EMERGING TRIBAL MODELS FOR THE CIVIL COMMITMENT OF AMERICAN INDIANS

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Abstract: Until recently, American Indian tribes lacked procedures for the commitment of mentally ill reservation residents. The Red Dog decision (White v. Califano) highlighted the difficult issues inherent in this situation. This article reports the experiences of IHS and tribal service providers who struggle with these issues and describes the commitment procedures developed by five different reservation communities. Similarities and differences in these models are discussed, with special emphasis on implementation.

Until recently, virtually all American Indian tribes lacked procedures for the commitment of mentally ill reservation residents. There were no civil commitment procedures articulated in either tribal codes or in federal statutes, which are the primary written laws applicable on most reservations. Even tribes governed by state law, in accordance with Public Law 80-280, lacked effective commitment mechanisms because they encountered significant obstacles in attempting to utilize state civil commitment procedures. The inability to civilly commit tribal members living on reservations has resulted in personal and social costs including untreated mental illness, perceived and actual danger posed by potentially violent and unpredictable people, and excessive expenditures of time and effort while attempting to develop ad hoc solutions to the problems presented by mentally ill and dangerous individuals.

The difficult issues presented by this situation were first highlighted in the courts in 1977-78 by an 8th circuit federal case, *White v. Califano*[1], more commonly known as the Red Dog decision. The dispute in this case arose over the narrow question of whether the federal government or the state of South Dakota was responsible for paying for involuntary psychiatric hospitalization of a mentally ill and dangerous resident of the Pine Ridge Indian Reservation. In deciding that the responsibility lay with the federal government, the courts addressed a number of related issues, including tribal sovereignty, the lack of controlling federal law, questions of due process safeguards, and points of interface between tribal and state judicial process and between federal and state health care systems.

Florence Red Dog was an indigent member of the Oglala Sioux Tribe who lived on the Pine Ridge Reservation. In April of 1976 an Indian Health Service psychiatrist determined that Ms. Red Dog was mentally ill and needed immediate treatment to protect herself and others from physical

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harm. The psychiatrist requested that the state's attorney commit Ms. Red Dog to the mental hospital in Fall River County which adjoins the reservation. The state authorities refused to act, saying they had no jurisdiction over an Indian residing on an Indian reservation.

Following the state's refusal of the case, the psychiatrist asked the tribal court to act. A tribal judge held an emergency hearing and ordered Ms. Red Dog committed to a mental hospital, namely, the mental hospital in Fall River County. Once again, the state authorities refused to cooperate, saying that they could not accept Ms. Red Dog's commitment to a state hospital on the basis of a tribal court order.

Behind this legal confrontation was a history of increasing dispute about who pays for the treatment of mentally ill reservation residents in state hospitals, there being no suitable facility on the reservation. South Dakota brought the issue to a head by deciding to decline jurisdiction in the Red Dog case.

Georgia White, the guardian of Florence Red Dog, took the state to federal court, alleging that South Dakota had denied Red Dog equal protection of the law by refusing to commit or hospitalize her as they would a citizen not living on the reservation. The trial judge, whose decision was later affirmed on appeal by the circuit court, noted that plaintiff Red Dog's equal protection argument was compelling and consistent. Nonetheless, he concluded, ironically, that the unique status of Indian reservation residents required him to reject Ms. Red Dog's argument. Because Indian nations are sovereign there are historical and constitutional limitations on the power of a state to intrude into Indian country. Thus, the state was correct when it refused to conduct commitment proceedings, which would have required investigation on the reservation and other intrusions on sovereignty. Furthermore, the court held that South Dakota could not even accept jurisdiction over Ms. Red Dog after she had been ordered to be committed by the tribal court, unless there were a vote by the majority of the Indians on the reservation to allow such transfers.

Having concluded that South Dakota had no authority nor obligation to act, the court then examined the responsibility of the federal government which also had been named as a defendant. Judge Bogue found that federal authorities had an unambiguous obligation to provide health care to Indians, stemming from the unique relationship between Indians and the U.S. government. Because Ms. Red Dog lacked an alternative source of health care, federal policy, as shown by legislative and administrative history, places responsibility for her care upon the United States.

> As to the allowable means for providing care, it makes no difference whether federal officials contract with state or private agencies or make commitments to federal facilities. In either case, commitment procedures that conform to the requirements of due process tribal officials have in commitment procedures is

of no concern here. *White v. Califano*, 437 f. supp 543, 536 (S. D., 1977).

After the circuit court affirmed the district court's decision, the federal government decided not to seek review by the U.S Supreme Court. Thus, the decision became law in the 8th federal circuit, encompassing the states of North Dakota, South Dakota, Nebraska, Missouri, Minnesota, Iowa, and Arkansas. Although not binding elsewhere, the decision was influential throughout the country. Federal, state, and tribal officials recognized that other courts might adopt the 8th circuit's reasoning. The decision prompted action, and not a little anxiety, on many reservations by tribal and Indian Health Service personnel to develop formal civil commitment procedures (Gonzalez & Henderson, 1979).

Since the conclusion of *White v. Califano* in 1978, a number of tribes have begun to develop mechanisms for effecting the civil commitment of tribal members. These efforts are the first attempts to arrive at formal solutions to problems that had previously either been ignored or handled on informal bases. An examination of the emerging models is warranted, since they demonstrate some options available to tribes which are just now beginning to study the problem and to seek solutions appropriate for their own reservations. Additionally, the ways in which tribes implement civil commitment systems have implications for interaction between tribal, state and federal jurisdictions in other subject areas.

This paper begins with a summary of the findings of a survey of service providers from several reservations about their experience with patients for whom civil commitment was believed to be the only means of obtaining needed psychiatric care. Having oriented the reader to the problems at hand, the paper next describes the commitment procedures that have been developed by five different reservations, and which represent the emerging models noted above. Lastly, this paper closes by discussing the similarities and differences among these approaches, highlighting the innovative aspects of each, and considering the issues that may arise upon full implementation.

Methods

In an earlier publication we discussed in detail the problems that face many American Indian tribes when they seek involuntary mental health care for their members (Bloom, Manson, & Neligh, 1980). These problems are multi-dimensional, involving issues of jurisdiction, fiscal responsibility, and availability of appropriate treatment facilities (Henderson, 1982). We described the dilemma that such problems pose for the concerned parties, and examined the historical context which underpins this dilemma. Anecdotal information was presented to illustrate the various tolls of severe untreated mental illness in the communities in question. In an attempt to collect more data we conducted a series of workshops for providers on

several reservations. Workshop participants were asked about cases which might have been suitable for civil commitment, the extent to which these cases are typical, how frequently they occurred, the manner in which such cases came to their attention, and dispositions. Data collection was unsystematic, in that a self-selected group of participants provided information about memorable, and thus perhaps atypical cases. Nonetheless the responses help to illuminate the extent of the problems.

Twenty-two workshop participants responded to a brief self-administered questionnaire. Twenty of the respondents were mental health or social service providers. Most were employed by the Indian Health Service (IHS). Some tribal program staffs were also represented. These were experienced individuals, having served in their present positions an average of 4 1/2 years, with an average of 14 years of professional experience.

The group identified 181 cases within the previous two years that, in their opinion, would have required commitment to obtain appropriate treatment. When asked to describe two cases in detail they noted 44 specific examples. Thirty-five percent of the latter came to their attention through IHS or tribal health care and social service programs, 29% through tribal law enforcement or tribal court, 17% through the individual's family, and 19% were observed in the community at large in a variety of ways that reflected no clear pattern of agency interaction. When asked to categorize these cases in a civil commitment framework, 40% of the cases were designated dangerous to others, 32% were thought to be dangerous to themselves, and 26% were believed to be incapable of caring for themselves.

Turning to dispositions, the respondents reported that no action was taken in 27% of the cases. Twenty-eight percent of the cases cited ended in criminal proceedings resulting in either incarceration or outright release with no treatment plans. Twenty-two percent of the cases were successfully persuaded to seek voluntary treatment or hospitalization. Seventeen percent resulted in civil commitment proceedings, one-third of those occurring in tribal courts which, at that time, had few treatment options for the "committed" person. The respondents described only a moderate likelihood that persons such as those represented by these case examples would obtain treatment. They clearly felt these cases were highly typical of the others that they regularly encounter.

Based on these workshops and on our previous experience, we believe that there are a significant number of mentally ill Indian people who fit typical civil commitment criteria and who do *not* receive appropriate treatment. Many end up in the tribal criminal justice system without treatment; some stay within the communities, untreated, and for the most part avoided by other tribal members.

Workshop discussions suggested a number of factors that have contributed to these circumstances. First, there seldom is a close working relationship between reservation programs and state authorities. Many of

the workshop participants did not even know their state counterparts, and only a few had ever visited any of the state facilities. Second, most reservations lacked appropriate facilities for the care of acutely mentally ill patients. There are virtually no secure beds available in either the tribal or local IHS system. Third, both direct care and contract health monies are scarce, which leads to drastic underfunding of acute mental health services. The lack of money is compounded by the existence of three separate jurisdictions (federal, state, and tribal), each of which has its own funding priorities. Fourth, the IHS has adopted a policy of not participating in detaining or transporting involuntary patients. Thus IHS is not equipped to deal with the needs of acutely mentally ill patients who are non-cooperative. Fifth, there is no federal civil commitment process. Though the ruling in *White v. Califano* placed the responsibility for the commitment and treatment of American Indians squarely on the federal government in the 8th circuit, neither IHS nor any federal agency has a pre-existing mechanism for complying even if given the authority by Congress. Finally, despite elaborate and well-articulated tribal codes in certain civil and criminal matters, few tribes have specific tribal mental health codes and virtually none have previously developed civil commitment provisions.

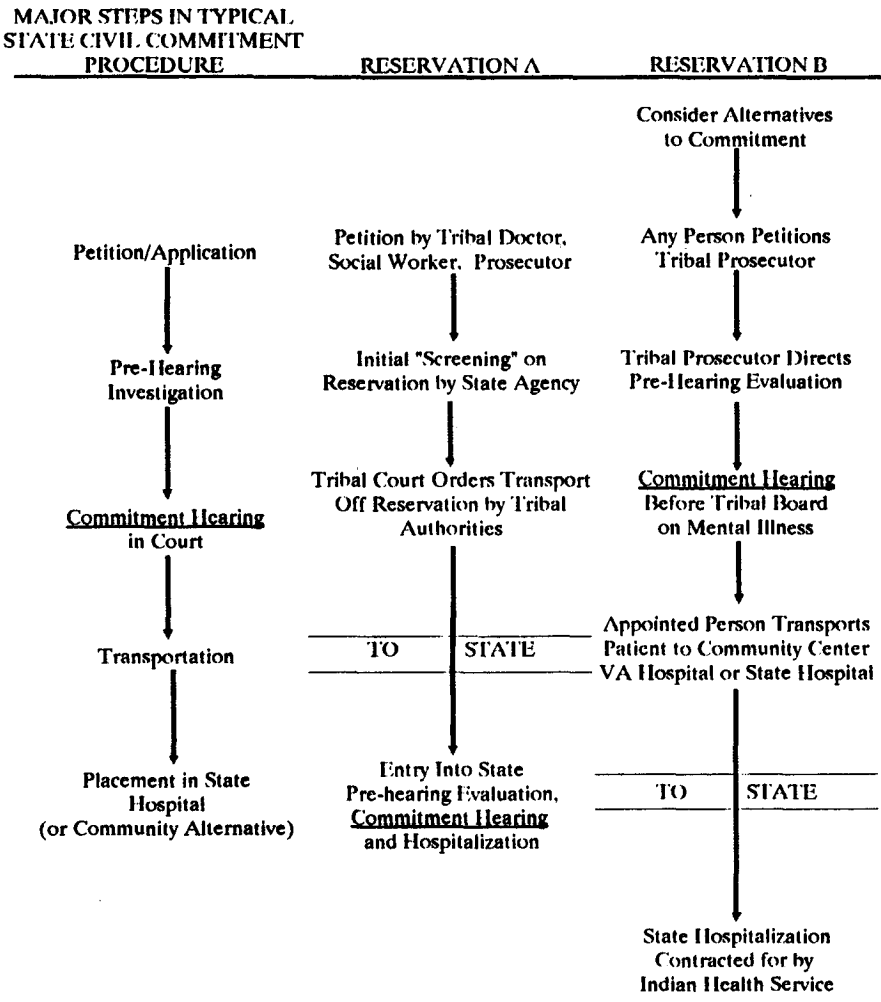
Results

Subsequent to *White v. Califano*, at least five tribes have developed civil commitment procedures. There are others in various stages of formulation, but are not yet sufficiently complete to present. The salient features of each of the five commitment procedures are outlined below and are summarized in Table I. We have chosen not to name the tribal communities from which these examples are drawn.[2] All five procedures include cooperative agreements among the major parties: the tribe and its court, the IHS, and the state government. In each instance, civil commitment procedures have been incorporated in the tribal codes.

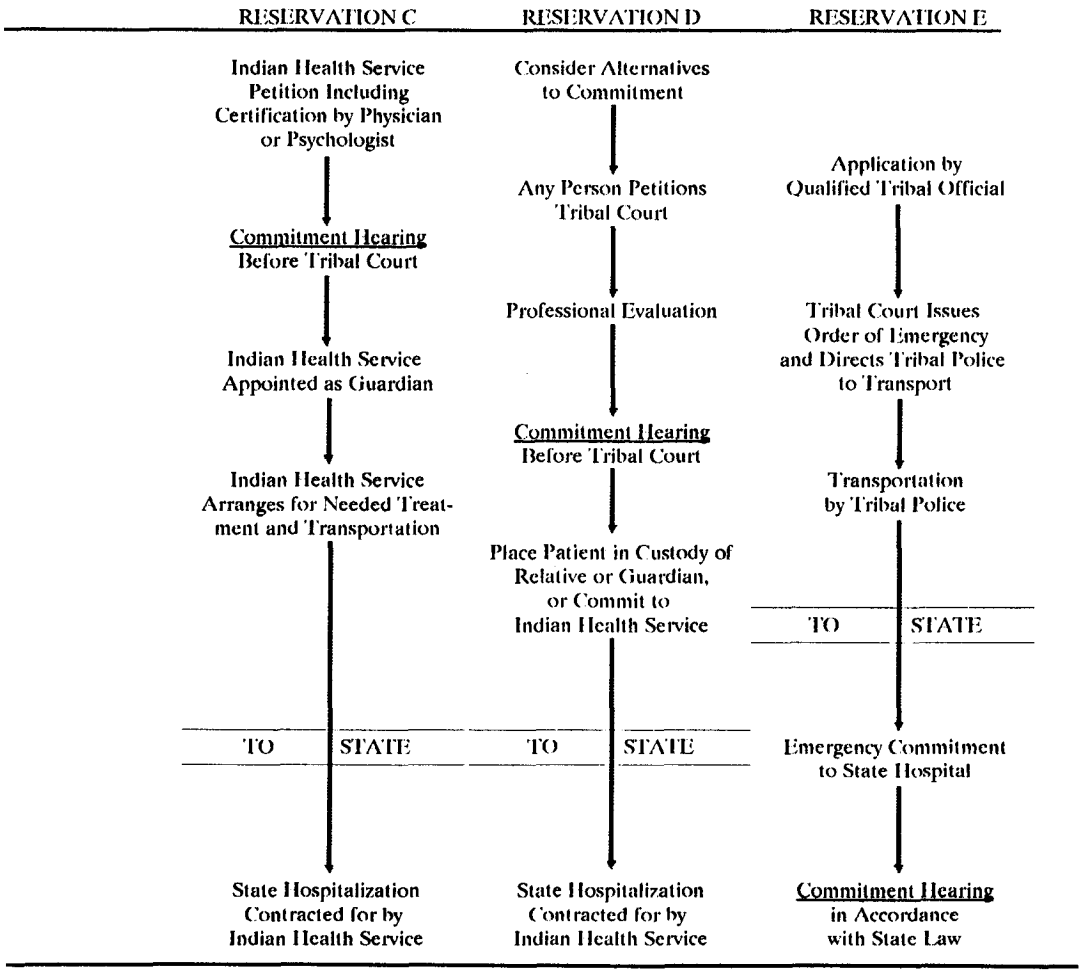
Any tribe that attempts to develop such a system encounters multiple layers of difficult decisions. One is the usual set of choices about what procedures will be effective as well as lawful. These decisions are similar to those faced by any state which revises its civil commitment procedures in light of current medical and legal thought, as well as economic reality.

Indian tribes are faced with additional considerations which make their task more complex and difficult. One group of considerations surrounds cultural values and traditions that may affect the acceptability and effectiveness of a proposed civil commitment system. Civil commitment often is seen as tantamount to expulsion from the tribe, which traditionally constitutes the most serious and unforgiving form of social control. Another area of complexity is the existence of multiple legal frameworks that are often poorly delineated. For instance, on many reservations tribal, state, and federal authorities have certain

TABLE I STEPS IN FIVE EMERGING



TRIBAL MODELS FOR CIVIL COMMITMENT



responsibilities and jurisdictions which may overlap, or, conversely, may totally disregard important needs. Thus, a major problem in developing civil commitment procedures is to decide which portions of the process should be handled by tribal, state, or federal mechanisms. This presents practical, as well as legal complexities. Finally, once these decisions are made, implementing them presents yet another set of difficulties. Will the actors in the various jurisdictions work cooperatively? Who will pay for the very expensive components of the process such as courts, attorneys, transportation, and hospitalization?

The systems being developed illustrate how some tribal governments have chosen to approach the problems just noted. Five emerging models for civil commitment are outlined in Table 1 and discussed below.

The models share many basic features. Each model incorporates steps designed to satisfy traditional notions of due process; thus, as shown in Table 1, each model has many similarities with conventional state commitment procedures. Each model starts with a tribal process, embodied in additions to tribal code. Each model ultimately relies on state hospitals to provide treatment. Although the judge in *White v. Califano* noted that the federal government could provide facilities for involuntary mental hospitalization on the reservation (as could the tribe itself) none of these models adopt that approach.

The models differ from each other in the number and types of steps taken by tribal authorities and courts. They also display variations in the fundamental issues around transferring the patient to the state. At what point in the process is this done? Is it done by a transfer of jurisdiction (in spite of *White v. Califano's* disapproval of this procedure) or by contract or by an unspecified process?

To allow the reader to see the complexities of these models and to compare their approaches, we turn now to a detailed description of the procedures utilized.

Reservation A

Reservation A is located in the Southwest, adjacent to a large metropolitan area, and is inhabited by a single tribe. Its approximately 4,200 residents live in a series of villages. A full range of outpatient health and mental health services are available on reservation. Dental and primary health care are provided by the Indian Health Service; the tribe operates an active mental health program. A large community mental health center and several hospitals are located off-reservation in the nearby city. As might be expected, given its proximity to an urban environment, the tribe living on this reservation has experienced rapid social and cultural change, yet manages to retain much of its heritage.

This community has chosen to have the tribe conduct only the preliminary steps in the commitment process. Following this initial

on-reservation activity, the individual is taken off the reservation and turned over to the state authorities for processing through the usual state civil commitment procedures. This process can be conceptualized in four steps: 1) tribal petition, 2) on-reservation screening by state agency, 3) transportation to state facility, and 4) the state's commitment process. Any physician, social worker, or prosecutor for the Indian community may apply for a court-ordered mental health evaluation of a person they feel to be, as a result of a mental disorder, a danger to self or to others or gravely disabled and who is unwilling to undergo a voluntary evaluation. The operative terms are defined in the tribal ordinance. The tribal court then decides if there is reasonable cause on the face of the petition to believe the allegations. If so, the court "requests" that a named state mental health agency screen the person.

The screening is conducted *on* reservation unless the tribal court finds that it is in the person's best interest to do the screening elsewhere. The person screened is not held in custody unless he or she is found likely to present a danger to self or others as a result of mental disorder, at which time the tribal court may order emergency detention. If detained, the person is told of the reasons for being held, of his or her right to a hearing, and of right to counsel. In any case, the person is not to be detained longer than is necessary to complete the screening and to submit a report to the tribal court. If the screening agency determines that there is reasonable cause *and* the patient refuses voluntary processing by the state or is likely to be a source of danger to self or to others before he or she would receive voluntary evaluation, the tribal court must order transportation to a mental health agency off the reservation, licensed by the state and recognized by the tribe. The tribal court serves as the "temporary guardian" for the purpose of transporting the person off reservation to the state authorities.

In this model subsequent evaluation and commitment procedures occur under state law. If committed, the person will be hospitalized in a state institution. To implement this part of the procedure, tribal and state officials have signed a memo of understanding. In this memo the tribe and its court agree to request initial screening from the state agency and to provide needed transportation. The state agency agrees to provide screening and to petition the state court for commitment of reservation residents to the state hospital when needed. The state hospital agrees to accept patients from the reservation who have been committed according to state law and to involve tribal authority in planning for discharge of patients back to the reservation.

The tribal ordinance adopting this procedure specifies that it is intended to provide mental health services to reservation residents. The ordinance notes that neither the facilities nor the expertise necessary to provide the services are available on the reservation, and that the state does not have the legal authority to provide involuntary mental health treatment to residents on the reservation. Thus the ordinance refers to the "Memo of Understanding" discussed above which, in conjunction with the

tribal procedures adopted in its ordinance, provides for involuntary mental health treatment by the state off reservation.

Reservation B

Reservation B is located in the northern Midwest, and is among the largest reservations in the country. The community numbers over 10,000 members from one Plains tribe, who are dispersed across the reservation in towns and villages ranging from 75 to 1,500 residents. This reservation supports a full complement of outpatient health and mental health services. The former are provided through the Indian Health Service; the latter are offered through the tribe. Tribal court and tribal law enforcement personnel are in close contact with the mental health program. There is a hospital on-reservation, but no beds are designated for mental health care. The Indian Health Service recently opened an in-patient psychiatric facility in a distant city to which some tribal members have been referred. This reservation community has resisted contemporary acculturative pressures and maintains an active ceremonial life.

By contrast with the above procedure, this tribe's approach relies much less on the state, as the entire commitment process is conducted by tribal authorities on reservation. If committed by the tribe the person may then be hospitalized, by agreement, in a state facility. The costs of hospitalization are paid by the Indian Health Service on behalf of the tribe. Another notable aspect is that the ordinance adopting procedures to commit mentally ill and dangerous tribal members explicitly provides for respecting tribal customs and traditions.

The procedure consists of six steps: 1) determination of available and realistic alternatives to commitment, 2) petition, 3) examination, 4) hearing, 5) transportation, and 6) review. Before involuntary commitment for mental illness is commenced, the immediate family of the individual in question must meet with the chief tribal judge, a qualified mental health professional or physician, and the tribal prosecutor to determine if there is an available and realistic alternative to commitment. This is an attempt to respect traditional methods of dealing with mental illness within familial and tribal support systems. If no alternative is found, any person may provide the tribal prosecutor with information sufficient to prepare a petition for commitment. The tribal prosecutor investigates the grounds for the petition and, within seven days, submits the petition and a written report to the Chairman of the Tribal Health Board on Mental Illness as to whether or not probable cause exists that the person in question is mentally ill. It is expected that the applicant will have made a "reasonable effort" to secure a certificate of examination of the individual in question which is to accompany the petition. If not, the petition must be accompanied by a detailed affidavit that explains the reasons for lack of such a certificate.

Given probable cause that the person is mentally ill, the Chairman of the Tribal Health Board issues an order to the Clerk of the Tribal Court

to convene a decision-making group called the Reservation Board of Mental Illness for a hearing on the petition within seven days. The tribal police personally serve the allegedly mentally ill person with copies of the petition and written notice of the hearing at least five days prior to the hearing date. The notice of the hearing includes the time, date, and place of hearing (usually the tribal courthouse unless the Chairman of the reservation board designates some other facility), notice of the right to counsel, and notice that he or she must be examined by a qualified mental health professional or physician to be designated by the chairman of the reservation board, and notice of the right to obtain an additional examination at the person's own expense. The chairman is authorized to compel the individual's compliance, with respect to the examination as well as attendance at the hearing.

At the hearing, if the board finds clear and convincing evidence that the individual is mentally ill and in need of treatment, the board by written finding may order him or her to undergo either inpatient or outpatient treatment at an appropriate facility, including a community mental health center, a VA hospital, or a state psychiatric institute. Should the person not comply, the board holds another hearing to determine compliance or non-compliance. If it is determined that the individual will not voluntarily accept treatment, the chairman of the reservation board is authorized to appoint someone (other than a relative of the patient) to transport the individual to the hospital wherein he or she is admitted for treatment and regularly reviewed by the board.

There is a separate procedure for persons who are alleged to be mentally ill *and* of danger to self or others. Any person age 16 or older may petition the chairman of the reservation board, attesting to these conditions, specifying the nature of the danger, summarizing the observations upon which the statement of danger is based, and stating the facts which called the person to the applicant's attention. If the chairman of the reservation board of mental illness concludes that the individual in question may be mentally ill *and* dangerous, then he can order the apprehension and transportation of the allegedly mentally ill person to an appropriate facility where he or she may not be held longer than 24 hours unless it is a properly equipped community mental health center or hospital. Immediately upon taking the person into custody, he or she must be notified of the right to a hearing within five days and of right to counsel. Within 24 hours of the apprehension of an individual who required emergency admission, a qualified mental health professional or physician shall examine him or her and immediately report the findings to the chairman of the reservation board of mental illness. The subsequent hearing is conducted as before and, if the individual is ordered to remain in the facility, a review is conducted after 90 days. Tribal police provide all necessary transportation.

As noted above, any hospitalization in a state facility which results from either of the above procedures is paid for by the Indian Health Service.

Reservation C

Reservation C is located in the northern midwest as well, but west of Reservation B. It is a small reservation that is inhabited by two tribes, one which was originally from the plains and the other from the northern woodlands. The local population numbers about 2,200. Like the others, this community has outpatient health and mental health services on reservation, with a similar division of tribal and Indian Health Service responsibilities. In-patient care is obtained in either of two distant hospitals.

The procedures developed here are similar to those on Reservation B. This ordinance also requires, where possible, a preliminary meeting with the mentally ill person's family to determine if there are culturally acceptable alternatives to commitment. Here, too, the actual commitment hearing is conducted on the reservation by the tribe--although by the tribal court, rather than by a board of mental illness as on the Reservation B.

A significant difference is that commitment is made to the Indian Health Service for treatment, not directly to a state or other facility. To implement its responsibilities to provide treatment to those committed to it, IHS has contracted with providers of appropriate hospital and treatment services. Thus, as on Reservation B, payment for treatment is provided through IHS, but by a somewhat different mechanism.

This tribe chose to adopt procedural and substantive standards for civil commitment which are virtually identical to those of the state in which the reservation is located. It was felt that this would facilitate cooperation by state facilities with IHS and would tend to avoid legal challenges.

The procedure consists of five steps: 1) petition, 2) certification, 3) hearing, 4) appointment of the Indian Health Service as guardian, and 5) transportation to hospitalization. In this case, the IHS is presumed to be the petitioner, identifying the allegedly mentally ill person, and attesting to the fact that he or she "is mentally ill, incompetent, and lacks the capacity to make informed decisions about treatment." The petitioners must attest to the fact that the person named is likely to harm himself or others unless he or she receives treatment, that the IHS is qualified and willing to be his or her guardian, that the IHS does not seek guardianship over his or her estate, and that the IHS can arrange for psychological and medical care which is likely to benefit the individual in question. Documentation must accompany the petition certifying that (a) either a licensed clinical psychologist or licensed physician personally examined the individual within a specified seven day period, (b) that the person is mentally ill at the time of the petition, (c) that in the absence of treatment the examiner believes that this mental illness is likely to cause major distress which will result in serious mental or physical deterioration, (d) that treatment is available which is likely to avoid serious mental or physical deterioration in the individual in question, (e) that this same person lacks the capacity to make informed decisions about treatment, and (f) that he or she is likely to harm himself or others or if he or she does not receive treatment.

On the basis of this petition and certification, the tribal court convenes a hearing. On the basis of evidence from witnesses and the certification warrant, the tribal court may appoint the IHS as guardian of the individual. This action requires findings that the person named is an enrolled member of the tribe, is physically present on the reservation, is mentally ill and lacks the capacity to make informed decisions about treatment, that the IHS can arrange for medical and psychological treatment which is likely to benefit him or her, and that he or she is likely to harm himself or others unless he or she receives treatment. The tribal court appoints the IHS guardian for 90 days to effect the necessary treatment.

Reservation D

Reservation D is a small reservation located in the Great Basin area of the rural central West. Inhabited by two small tribes, this community numbers approximately 1,800 members. Health care is limited and is provided by the Indian Health Service. The mental health services consist of a supportive counseling program with part-time psychological consultation. In-patient facilities are located off-reservation in a large metropolitan area at some distance from this community.

This reservation has proposed procedures which also rely heavily on IHS. The tribal court can appoint IHS to arrange individualized treatment and transportation as necessary. The procedure can be described as follows: 1) determination of alternatives to commitment, 2) petition, 3) evaluation, 4) hearing, 5) disposition, and 6) hospitalization. Before involuntary commitment for mental illness is initiated, the immediate family of the individual in question is to meet with the chief tribal judge, a qualified professional person and the tribal prosecutor to determine if an alternative to commitment is available and realistic. If not, the applicant petitions the tribal court, stating that he or she believes that the person is, as a result of mental illness, a danger to self or others, indicating the specific nature of the danger, summarizing the observation upon which this statement of danger is based, and describing the facts that called the person to be committed to the applicant's attention. A professional evaluation is to accompany the petition if at all possible. The tribal court may find that on the basis of the petition an emergency situation exists, and can then order the respondent to be detained in the least restrictive environment necessary to protect others or the individual. Detention may not exceed 72 hours; an evaluation is mandated within this period. If the tribal court finds probable cause, a hearing is set no later than seven days from the date of the petition. The allegedly mentally ill person, the responsible person, counsel for the respondent, and the professional person are notified of the hearing date, the former in writing, the latter three verbally. If the respondent has not recently been evaluated by a professional person, the court requests such evaluation. The court is authorized to apprehend and detain the individual

in question to achieve the evaluation if he or she does not voluntarily submit to it.

A hearing is held to determine whether the evidence proves beyond a reasonable doubt that the person is seriously mentally ill, which is defined to mean that the individual in question suffers from a mental disorder and that this disorder "has resulted in self-inflicted injury or injury to others or the imminent threat thereof or has deprived the person afflicted of the ability to protect his or her life or health." If the respondent is determined to be seriously mentally ill at the conclusion of the hearing, the court may either commit the patient to the IHS for treatment for a period not to exceed 90 days or order the patient to be placed in the custody of his relatives, guardian, or some other appropriate place. In each case the court is obliged to choose the least restrictive alternative necessary to protect the patient and the public. IHS may contract for hospitalization in a state facility.

Reservation E

Reservation E is located in the Pacific Northwest and encompasses a large tract of land that extends from the foothills of the mountains to the arroyos of a semi-arid central plateau. Tribal membership numbers approximately 3,800 and is comprised of several confederated tribes. The health and mental health facilities on reservation include a wide range of outpatient services. Most of these services are tribally operated, though primary care remains an Indian Health Service responsibility. A tribal court hears criminal and civil matters and works closely with tribal mental health personnel. The nearest hospital, to which the IHS physicians and tribal psychiatrist have admitting privileges, is located off-reservation in a small rural town. The tribes living on Reservation E have been subjected to a long history of acculturative pressures, but much of the traditional ceremonial life has remained intact, and is undergoing active revitalization.

This reservation is enacting procedures that allow transfer of the mentally ill reservation resident to the state for civil commitment, similar to the mechanism of Reservation A. However, unlike Reservation A, state authorities do not come onto the reservation to conduct the screening. Rather, the amended tribal code allows the tribal court to order prompt emergency detention and transportation of patients off the reservation by the tribal police. Pursuant to a memorandum of agreement with the state mental health division, the patient is then admitted to a state hospital under the emergency commitment provisions of state law.

The procedure consists of five steps: 1) application, 2) emergency detention order, 3) transportation, 4) emergency commitment to state hospital and 5) state's commitment process. By sworn affidavit or on the record in tribal court, any qualified tribal official may apply for an order of emergency detention. Qualified tribal officials are reservation physicians, the tribal mental health director, or the tribal health and social service manager. The application must establish that the patient is a mentally ill

person under tribal jurisdiction, and the reasons why short or long term emergency detention is needed. The tribal court then determines if the patient is under its jurisdiction, if there is probable cause to believe the person is mentally ill as defined in the code, and whether the patient poses serious harm or danger to self or others requiring immediate detention. No screening or hearing is required to make this determination; rather it apparently can be made summarily by the court. A mentally ill person is defined identically as in state law as a person who, because of a mental disorder, is either a) dangerous to himself or others or b) unable to provide for his basic needs and is not receiving such care as is necessary for his health or safety.

If the tribal court issues an emergency detention order, the tribal police, who are cross-deputized as county sheriffs, are directed to take the person into custody and transport him off the reservation to a state hospital. In accordance with state statutes the state mental health division has contracted with the tribe to provide services in the same manner as is done with county mental health programs. Thus, the mentally ill person is admitted to the state hospital under state emergency commitment procedures for a maximum of 15 days. If additional hospitalization is needed, full civil commitment proceedings can be initiated by the state hospital staff. The tribe agrees to cooperate with investigation needed prior to a commitment hearing.

Discussion

As noted, these civil commitment procedures represent the first attempts by tribes to develop systematic approaches to effecting involuntary psychiatric observation and treatment for dangerously mentally ill community members. They are being closely studied by many other tribes for possible application in different settings. Undoubtedly, these procedures will have to be modified to fit local circumstances; moreover, they will surely evolve in response to problems that may arise during implementation.

Legal challenges may constitute a major set of problems. Considering just Reservation A, for example, the adopted procedure is inconsistent with the reasoning of *White v. Califano*, though this particular community does *not* fall within the 8th circuit. In the 8th circuit, entry onto the reservation by state authorities to conduct the screening would represent an unconstitutional invasion of tribal sovereignty. The District Court explicitly stated that even a cooperative agreement between the tribe and the state providing for intrusion into Indian country would be unlawful[3]. However, if this aspect of the procedure was challenged at Reservation A, or other reservations with similar approaches, there might be several ways of overcoming the objection. First, of course, the controlling district and circuit courts might reject the reasoning of the 8th circuit. Second, even following the 8th circuit's reasoning, it might be successfully argued that

when the "qualified agency" or other authorities enter the reservation to conduct the screening, they are *not* acting in their state capacities, but are merely providing a service by contract to the tribe. A "Memo of Understanding" that accompanies the newly developed commitment procedure indicates that the state apparently will pay for such screenings. If so, the claim that they are merely acting as agents of the tribe by contract may be weakened.

A second potential legal problem in Reservation A's procedure is that after the person is referred to a "qualified evaluation agency" (actually a state institution of one form or another), jurisdiction is apparently assumed by the state. The 8th circuit ruled that jurisdiction can be assumed by a state over civil matters arising on the reservation only with the consent of a majority vote of the enrolled Indians within the affected area[4], not just by tribal council action - as apparently is the case in Reservation A's procedure. A vote of the tribal members is, then, one possible solution.

Third, the procedure provides for transportation of a person (including against his or her will) off reservation by tribal authorities. This aspect might be challenged as beyond the power and jurisdiction of the tribe. Apart from whether or not such a challenge would be successful, the threat of it alone might make tribal police (and others involved in transportation) reluctant to proceed beyond the reservation boundaries. This potential problem is lessened, or at least greatly alleviated, if tribal police are cross-deputized in the adjacent state at least for purposes of transportation.

Another type of legal problem that might arise is illustrated by Reservation E's model. The tribal code, which provides for emergency detention orders, gives the patient no procedural rights such as notice, a hearing, or representation. Although this is consistent on its face with the summary procedures, the state statute allows the use of the summary procedure only when no state judge is available in an emergency. However, under the tribal code, a tribal judge is issuing the order. A challenge could arise to the use of this summary procedure as being in violation of the Indian Civil Rights Act[3].

Although the new commitment procedures may encounter some legal challenges, postponing action for fear of potential litigation would needlessly hamper obtaining badly needed psychiatric care for severely mentally ill persons who pose a danger to self and to others. If, with the cooperation of all parties, procedures are developed which provide the necessary services, legal challenges will be unlikely. Ultimately the success of these emerging processes will depend on the cooperation of many persons and agencies in overlapping legal jurisdictions. The development of the models discussed has demonstrated the ability of tribes and states to work together in spite of the practical and legal difficulties of solving the complex problems surrounding the commitment of Indians residing on reservations.

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Notes

1. *White v. Califano*, 437 F. Supp 543 (Dist. S. Dakota, 1977), Affirmed 581 F-2d-697 (8th Cir. 1978).

2. We do not name the tribes because of the nature of our research agreements with the Indian Health Service. Readers interested in additional detail are invited to contact the authors.

3. *White v. Califano*, supra., 437 F. Supp at pp 549-551.

4. Title 25, United States Code, Section 1301 et. seq.

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