental illness in American Indian communities. Either, or both, of these problems often affect education, relationships, and community morale.

The stigma of mental illness, limited access to mental health care facilities, and the low quality of existing care options have been proven to result in an extremely high rate of mental illness among American Indians.<sup>125</sup> If these high rates of mental illness continue in these communities, individuals will continue to suffer from these behavioral disorders, which will in turn have an effect on their everyday lives. Education quality for these particular individuals will likely suffer because of lack of focus or because of the mental illness itself. If the quality of the education received decreases for these individuals, grades could go down. Because the rates of mental illness are so great in American Indian communities in comparison to the United States generally, it follows that these effects on the education of these individuals will result in a lesser quality of education for a higher percentage of the population in comparison to the populations of the entire nation.

The same type of effect could occur to relationships of all kinds including people in the American Indian communities suffering from a mental illness. If not properly treated or understood, mental illness causes

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124. 18 U.S.C. § 4241(b).

125. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at i.

tension between families, spouses, and the communities as a whole. As noted earlier, violence and substance abuse are higher in American Indian communities as well.<sup>126</sup> If this is related to the high rate of mental illness, these negative consequences would also increase, causing even more tension between the personally-affected American Indians and the ones that they love.

#### *IV. Viable Alternatives and Recommendations*

##### *A. Improving Issues with Mental Health*

There are multiple things the government and the health care community could implement to improve both the mental health care provided to American Indian communities and physical access to the health care providers that are currently present and offer mental health care services. First, using telehealth to create easier communication between patients and health care providers. Second, creating a national database of health care provider information and statistics so that the government can be more aware of where these mental health care services are lacking. Lastly, assuring that the law allowing the government to create these services for American Indians is written to be more effective and is followed by the federal government.

##### *1. Telehealth*

The Department of Health and Human Services notes in a 2011 study that “telemedicine can be a practical and cost-effective way to expand health services to offsite locations.”<sup>127</sup> Telehealth is a method of long-distance health care, where telecommunications are used to facilitate communications between physician and patient.<sup>128</sup> Though these services are often used for healthcare involving physical health problems, though only 17% of facilities participating in the study used the technique to cater to mental health needs.<sup>129</sup>

Given the dearth of licensed mental health care providers on Indian reservations, telehealth could represent a convenient, cost-efficient solution

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126. AM. PSYCHIATRIC ASS’N, *supra* note 12.

127. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 17.

128. *Telehealth and Telemedicine*, FCC, <https://web.archive.org/web/20140525072234/http://transition.fcc.gov/indians/internetresources/tt.html> (last visited Nov. 2, 2014). “Telehealth” is also sometimes referred to as “telehealth.” “Telehealth” will be used for consistency throughout this comment.

129. ACCESS TO MENTAL HEALTH SERVICES, *supra* note 7, at 17.

for addressing the needs of American Indian communities. Telehealth has previously been implemented with great success in the rural Native communities of Alaska.<sup>130</sup> Although telehealth may be effective at defraying the cost of transportation to such remote communities, telehealth need not be limited to remote communities. It must be remembered that even in accessible places it may still cost a large amount of money to bring in providers based solely on their rural.

The federal government should thus consider fulfilling its duty to meet American Indians' mental health needs by implementing telehealth. Such an approach would eliminate travel costs while providing native populations with immediate and convenient access to licensed mental health care providers. The study by the Department of Health and Human Services suggests that

IHS should continue to provide technical assistance, if needed, to tribes that use telehealth to ensure that they have the capability to bill Medicare, Medicaid, and third-party payers for appropriate telehealth services. By being able to change third-party payers, the facilities can increase their revenue to support facility-specific telehealth services.<sup>131</sup>

Telehealth thus represents a viable option for the federal government to further the legislative intent of the statutory scheme.

Although telehealth will pose significant start-up costs, both with respect to creating a telecommunications infrastructure and recruiting mental health professionals, the long-term benefits will outweigh the costs. The federal government's money and time will not be wasted if the mental health of many large communities throughout the United States will be improved.

## *2. Create a National Database*

The study done by Department of Health and Human Services was extremely limited in the information available because of the lack of data on each of the IHS facilities, what services they offer, and other important information.<sup>132</sup> To solve the problem of limited data, as the report suggests, the federal government should consider creating a national database containing key information for each IHS facility.<sup>133</sup> "Such a database would assist the Secretary [of HHS] in meeting the Administration's mandate to

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130. *See id.*

131. *Id.* at 22.

132. *See id.*

133. *See id.*

‘formulate a comprehensive approach to Indian health care reform’ and provide planning information relative to the distribution of health services for [American Indians and Alaskan Natives] throughout the country.”<sup>134</sup> To create this database, the IHS should work with state, tribal, and federal agencies to develop a plan to capture data from all health care facilities designed to serve American Indians—even those not directly funded by the federal government.<sup>135</sup>

The development of such a database would be helpful in a multitude of situations. It is always important for accurate and thorough records to be kept in order for the responsible entities to monitor what is happening and to address any current or potential issues that may be prevalent. “Such a database would assist the Secretary [of HHS] in meeting the Administration’s mandate to formulate a comprehensive approach to Indian health care ‘reform’ and provide planning information relative to the distribution of health services for AI/ANs throughout the country.”<sup>136</sup> Such a database should document basic details of existence for each facility, the mental health needs addressed by each facility, and treatment methods employed. These details should include, at the least, what each facility offers in the way of mental health care, any specialties held by the contracted physicians in each facility, and what types of treatment they most heavily rely on, including prescription medications and traditional methods of healing. Such data is necessary to identify and address shortcomings.

Although such a national American Indian mental health treatment database, much like telehealth, is likely to face upfront infrastructure and personnel costs, these obstacles can be overcome, and the benefits of the database would outweigh the burden of upfront costs. The implementation of telehealth services would provide many American Indians with the mental health care they both need, desire, and are statutorily entitled to.

#### *B. Assuring the Laws are Adequately Written and Followed*

##### *1. Federal Government Responsibility*

The federal government’s statutory burden should be mandatory, and it should be enforced. They must be held accountable for the high incidence of mental illness among American Indians, as well as the lack of awareness needed to fix problems that come about in American Indian communities because they have the ability to do more, and should take advantage of that

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134. *Id.*

135. *Id.*

136. *Id.*

ability. To fully follow the text of the statute, the federal government cannot only do the minimum, and then leave the rest to chance. If an action is to be effective, it must be maintained and monitored. If the effectiveness of the facilities already in place are not monitored in some way, they cannot be said to work to their full advantage. Erecting federal IHS facilities to serve the statute's purpose is not enough to ensure a high quality of care for the American Indian population. It is also not adequate to ensure that the facilities are actually physically available and properly funded for these populations. It is a waste of government funds to spend money on these facilities that are not carrying out their intended purpose.

To ensure that mental health facilities are adequately serving native populations, the legislature should impose biannual reporting requirements. These mental health facilities should be required to report how many patients they have served, the types and quantities of diagnoses, and other measures of general operational efficiency throughout the applicable reporting period. Such information would assist the federal government in ensuring effectiveness and adequacy of mental health facilities that address the needs of American Indians. Such a reporting program would assist in efficient spending of government funds. Though this type of record-keeping will be an extra step that needs to be taken, possibly creating an inefficiency, the potential results that could come from exerting those efforts would be well worth the endeavor. Inefficiency serves a small purpose in comparison to the larger purpose of improving the health of a extremely large community within the U.S.

## *2. Legislators May Change the Text of Relevant Statutes*

The underlying problem is likely to stem from statutory language. Multiple amendments should be made to hold the federal government accountable for adequately meeting American Indians mental health needs. Once again, providing individuals the opportunity to sue under the statutes for lack of providing adequate facilities and care could serve to aid in the enforcement of the statute's requirements.

Also, relying officially on more state action is an option. The states' agencies and local non-profits seem to be of more help to the American Indian communities in those states where such assistance is available. This is because they are more trusted by and more familiar with the particular communities they serve, thus, there are strong cultural advantages that state actions have over federal measures. Nevertheless, there are potential disadvantages as well, for instance, there would be great variation in how mental health issues are treated and cared for throughout the country. A

preferable system might be to create a uniform system by which states could administer assistance; but then again, this may take away from the cultural advantages previously mentioned. Furthermore, fifty separate systems would make it more difficult to create the national database that seems so helpful.

A uniform system of health care better fits that technique of gathering data, so using state actions to reinforce would add an extra level of protection for the Indian populations in that particular state. Though many states already have these types of reinforcement agencies and organizations, it could be a formalized obligation by statute if subsequently changed to include required state action.

Though there do not seem to be any predictable negative affects to changing the statutes, this may take more time than the other recommendations, meaning more than one of these listed suggestions should be implemented during the waiting period. Awareness must become more widespread in order for something of this magnitude to see noticeable change. If no one with the power to change the statutes notices the problem occurring, no further action is likely to be taken. Spreading awareness takes time, but taking the time to get the word out about an important issue such as this is worth the time and effort it takes. Changing the way these statutes are structured could change not only the lives of the individuals directly affected, but could also change the morale of the communities as a whole.

### *3. Awareness*

If the IHS is to fulfill the needs of American Indians, the government must enable the IHS to do so. The government needs to do more to improve their performance of responsibilities. The federal government needs to be more aware not only of the lack of access to mental health care for American Indians, but also of the potential consequences that the lack may bring. Though a study was done and published in 2011 stating the current issue, these types of studies do not always cross the paths of the general public and may not have been seen by many people at all. More widespread knowledge of the issue is required.

In Part II, multiple state programs and agencies were discussed, along with how they helped American Indians at a more localized level of government. States should make these programs more prevalent, especially those states that hold larger American Indian populations. Though the federal government has the responsibility here to provide health care services to American Indians, a state effort would be a helpful addition to the obligatory actions the federal government is already expected to take.

Awareness and funding tend to go hand in hand in solving the problems the Indian communities are currently facing with mental health. Above all else, awareness is key to getting the needed help for potential mental health patients within the American Indian population. Nothing can be done to help if the people who can are not aware there is an issue. The suggestion above, creating a national database of IHS facilities, is one step toward the ultimate goal of nation-wide awareness, but creative minds must be enlisted to find other ways to spread the word to people who can assist these populations that are in need of better mental health care.

In addition to the other suggestions discussed above, bringing awareness to the people higher up the chain of command in American Indian healthcare could do many wonderful things for reducing or even replenishing all of the recent cuts to funding. If people in the government knew of the importance of better providing mental health care to American Indians, maybe the cause would be weighed more heavily when distributing funding, and receive an amount closer to what is actually needed to help the population succeed. Even making the public more aware can be a strong tool when attempting to put pressure on the government to take action. Increasing awareness of the issue, and funding toward its aid, are two potentially successful methods that could be used to work toward improving mental health.

Bridging the culture gap between American Indians and Non-Indians is also an important goal that the government should focus on. Building and improving upon the lack of trust by Indians toward the federal government would create a new line of communication, once again leading to further awareness in the government of the issues currently being suffered by American Indians. Without this sense of trust, it would be difficult to communicate and work out current problems and possible future problems, including unintentional lack of fairness in the American legal system.

Others that are involved in the legal process should be aware and vigilant. This includes, judges, agency workers, prosecuting attorneys, defense attorneys, and anyone else who may be heavily involved throughout. People involved in the legal process need to be cognizant of what is happening. It may seem less helpful, but it still goes back to the idea of awareness. Its importance cannot be overemphasized. Warning all of these types of individuals of the potential consequences of continuing ineffective statutes may be the only way to ensure that the voices of the American Indian victims are heard.

Overall, giving facts to the public will not be enough. Something must be done to make people care and relate to the victims in Indian communities. Warning of the consequences and allowing the truth to escape of the current

situations of some American Indians suffering from behavioral disorders is necessary in order to communicate just how important solving this problem has become.

#### V. Conclusion

The rates of mental illness and resulting suicide among American Indian communities are very large, especially among the youth in these populations.<sup>137</sup> The large rates of mental illness in American Indian communities, in comparison to the rate of all in the United States, are a result of either shirking of responsibility by the federal government, the initially ineffective statutes that ultimately need revision to begin to mitigate those numbers, or both. Though the federal government, through the Department of Health and Human Services, has been given the responsibility of providing health care facilities and opportunities for American Indians, their efforts have not been effective. In addition, the statutes as they are now do not provide for an individual right of action and do not specify any governmental duties after the facilities have physically been put into place.<sup>138</sup>

These problems could lead to many consequences, either currently or in the near future, including allowing incompetent Indian defendants to testify at trial. To avoid further responsibility shirking by the federal government, the federal government could implement widespread telehealth capabilities and create a national database that would allow for better record keeping. Multiple things could be done to solve these issues, including implementing telehealth and a national database, further, more effective, federal action, statute amendments or rewriting, and general awareness of the issue at hand. Awareness is key is warning the legislator, judges, attorneys, and others involved of the potential consequences of inadequate statutes and inadequate adherence to those statutes.

Statutory ineffectiveness should not be the reason that so many suffer on a daily basis. Statutory law, though powerful, is not set in stone, and does continue to withstand criticism. Lack of adequate mental health care and lack of access to that care can be resolved, at least partially, in order to provide for better health care and better lives for all American Indians suffering from mental illness. The road to doing so may be a long one, but it is not impossible.

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137. MENTAL ILLNESS FACTS AND NUMBERS, *supra* note 17.

138. *See* 42 U.S.C. § 2001 (2012).