CHAPTER 12
American-Indian Mental Health Service Delivery
Persistent Challenges and Future Prospects
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As early as the Community Mental Health Movement of the 1960s, psychologists have recognized that conventional mental health services have failed to reach a significant segment of the American population who might truly benefit from appropriate support and assistance while experiencing profound psychological distress (Albee, 1968). Although this observation continues to characterize service delivery with regard to many troubled persons in today’s society, it would be difficult to identify a more underserved group of people than this country’s small population of American Indians and Alaskan Natives (Nelson, McCoy, Streiter, & Vanderwagen, 1992). The cultural, political, and economic isolation of Native Americans from adequate mental health services is even more remarkable when one considers that the federal government is legally and morally obligated to provide such services, given the unique political status of tribal groups in their historic government-to-government relationship with the United States (LaFromboise, 1988; Pevar, 1992). This chapter reviews the principal challenges confronting mental health researchers, professionals, and policymakers as they seek to most effectively address the mental health needs of American Indians before suggesting alternatives to conventional mental health service delivery. It is the firm conviction that Native American people deserve fully accessible, culturally appropriate, and demonstrably effective mental health services during times of psychological distress that motivates this chapter’s commitment to re-envisioning mental health service delivery in American-Indian communities.

THE INSTITUTIONAL CONTEXTS OF MENTAL HEALTH SERVICE DELIVERY IN INDIAN COUNTRY

Any valid assessment of the status of mental health services for Native American communities must begin with a basic understanding of tribal sovereignty and the U.S.
federal Trust Responsibility, which provides the requisite political and legal contexts for re-envisioning Indian mental health service delivery.

Tribal Nations

The United States currently maintains government-to-government relationships with some 560 federally recognized tribes of American Indians or Alaska Natives. These tribal groups are the surviving remnants of a pre-Columbian U.S. indigenous population of over 5 million individuals comprising over 400 cultures prior to the American colo-
nial holocaust (which reduced the population to just 250,000 by the close of the 19th century). Even today, the cultural diversity of Native America renders virtually any generalization about American Indian problems. What most Native Americans do share in common, however, is the legacy of European-American colonization. Owing primarily to a history of treaty-making with the United States prior to 1871, contemporary tribal communities are recognized by the federal government as "domestic, depen-
dent nations" that exercise constitutionally limited powers of sovereignty attendant to this status. Moreover, Congress maintains a "general trust relationship" with these federally recognized tribal nations, which is "marked by peculiar and cardinal distinc-
tions which exist nowhere else" in Western jurisprudence, according to the Supreme Court. This trust responsibility "enables a fact to an individual and implies a federal "duty of protection." History routinely attests, however, to the failure of the United States to fulfill this obligation of trust and protection to tribal nations. (See Poore, 1992, for a thorough and accessible overview of federal Indian law and practice.)

The most recent U.S. census (U.S. Census Bureau, 2002) determined that 2.5 million Americans identified solely as American Indian or Alaska Native, with an additional 1.6 million identifying as multiracial with Native American ancestry. Taken together, these individuals comprise 1.5% of the population of the United States. Cen-
sus identification trends over the past few decades indicate that more Americans are choosing to identify as American Indian or Alaska Native over time because both birth rates alone cannot possibly account for the increasing growth in the self-identified popula-
tion during this period. Thus, one of the dilemmas confronting American Indian mental health researchers is simply determining who in fact is an Indian for the purposes of their investigations. Inasmuch as American-Indian identity attributes are both complex and contested (Gose, in press), easily confusing the range of simplistic (usually essentialist) conceptual strategies, any particular approach to defining "Indianeness" is vulnerable to critique or complaint. Nevertheless, for this chapter, an American Indian or Alaska Native is simply defined as an enrolled member (or "citizen") of a federally recognized tribal nation.

There are many reasons for privileging African-American identity over Indian identity, namely through the federal programs provided on behalf of tribal nations and their citizens in fulfillment of the federal Trust Responsibility. Thus, in contrast to

the 2.5 million Americans who self-identified solely as American Indian or Alaska Native in the most recent U.S. census, this chapter will instead consider the 1.4 mil-
lion enrolled members of federally recognized tribal nations as the population of Na-
tive Americans of interest owing to the significance of the federal services context for the discussion to follow. Once again, however, it is crucial to note that this conserva-
tive strategy for defining "Indianeness" overlooks many categories of people who might legitimately lay claim to viable American-Indian identities.

The kind, quality, and number of federal governmental institutions and programs that most American-Indian people—especially those residing on reservations—encounter on a daily basis are difficult to adequately convey to mainstream Americans. Fortunately, during the Nixon administration Congress passed Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1975. This law sought:

To respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities. As a result, modern tribal governments wield substantial influence in their dealings with federal agencies and can even "contract for" directly administer federal programs and services to their own communities using the same federal dollars that would oth-
erwise sustain the programmatic activities of the relevant agency.

The purpose of describing the governmental-tribal-governmental relationship in such detail is twofold. First, it affords the unfamiliar reader some sense of the scope and complexity of Indian affairs in the United States. Whether codified in fed-
eral law, established through bureaucratic processes, or defined by moral and ethical obligation, or exacted by modern, politically savvy tribal leaders, the state apparatus designed to regulate and control, support and protect Native Americans—just 1% of the population of the United States—is monolithic. Most important, this distinctively American colonial legacy yields a notion of "Indianeness" as not merely another race, ethnicity, or subculture, but instead as an utterly unique political status afforded to citizens of tribal nations that traces its origins to the Commerce and Treaty clauses of the U.S. Constitution.

Second, this review illuminates the degree to which government intrusion and control has shaped American-Indian lives historically and renders contemporary reactions of cynicism and suspicion within Indian communities toward such intervention intelligible. That is, the long colonial history endured by American Indians and Alaska Natives has profound psychological consequences for both individuals and their commu-
nities, ranging from the idiosyncratic fear and hatred of European-Americans in some instances to a more general (often desperate) pursuit of postcolonial alternatives for grounding personal and communal meaning-making. It is this latter, nearly frantic search for a viable postcolonial source of coherence, connectedness, and continuity that renders the colonial legacy utterly inextricable from contemporary concerns about American-Indian mental health.
The Indian Health Service

Within the federal services context, the principal health care organization entrusted with providing health and mental health services to the enrolled members of federally recognized tribes is that branch of the U.S. Public Health Service known as the Indian Health Service (IHS). Although American Indians and Alaska Natives are technically eligible for health services through the usual venues that provide health care for other Americans (e.g., state and county health clinics, Health Maintenance Organizations, or professionals in private practice), many enrolled tribal members depend primarily on the largely reservation-based IHS for a wide variety of health care services, including mental health services.

Legal Authority and Organization

As one expression of its Trust Responsibility for tribal nations, Congress passed the Snyder Act in 1921 authorizing health services for American Indians to be administered through the Bureaus of Indian Affairs (or BIA). In the mid-1930s, Congress established the IHS to assume responsibility for such services. In addition to this early legislative authority, the federal obligation to provide health services to Native Americans was bolstered by Public Law 94-437, the Indian Health Care Improvement Act of 1976. In response to findings that American Indians and Alaska Natives suffered from much poorer health status than other Americans, Congress boldly declared that:

- It is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all the resources necessary to effect that policy.

Thus, the Indian Health Care Improvement Act—enacted three times since 1976—remains the modern legal capstone supporting federal provision of health services to Native Americans. Despite this express legal commitment to providing "all the resources necessary to effect improved health status in tribal communities, both urban and rural," the Director of the IHS recently commissioned a study that determined that recent Congressional allocations to the IHS represented just 52% of the costs of hypothetically assuring personal health services to a comparable number of federal employees (Federal Disparity Index Workgroup, 2002).

The IHS serves the enrolled members of federally recognized tribes and their descendants, currently comprising a service population (defined as eligible persons residing in geographic areas for which the IHS maintains responsibilities) estimated at 1.5 million (IHS, 2002). Empowering a staff of nearly 16,000 from every conceivable health care profession with an annual appropriation of roughly $2.9 billion, the IHS is organized into 12 regional administrative units called Area Offices that are collectively overseen by a Central Office. Within these IHS regional Areas, direct health care services are typically provided by the most basic administrative unit within the IHS, the community-based Service Unit. The Service Unit may include a hospital, clinic, or health station, depending on local need and budgetary considerations, and typically administers a wide range of health programs, including primary medical care, behavioral health, substance abuse treatment, health education, injury prevention, public health nursing, and sanitation facility services. As of October 1998, the IHS directly administered 66 Service Units (IHS). Although American Indians and Alaska Natives are technically eligible for health services through the Self-Determination Act to directly administer 85 Service Units. In sum, the IHS provided health services to American Indians and Alaska Natives through 59 health centers, 44 health stations, 37 hospitals, and four school-based health centers, while tribal governments contracted to provide their own health services through 155 health centers, 76 health stations, 12 hospitals, three school-based health clinics, and 160 Alaska village clinics. In addition to these reservation-based health programs, the IHS also funded 36 urban Indian health projects (IHS, 1998–1999) for Native Americans who have relocated to large urban centers. Approximately 80% of all IHS Service Units maintain mental health (or "behavioral health") programs tasked explicitly with meeting the mental health needs of Indian country.

Indian Health Service Mental Health

The first IHS Office of Mental Health was established in 1965, with an annual appropriation of $500,000. More recently, the coordination of mental health and substance abuse services throughout Indian country has been assigned to the Mental Health Programs Branch and the Alcoholism/Substance Abuse Services Branch of the IHS. The Congressional allocations for these services appear as separate line items in the IHS budget, totaling $47 million for mental health services and $13.5 million for substance abuse services, respectively, during fiscal year 2002. Together, these allocations represent less than 7% of the total IHS budget this year. Within its mental health programs specifically, IHS employs over 500 full-time staff, including more than 20 psychiatrists, 60 psychologists, and 110 social workers (J. Davis-Hueston, personal communication, June 22, 2001). Because of a hiring policy that emphasizes Indian preference, the IHS mental health workforce is largely American Indian, although the majority of its professionals is largely European-American (with only two Indian psychologists and 17 Indian psychologists employed in the system). This trend among doctoral-level mental health professionals employed by the IHS does not reflect the fact that only 0.1% of clinically trained psychiatrists and 6% of clinically trained psychologists in the United States are American Indian or Alaska Native (West et al., 2000). In the context of these resources, the IHS anticipates providing mental health services at the annual rate of 200,000 "client contacts" (i.e., assessment or treatment sessions) during the current fiscal year. Although systematic information is difficult to obtain, a small body of sources indicate that the majority of these client contacts involve involvement in psychotherapy spanning a range of theoretical orientations. Although psychotherapeutic treatment is not uncommon either, it would appear that much of the responsibility for monitoring psychotherapeutic medications falls to general practitioners within the service system owing to the shortage of psychiatrists. Given the estimated size of the service population, the IHS currently employs...
among mental disorders was high, in that over 50% of those reporting diagnosable distress qualified for more than one lifetime diagnosis. Most importantly, only 40% of those with a lifetime disorder reported ever obtaining professional treatment for their problems.

The quandary evident in these statistics is not the higher-than-expected rates of psychiatric distress afflicting much of the adult American population, but the comparability of such rates to the actual availability of qualified mental health service providers to treat them. Consider that the entirety of clinically trained (although not necessarily clinically active) mental health professionals in the United States (including psychiatrists, psychologists, social workers, psychiatric nurses, counselors, marriage and family therapists, and school psychologists [see West et al., 2000]) counts just over 400,000 service providers for a national population of 280 million—a rate of approximately 150 mental health professionals per 100,000 populations. Even such a robust and appropriate mental health services than their reservation to financial constraints, transportation issues, unlicensed service providers, etc. Thus, service delivery issues related specifically to urban Native American mental health needs are even more contested than those described in the remainder of this chapter. (See Winko, in press, for the specific issues pertaining to American Indian mental health in urban settings.)

FORMIDABLE CHALLENGES CONFRONTING MENTAL HEALTH SERVICE DELIVERY IN INDIAN COUNTRY

The obstacles to delivering appropriate, accessible, and effective mental health services for American Indian and Alaska Native communities are manifold and complex. This section concentrates on two especially formidable challenges that warrant closer scrutiny in this regard: (a) the inadequate availability of conventional mental health services in Indian country; and (b) the inevitable cultural incongruence of conventional mental health interventions in Indian country.

Infinite Insufficiency

The first formidable challenge to delivering appropriate, accessible, and effective mental health services to American Indians represents a simple extension of a more general national quandary. The most recent, representative, and thorough national epidemiological survey of the prevalence of mental illness in America revealed that nearly half of the U.S. adult population suffered from a diagnosable mental disorder at some point in their lifetimes. The most recent, representational, and thorough national epidemiological survey of the prevalence of mental illness in America revealed that nearly half of the U.S. adult population suffered from a diagnosable mental disorder at some point in their lifetimes. The most recent, representative, and thorough national epidemiological survey of the prevalence of mental illness in America revealed that nearly half of the U.S. adult population suffered from a diagnosable mental disorder at some point in their lifetimes. The most recent, representative, and thorough national epidemiological survey of the prevalence of mental illness in America revealed that nearly half of the U.S. adult population suffered from a diagnosable DSM-III-R disorder was 48% in the adult population, including major depressive episodes (or clinical depression) among 17% of the population and alcohol dependence among 14% of the population. In addition, 29% of the adult population suffered from a diagnosable DSM-III-R disorder within the previous 12 months. Furthermore, comorbidity
likely to benefit Native persons in distress. In the absence of valid scientific data, professional claims regarding the effects of conventional mental health treatments for American-Indian clients or patients remain highly speculative. Therefore, I must leave the question of whether established interventions are effective and efficacious with Indian people to the realm of empirical investigation (see O'Neil, 1989, for a review and critique). In a report to the Senate Select Committee on Indian Affairs, Congress' Office of Technology Assessment (1990) reported that American-Indian adolescents were more likely to encounter problems related to developmental disability, depression, suicide, anxiety, alcohol and drug abuse, poor self-esteem and alienation, running away from home, leaving school prematurely, and possibly posttraumatic stress disorder in comparison to non-Indian adolescents. The trends in these studies clearly support the conventional wisdom among U.S. mental health professionals that American-Indian and Alaska-Native communities generally experience higher rates of distress than their mainstream counterparts. Nevertheless, mental health researchers are persistent in their call for more sophisticated, rigorous, and culturally appropriate studies to provide more conclusive information regarding mental health status within Native communities.

For now, the best available evidence reveals a key tension in Indian mental health, with overwhelming community need on the one hand and a limited professional base within these communities on the other. More specifically, if mental health experts are willing to stipulate that conventional mental health services are essential for the effective and humane treatment of distress in American-Indian and Alaska-Native lives, then it follows that the anticipated production of mental health professionals (especially at the doctoral level) who serve these communities, when compared to the evident levels of distress that confront them, is so discordant that it recommends despair. This infinite insufficiency of mental health resources in Indian country gives rise to an important question: Given that available resources will never be adequate to meet the needs of Indian communities under existing mental health service delivery conventions, how might researchers, practitioners, and policymakers effectively cultivate and multiply these limited resources such that they become more widely available for meeting the vast mental health needs of Indian country?

Inevitable Cultural Incongruence

There can be no question that the long search by mental health researchers for effective psychological treatments, treatments, and interventions has generated a variety of techniques that are clinically proven to reduce psychological suffering, impairment, and distress in the lives of individuals struggling with "mental illness" (see, e.g., Chambless & Ollendick, 2001). In fact, mental health professionals now command an arsenal of empirically supported treatments specifically developed to assist people suffering from nearly every major category of disorder classified in the DSM. Nevertheless, there is not a single, rigorously controlled outcome study that has assessed the efficacy and/or effectiveness of a conventional psychological intervention with American-Indian and Alaska-Native clients. It remains an empirical question, then, as to whether—and under what conditions—state-of-the-art mental health interventions are effective and efficacious with Indian people to the realm of empirical investigation.
deep cultural assumptions is the organizational segregation of "mental health" from the rest of biomedicine within Western health care systems. In contrast, most Native cultures conceptualize the person in holistic terms without fragmenting selves into physical, mental, and social components. Furthermore, most illness is understood in Native cultures to result from disordered spiritual and social relationships. Finally, and most importantly, healing in Native communities is modally understood to require access to sacred power. (For a more detailed review of such cultural contrasts, see Trninic, Masson, Dinges, & Medicine, 1984.) And yet, the Western cultural assumptions exported through conventional psychotherapeutic practices are not merely mundane ideological alternatives—instead, they emerged historically in the context of a brutal U.S. colonialism. Thus, any particular instance of an American-Indian client or patient seeking assistance from a Western mental health professional is inherently shaped by a colonial tradition of power relationships, the troubling implications of which have been widely unexamined within mental health research.

Given the inevitable cultural incongruities of Western mental health interventions with American-Indian and Alaska-Native ethnopsychologies in the historical context of U.S. conquest and colonialism, the disturbing possibility arises that conventional mental health practices may actively undermine the stated commitment of most contemporary tribal communities to cultural preservation and revitalization by hermetically displacing key facets of the local ethnopsychology with those of Western ethnopsychology. Thus, it would seem that providers of conventional mental health services must directly confront the distinct possibility that their therapeutic practices represent a nearly invisible (but ongoing) "cultural proselytization" of distressed Native clients in their most vulnerable hour. Based on this potential for subtle cultural proselytization (which follows, of course, from the inevitable cultural incongruence of conventional mental health services in Indian country), I suggest that embracing and disseminating Western mental health concepts in Native communities—particularly when there is no compelling empirical reason to do so—is not only counterproductive to cultural preservation and reproduction but also a clear extension of European-American ideological hegemony.

In one sense, then, this volume’s concern with resistance to multiculturalism in mental health service delivery is somewhat ironic, for it is the mental health profession as credentialed therapeutic expert—even when explicitly dedicated to cross-racial sensitivity and multicultural competency—who typically manages to "resist" the unsettling cultural implications of the deep Western ethnopsychological foundation on which the "talking cure" born in Vienna over a century ago ultimately rests. Even as American-Indian and Alaska-Native mental health professionals—having invested a great deal of time, energy, and money in our own training—are we reluctant to consider the sociocultural ramifications of our conventional practices within Native communities. In fact, when Indian psychologists actively resist the conventions of our training, we are most likely to disparage and dismiss the scientific foundations of disciplinary psychology while retaining a vast collection of concepts, categories, and commitments to human resource development, progressive political activity, and rigorous psychological science in the context of a paradigm that explicitly embraces

promise of empirically supported interventions on the one hand and the dangers of Western cultural imperialism on the other. This inevitable cultural incongruence of professional mental health practices with extant Native cultural tradition gives rise to a second important question: Given that even our empirically supported treatments have not been assessed with Indian people and depend on Western ethnopsychological theories of self, mind, and personhood, how might researchers, practitioners, and policymakers develop and assess interventions for Native communities that are culturally appropriate, demonstrably effective, and "empowering" in the American postcolonial context?

RE-ENVISIONING MENTAL HEALTH SERVICE DELIVERY IN INDIAN COUNTRY

This, then, is the crucible of mental health service delivery in American-Indian and Alaska-Native communities: The mental health needs of Indian country require a great deal more of the kinds of professional services that do not yet exist. That is, the infinite insufficiency of mental health resources in Indian country requires that mental health researchers, professionals, and policymakers find innovative opportunities to cultivate underdeveloped professional competencies in Native communities. They will promote wellness and prevent dysfunction with much greater efficiency thus established professional competencies currently afford. In addition, the inevitable cultural incongruence of Western clinical interventions (and their implicit Western ethnopsychology) with extant tribal traditions requires that mental health researchers, professionals, and policymakers sponsor innovative efforts to construct culturally local alternatives to the more conventional and familiar helping services. Finally, any call to innovation in the absence of an explicit commitment to systematic outcome assessment serves no one—the measured applicability of scientific methodology ensures that associated claims are disciplined by the evidence at hand. Taken together, these commitments provide the impetus for re-envisioning therapeutic intervention in American-Indian and Alaska-Native communities.

CULTIVATING UNDERDEVELOPED RESOURCES

Having observed that Indian country requires a great deal more of the kinds of mental health services that do not yet exist, I should quickly clarify that the lack of appropriate services in no way implies the lack of a well-established means of developing them. With specific regard to the project of cultivating underdeveloped helping resources in Native communities, the enduring legacy of community psychology affords a sophisticated approach to undertaking innovative work that required in Indian country. Established in the 1960s as a critical alternative to conventional clinical psychology, community psychology (Rappaport, 1977) has sought to integrate its professional and commitments to human resource development, progressive political activity, and rigorous psychological science in the context of a paradigm that explicitly embraces
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Beside the obvious ceremonial leaders, however, there are undoubtedly other classes of existing natural helpers. For example, most Indian leaders know that tribal affairs contract to administer the federal Community Health Representatives (CHR) Program. This program employs and trains paraprofessional staff who travel to the homes of the elderly and sick to deliver medications, check blood pressure or blood sugar, assist in limited home care, provide transportation to health care appointments, etc. Naturally, CHR providers regularly "counsel" those in their care by expressing empathetic support or offering helpful advice. In addition, they are frequently the first to know when struggling community members encounter crisis. As a result, the CHR providers within tribal communities retain an obvious mental health resource that is largely underutilized in the sense that they receive very limited training with regard to assisting persons in psychological distress—even a modest education and support structure within the local mental health service system could enable CHR providers to help community members cope more effectively with distress or refer community members to more experienced helpers in appropriate situations.

Additional examples of natural leaders who might substantially extend the reach of community-based service systems include tribal college students and key family members. On many reservations, tribal governments operate locally controlled community colleges that enroll a significant number of community members as students. In most tribal colleges, students pursue associate's degrees in vocational curricula such as nursing. Such students may benefit substantially from structured Human Services practice that could be coordinated jointly by the tribal college and the mental health service system. Indeed, the establishment of a college-based Mental Health Worker's Program could provide a regular supply of talented and energetic community members available to staff a crisis hotline or run a youth prevention program in exchange for some financial resources but for course credit toward their degrees. Beyond tribal college students, certain key members of large extended family networks—often respected elders—already serve as helping resources in Native communities for others to turn to in times of crisis or distress. Such natural helpers routinely advise, counsel, and support their relatives in accordance with tribal kinship traditions, but may nevertheless encounter occasional situations (e.g., a suicidal family member) in which they become overwhelmed by dire circumstance. Informal partnerships between the mental health service system and such helpers may ensure that these resourceful individuals obtain the knowledge, skills, and support to more effectively serve their families in times of need.

A final strategy promoted by community psychologists for cultivating underdeveloped helping resources involves the professional facilitation and support of community-based self-help programs. Once again, a fledgling scientific literature has begun to attend to the therapeutic power of self-help efforts (Gould & Clum, 1993). These kinds of interventions represent one approach to extending the availability of therapeutic resources in the context of a community-based service system. More familiar to mental health professionals in Indian country, however, are the 12-step groups such as Alcoholics Anonymous (AA). Although the philosophy and values of groups like AA distinguish them from professional service delivery in key ways, there can be no question...
that professional encouragement and support of such groups remains a cost-effective way to multiply the helping resources available to struggling community members. Additionally, many Native communities welcome and celebrate various Christian practices that resemble self-help. For example, several northern Plains tribal communities with long histories of First Nations Catholic missionary involvement participate in the Cursillo movement in which adherents gather for emotionally and spiritually intense weekend retreats for cleansing and renewal. Finally, it should be clear that traditional participation in Native ceremonies represents an additional healing resource that might benefit from professional referral and support in the context of a service system’s commitment to extending help as widely as possible within the community.

Nevertheless, merely extending the reach of helping services within American-Indian and Alaska Native communities in and of itself is no solution to the crucial problem of American-Indian mental health service delivery unless such efforts take seriously the call to construct alternative helping interventions that overcome the dangers of subtle Western cultural proselytization in the guise of aiding those in distress.

Constructing Alternative Interventions

The strategies described in the preceding undoubtedly assist the mental health professional in offering a great deal more to Native communities, but before acceptable progress can be made, the existing process must be transformed. In particular, the process of actively constructing appropriate alternative interventions depends first and foremost on the systematic exploration of the cultural foundations of such interventions. More specifically, the first stage of program development in Native communities requires the formulation of a reasonably sophisticated ethnotheology in order to ensure that newly created interventions avoid reproducing the colonial legacy. Such exploration will undoubtedly proceed in interdisciplinary fashion insofar as scientific psychology (Milton, Blasey, & Davis, 1999), psychiatric anthropology (Kleinman, 1987), community psychology (Rappaport & Seidman, 2000), sociolinguistics (Hymes, 1974), and the philosophy of social science (Fiske & Shweder, 1986) have obvious relevance. Nevertheless, the most prominent interdisciplinary tradition of interest here is the re-emerging field of cultural psychology (Shweder & Sullivan, 1993).

Cultural psychology takes as its defining feature the examination of culture and mind (Shweder, 1990). Its central focus of inquiry therefore concerns the semiotic (i.e., symbolically mediated) nature of human experience, which implies several fundamental commitments. The first of these commitments is the empirical elucidation of human “psychic diversity” across cultures. A second commitment is its focus on human action (or cultural practice) that, in this context, implies situated and meaningful human behavior. The third commitment of cultural psychology is the procedural leg of interpretive methods in an effort to understand cultural meanings inherent to such action. A fourth commitment of cultural psychology is the careful analysis of discourse (or situated communicative practices). The analysis of discourse practice typically focuses on language usage as fundamental to human experience, where lan-
determines with involved community members what the focus of the intervention should be (e.g., to promote protocol behavior among troubled community youth, to facilitate effective support and advocacy by individuals on behalf of distressed family members, to consolidate and extend treatment/balancing resources within the community etc.). Fourth, the psychologist would consult with community members to design a specific intervention with careful attention to targeted participants, required resources, desired outcomes, and assessment methodology. Fifth, extramural funding from government agencies or private foundations should be pursued to fund the project. Sixth, the psychologist implements the intervention in close collaboration with community members. Seventh, intervention outcomes are assessed. Finally, results, revisions, and modifications, if needed, are made in both scientific and grass roots circles. The emphasis here is thus on the development of demonstrably effective, culturally grounded interventions that directly address the pressing "mental health" concerns of the communities of interest.

CONCLUSION AND SUMMARY RECOMMENDATIONS

No contemporary culture exists in a vacuum, and in the postmodern era of rapid globalization, cultural transformation is inevitable and sometimes even desirable. But in the context of postcolonial America, it is essential that Native communities be afforded the opportunity to negotiate cultural transformation explicitly and on their own terms. Indeed, the dilemma posed by conventional mental health services in Indian Country is not that cultural transformation might occur, but that it might occur without the explicit awareness of either tribal members or the mental health professionals who treat them. My suspicion is that the greatest opportunities for formulating and implementing culturally grounded alternative interventions lie in the arena of community psychology, which has sought over three decades now to explicitly de-emphasize the resource-intensive practice of individual psychotherapy in favor of commencing collaborative, cumulative, and empowering relationships with communities of citizens (in this instance, tribal communities) whereby innovative, culturally grounded interventions may be developed, refined, and scientifically assessed in close consultation with local Native people. Such efforts will ultimately depend on the conceptual and methodological approaches of cultural psychology insofar as ascertaining the character of local ethno-psychologies is essential to the success of these endeavors. In sum, the development of such novel community-based interventions holds the greatest promise for overcoming the crucial of American-Indian mental health service delivery.

In mental health professionals working to cultivate strategies of intervention that proactively assess and surmount the dangers of subtle "cultural prostylization" in cross-cultural contexts and encounters, four principles must guide our fledgling efforts. First, we must always keep culture in mind. That is, we must never forget that our professional concepts and categories, and tools and techniques are cultural products or artifacts whose meanings and meanings emerge from and depend upon the

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cultural intelligibility of their operations to both "practitioners" and "clients." As cultural artifacts, these interventions must be understood in terms of their historical origins and evolution within the West as just one example of how humans might conceptualize therapeutic interventions more broadly. Second, we must always keep culture in mind. That is, we must never forget that the foundations of mind, self, and personhood (i.e., the "psyche") are themselves cultural and therefore vary in remarkable ways across communities around the world. As fundamental constituents of the psyche, cultural meanings and practices must be examined as they pertain to key facets of the local ethno-psychology in order for professional helpers to proceed most appropriately. Third, we must develop, implement, and evaluate innovative, culturally appropriate interventions collaboratively. That is, the program is disseminated in both scientific and grass roots circles. Finally, we must assess process and outcome more comprehensively. This is, given the kinds of innovations that result from collaborative program development, the assessment of effects—both therapeutic and countertherapeutic—throughout the course of an intervention must be both extensive and rigorous. More specifically, in addition to searching for the desired outcomes of such novel efforts, professional must also attend more comprehensively to the miscommunications, standoffs, breakdowns, and failures in the course of implementing services because such mishaps may signify subtle and implicit incommensurabilities between therapeutic models and the local ethno-psychology.

In considering the foregoing elaboration of my commitment to re-envisioning mental health service delivery in America-Indian and Alaska-Native communities, many may quickly dismiss this approach as too idealistic and impractical. In this instance, the institutional context of mental health service delivery in the 21st-century United States. Were I constrained by the realities of conventional service delivery in the modal health care system, I would agree with such critiques. The point of reviewing the institutional context of IHS mental health service delivery in such detail, however, was to make clear that federally recognized tribal governments retain the authority under present federal law and practice to contract for such novel, community-based mental health services using resources allocated federal monies. This unique right sovereign tribal governments extend even the assumption of control over the entire local mental health service system. Thus, the possibilities for reconfiguring such systems in direct response to the extensive mental health needs of the community are constrained only by the imaginations of tribal leaders and the expertise of the mental health professionals to whom they have entrusted the vision of visionary tribal governments will ultimately recognize the crucial of mental health service delivery and, in response, take measures that will actively facilitate the creation and establishment.
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