



American Indian/Alaska Native
**BEHAVIORAL HEALTH
BRIEFING BOOK**





American Indian/Alaska Native Behavioral Health Briefing Book

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The Briefing Book is designed to provide background and reference for the American Indian and Alaska Native Strategic Plans on Behavioral Health and Suicide Prevention.

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1. INTRODUCTION

Across Indian Country today, the high occurrence of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, families, and communities, both on- and off-reservations. For example, American Indian and Alaska Native (AI/AN) people are significantly more likely to report past-year alcohol and substance use disorders than any other race,¹ and suicide rates for AI/AN people are 1.7 times higher than the U.S. all-races rate.² Domestic violence rates are also alarming, with 39% of AI/AN women experiencing intimate partner violence—the highest rate in the U.S.³

In the ongoing effort to meet these and other behavioral health challenges, there is also a trend toward Tribal management and delivery of behavioral health services in their communities. Particularly in the last decade, Tribes have increasingly contracted or compacted via the Indian Self Determination and Education Assistance Act, Public Law 93-638, to provide those services themselves. As of this report, 54% of the mental health programs and 84% of the alcohol and substance abuse programs are now Tribally operated. This evolution in behavioral healthcare delivery and management is changing the face of behavioral health services in Indian Country.



Where Indian Health Service (IHS) was previously the principal behavioral healthcare delivery system for AI/ANs, there is now a less centralized and more diverse network of care provided by Federal, Tribal, and Urban Indian health programs. We now speak of the “Indian Health System” to denote this larger network of programs and the evolving care delivery system across Indian Country. Meeting the needs of this system will require an evolution in IHS and Tribal collaboration as well, particularly as Tribal programs take more direct responsibility for services and IHS supports them in doing so.

This Briefing Book is intended to provide context for the AI/AN National Strategic Plans on Behavioral Health and Suicide Prevention, both finalized in 2011. The plans identify priorities, goals, and strategic action steps to further develop this system of care and to better address behavioral health concerns in Indian Country. It is intended to inform the individual and collective efforts of substance abuse, mental health, and social work providers working in IHS, Tribal, and Urban Indian health programs. As explained in the strategic plans, “The future of AI/AN health depends largely upon how effectively behavioral health is addressed by individuals, families, and communities and how well it is integrated into community health systems.”

Across the Indian Health System, behavioral health initiatives are currently focused on integrating behavioral health into primary care in an effort to improve health outcomes. By addressing the intersections between alcohol and substance abuse, mental health, suicide, violence, and even preventable chronic health conditions, behavioral health approaches rely on an integrated and holistic perspective. In so doing, they become more closely compatible with Tribes’ traditional healing practices and commitment to restoring the balance of the mind, body, and spirit. This Briefing Book seeks to document the current efforts to address a range of serious behavioral health issues on a national, regional, and local basis.

This Briefing Book has been prepared to benefit a variety of audiences. It offers an introduction and historical background on behavioral health issues for Tribal leaders who direct health policy for their communities. It provides context to the work of behavioral health professionals throughout the Indian Health System as they confront health issues in the field and determine how their program goals and services may align with the IHS priorities. In addition to Tribal leaders and behavioral health workers, this Briefing Book will be informative to public and private IHS partners, including Federal agencies collaborating with the IHS to address behavioral health issues in Indian Country.

The Briefing Book begins in Chapter 1 with a brief history of efforts to address alcohol and substance abuse efforts in Indian Country. It then describes the evolution to a more holistic, integrated focus on behavioral health.

The Issue Profiles found in Chapter 2 of this Briefing Book paint a picture of the serious behavioral health issues that face AI/AN individuals and communities. These issues include alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases.

Chapter 3 of this Briefing Book presents an overview of the funding available to pay for behavioral health interventions. It also describes the additional efforts and resources dedicated to supporting behavioral health in AI/AN communities.

Chapter 4 provides a profile of current behavioral health activities in each of the 12 IHS Areas. To further illustrate Area efforts to prevent and address behavioral health issues, each Area has identified one local behavioral health program to be spotlighted within this Briefing Book. These program spotlights illustrate the range of approaches being used to treat and heal Tribal members. It should be noted by the reader that these spotlights provide only a glimpse of the breadth and depth of programmatic efforts being successfully implemented all across Tribal and Urban Indian communities.

This Briefing Book and the AI/AN National Behavioral Health and Suicide Prevention Strategic Plans support efforts by the IHS, Tribal, Urban Indian health programs, and other partners to address behavioral health issues throughout Indian Country. More broadly, IHS efforts are informed by the IHS priorities listed below:

1. To renew and strengthen our partnership with Tribes;
2. To reform the IHS;
3. To improve the quality of and access to care; and
4. To make all our work accountable, transparent, fair and inclusive.

It is the goal of the IHS to align these priorities with all its work within IHS Areas. Together, the IHS, Tribes, and Urban Indian health organizations will fulfill the IHS mission of improving the mental, physical, social, and spiritual health of AI/ANs to the highest levels possible, especially in the critical area of behavioral health.

BACKGROUND

The journey toward an integrated and holistic perspective on health and behavioral health services has been a long one. In order to understand today's behavioral health efforts, it is important to first take a brief look back at the movement from alcohol and substance abuse programs and policies toward integrated behavioral health programs and policies.

In 2002, the IHS commissioned a Briefing Book focused exclusively on alcohol and substance abuse. This document describes in great detail the history of alcohol and substance abuse in Indian Country. This 2011 Behavioral Health Briefing Book is a companion to the 2002 Alcohol and Substance Abuse Briefing Book. Rather than duplicate here the extensive documentation of alcohol and substance abuse efforts, readers are encouraged to consult the 2002 briefing book for more information. Nevertheless, in order to understand the movement toward integrated behavioral health approaches, it is important to briefly review the historical efforts that have brought behavioral health efforts in Indian Country to where they are today.

History of Alcohol, Substance Abuse, and Mental Health Efforts in Indian Country

The U.S. Federal government has a long history of working to address alcohol and substance abuse and mental health issues in Indian Country. In the early 1800s, when the Federal government viewed Tribes as its wards, the Federal government approach to addressing problems with alcohol was simply to prohibit the sale of alcohol to Tribes—a prohibition that was difficult to enforce in rural frontier areas. Nonetheless, this prohibition continued until 1953, when Tribes were given the right to regulate alcohol on reservations and purchase alcohol off-reservation. In 1955, the IHS was established to take over healthcare from the Bureau of Indian Affairs (BIA).



In the 1960s, the Office of Economic Opportunity funded the first Indian alcohol treatment programs, which was followed by additional funding from the National Institute on Alcoholism and Alcohol Abuse (NIAAA). Indian Self-Determination in the 1970s saw an increase in Tribal control over the healthcare delivery systems. In 1976, the Indian Health Care Improvement Act (PL 94-437) officially identified alcohol as an Indian health problem, and the IHS assumed administrative and programmatic oversight for the many NIAAA programs in Indian Country.

Throughout the 1980s and 1990s, alcohol and substance abuse issues in Indian Country continued to receive increased attention, accompanied by the funding of Youth Regional Treatment Centers (YRTCs) in IHS Areas and the allocation of alcohol and substance abuse funds for Urban Indian health programs. During this time, the Federal government took steps to work with Tribal governments through Tribal Action Plans addressing substance abuse prevention. In 1994, President Clinton signed a

Presidential Memorandum requiring government agencies to consult with Tribal governments before taking actions that would affect Tribes.

Public Law 106-554, the 2001 Omnibus Appropriations Act, known as the “Stevens Bill,” provided \$30 million to the IHS budget to address alcohol and substance abuse, half dedicated to efforts in Alaska and half allocated to efforts in the lower 48 States. In 2002, the IHS empanelled a National Alcohol and Substance Abuse Workgroup composed of Tribal leaders, urban program directors, and IHS Area alcohol coordinators. This group developed an IHS Alcohol and Substance Abuse National 5-Year Strategic Plan

and Fund Distribution Formula to address alcohol and substance abuse. During this same time, the IHS began integrating the field of alcohol and substance treatment and prevention with the field of mental health. In 2003, for example, the agency collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA) to sponsor the first Mental Health and Alcohol and Substance Abuse Conference, now called the National Behavioral Health Conference.

A New Approach: Behavioral Health

In 2005, the IHS formalized its focus on holistically addressing the health and wellness of AI/AN communities when it announced the Behavioral Health Initiative. This initiative, and its four major areas of focus (Methamphetamine Reduction, Suicide Prevention, the Behavioral Health Management Information System, and Child and Family Protection), concentrated on the strength and resilience of AI/AN communities.

Suicide prevention efforts have focused on five targeted approaches: 1) assisting IHS, Tribal, and Urban Indian health programs and communities in addressing suicide utilizing community level cultural approaches; 2) identifying and sharing information on best and promising practices; 3) improving access to behavioral health services; 4) strengthening and enhancing the IHS' epidemiological capabilities; and 5) promoting collaboration between Tribal and Urban Indian communities with Federal, State, national, and local community agencies.

Additional IHS behavioral health priorities are developing child and family protection programs, improving health information management systems, and increasing the integration of behavioral health into primary care. To help victims of violence, the IHS provides direct services, advocacy, interagency consultation, and collaboration with other Federal agencies to provide child and family protection services to AI/AN children, families, and communities. The Resource and Patient Management System (RPMS) is a national



health information system that captures diagnostic, treatment, outcomes, and referral information regarding significant health issues. To support clinical best practices and disease surveillance, RPMS includes standardized tools for screening as well as clinical decision support tools to facilitate routine and effective screening. RPMS output reports and clinical quality performance measurement tools provide information, from local facility to national level data, on screening results and screening rates. IHS also supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the “Medical Home.” This offers new opportunities for interventions that identify high-risk individuals before their actions or behaviors become more clinically significant. One primary care-based behavioral health intervention is the Alcohol Screening and Brief Intervention, which IHS is broadly promoting as an integral part of a primary care-based behavioral health program.

The Methamphetamine and Suicide Prevention Initiative (MSPI) is a Congressionally appropriated, nationally coordinated demonstration program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. The \$16.391 million annual appropriation supports 127 pilot projects throughout Indian Country to promote the development of innovative evidence-based and practice-based models created and managed by communities themselves, but connected to the entire national network of recipients to share program, service, and evaluation information. All MSPI pilot programs are community developed and

delivered and represent the developing support from IHS to help communities address the dual crises of methamphetamine abuse and suicide in Indian Country.

The Domestic Violence Prevention Initiative (DVPI) supports pilot programs in AI/AN communities addressing domestic violence and sexual assault response and advocacy. The \$10 million annual appropriation supports 65 pilot projects throughout Indian Country. With these funds, the IHS is expanding its outreach advocacy programs into Native communities, expanding the Domestic Violence and Sexual Assault Pilot project, and providing funding for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner (SANE) and Sexual Assault Forensic Examiner (SAFE) programs. The DVPI funding represents an opportunity to address the dual crises of domestic violence and sexual assault in Indian Country.

In 2007, the IHS Director empanelled an IHS National Behavioral Health Work Group (BHWG), a technical group of subject matter experts charged with providing guidance in the development of programs and services for behavioral health for AI/AN communities. The BHWG is composed of Tribal and urban representatives who are providers and experts in the field of behavioral health and/or substance abuse. In 2008, the IHS also convened a National Tribal Advisory Committee on Behavioral Health (NTAC), a policy and advocacy body of Tribal leaders providing advice and recommendations in support of IHS efforts to address behavioral health. NTAC is composed exclusively of elected Tribal leaders who are designated by the IHS Area Director from each IHS Area. Both groups have increased communication and cooperation between IHS and Tribal partners. NTAC's leadership has resulted in innovative partnerships with IHS to redesign service delivery by and for Tribal communities and to create and extend a national support network for ongoing program development and evaluation. The efforts of both groups have been instrumental in developing the behavioral health initiatives sponsored by the IHS today as well as in creating the AI/AN National Strategic Plans on Behavioral Health and Suicide Prevention (2011-2015).

Recent and groundbreaking changes in Federal health policy also signal an increased recognition of the importance of behavioral health to overall health for AI/ANs and others. In 2010, the Patient Protection and Affordable Care Act (ACA) was passed, a substantial piece of health reform legislation that included the Indian Health Care Improvement Reauthorization and Extension Act (IHCIA). From a behavioral health perspective, the key feature of the IHCIA is Title VII, amended to encompass the broader focus of behavioral health, expanding the IHCIA's previous focus on substance abuse. Title VII directs IHS to establish a comprehensive behavioral health plan for AI/ANs and, where feasible, to provide a comprehensive continuum of behavioral health prevention, intervention and treatment, outpatient, and aftercare services to all ages of the AI/AN population. Other sections of the IHCIA address domestic violence and sexual assault, suicide prevention (with a special focus on youth), primary prevention of childhood sexual abuse, and behavioral health research. The reauthorization of the IHCIA demonstrates Federal recognition of behavioral health service needs and promises ongoing support for identified behavioral health priorities in Indian Country.

Along with the ACA, the Mental Health Parity and Addictions Equity Act of 2008 supports the provision of behavioral health services and increases insurance coverage for behavioral health services, offering greater billing and reimbursement opportunities. The Act requires insurance plans to offer benefit coverage for mental health and substance abuse treatment services comparable with the plan's coverage for conventional medical or



surgical services, a significant improvement over previous coverage practices where limitations in the number and scope of behavioral health services covered were often paired with higher cost sharing. For AI/ANs with insurance coverage through a private provider (such as employer-sponsored health insurance), more behavioral health services are now covered.

Along with supporting a new and more holistic health paradigm, recent legislative changes also promise an increase in access to behavioral health services for AI/ANs. The ACA increases behavioral health coverage for AI/ANs in two ways, increasing Medicaid coverage and insurance coverage. First, the ACA mandates the expansion of Medicaid coverage by 2014 for people up to 138% of the Federal poverty level and removes existing State restrictions on coverage for certain groups, making an estimated 200,000 to 300,000 AI/ANs newly eligible for Medicaid coverage. An estimated 65% of these AI/ANs will be males as Medicaid coverage is expanded to childless adults. It is further estimated that 20 to 40% of the newly eligible Medicaid population (50,000 to 100,000 persons) will require behavioral health services because they belong to high-risk and high-need demographics such as people in poverty. Second, the ACA will likely increase the private insurance coverage of AI/AN populations. The ACA requires that all individuals meeting certain income standards have health insurance coverage, and it supports this mandate by creating Health Insurance Exchanges, competitive market pools where individuals or employers can purchase affordable health plans. Any insurance plan offered through a Health Insurance Exchange is mandated to include coverage for behavioral health services as part of the standardized —essential benefits package.” An estimated 200,000 to 400,000 AI/ANs are expected to gain health insurance through Health Insurance Exchanges. (The wide range of this estimate is due to the unknown effect of the existence of premiums for AI/ANs and the AI/AN exemption from any penalty for not obtaining insurance.)⁴

The Tribal Law and Order Act (TLOA) of 2010 signifies another important step in strengthening behavioral health efforts in Indian Country by helping the Federal government better address the unique public safety challenges that confront Tribal communities. The Act includes a strong emphasis on decreasing violence against AI/AN women. It expands training of Tribal law enforcement officers in two important areas that relate to domestic violence and sexual assault: 1) best practices in interviewing victims and 2) practices in evidence collection that can improve conviction rates. It also strengthens Tribal law enforcement by increasing Tribal court sentencing authority from 1 to 3 years imprisonment for Tribal criminal law violations. Section 241 of the TLOA amends the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, expanding the number of Federal agencies who are required to coordinate efforts on alcohol and substance abuse issues in Indian Country. Agencies included in coordinated efforts are the Department of Justice (DOJ) and SAMHSA, along with the Department of Interior, the BIA, and the IHS. This amendment also breathes new life into Tribal Action Plans (TAP) on substance abuse prevention, first authorized in 1986, and promises improved Federal interagency coordination on substance abuse policy by the establishment of an Office of Indian Alcohol and Substance Abuse within SAMHSA. All these elements of the TLOA offer important policy support for health, wellness, and public safety in AI/AN communities and a recognition of the multiple factors that influence behavioral health concerns.

The new possibilities for behavioral health efforts brought about by the passage of important legislation like the ACA and the TLOA, along with the permanent reauthorization of the IHCA, have significant implications for increasing resources to improve the health and well-being of AI/ANs. Sufficient resources are critical in the efforts to improve AI/AN health and well-being, because community needs, particularly in the area of behavioral health, are significant. The demonstrated health disparities experienced by AI/ANs in all areas of behavioral health are the topic of the next chapter of this Briefing Book.

2. ISSUE PROFILES

This chapter of the Briefing Book provides a profile of several serious behavioral health issues facing AI/AN people today: alcohol and substance abuse, mental health disorders, suicide, violence (including domestic and sexual violence), and behavior-related chronic diseases. The current state of each problem is described through a combination of available data and descriptive evidence of the problems.

Data such as health statistics can help describe the scope and severity of health issues, but it is important to acknowledge the severe limitations present in behavioral health data currently available about AI/AN populations. Along with a general lack of epidemiology and surveillance of mental and behavioral health issues in minority populations,⁵ underreporting among AI/AN populations occurs frequently because of many factors, including stigma around seeking behavioral healthcare services, a lack of access to services, a lack of culturally acceptable practices, and the lack of technical resources for existing treatment and prevention programs in Tribal communities to collect and analyze data. In addition, data related to AI/AN communities often receive insufficient analysis because AI/AN population groups are numerically small in relationship to total populations. While “statistical insignificance” has an objective meaning within the field of statistics, such labels tend to perpetuate the invisibility of significant public health problems to funders, policy makers, and the general public. For these reasons, health data presented in this Briefing Book are supplemented with the testimony of Tribal leaders and Tribal members and examples from AI/AN communities. It is important to note that the examples attributed to specific Tribal leaders and Tribal members are intended to illustrate the severity of the problem as experienced by those Tribes’ members and are not intended to serve as a generalization about the experiences of all groups. These examples illuminate the problem in a way that data fraught with limitations cannot. Through the willing testimony of Tribal members and Tribal leaders, our understanding of the problem is transformed as we see what the problems look like in the context of human experience.

ALCOHOL ABUSE

Alcohol abuse has plagued Tribes since the introduction of alcohol by frontiersmen and explorers early in colonial history. Today, alcohol misuse and its related health issues continue to threaten the health and well-being of communities. In fact, in the years 2002 through 2005, AI/ANs were more likely than any other race to have a past-year alcohol or illicit drug use disorder.⁶ Despite a new study that indicates that the alcohol-use rate among AI/ANs from 2005 to 2008 was below the national average (43.9% versus 55.2%), the same study shows that AI/ANs adults have a rate of past-month binge drinking above the national average (30.6% versus 24.5%).⁷ That study revealed that other high-risk characteristics, such as living in poverty or being uninsured, increased the likelihood that AI/ANs had binged on alcohol in the past month.

39.4% of AI/ANs aged 26 to 49 reported binge drinking in the past month compared to the national average of 28.9%.

Because alcohol misuse is a significant contributor to negative health and social consequences, these statistics are alarming. Overall, IHS data find that AI/AN alcoholism death rates in 2003-2005 were 519% higher than the alcoholism death rate for all races in the U.S. in 2004.¹

¹ Age-adjusted rates (for data years 2003-2005), not yet published, have been adjusted to compensate for misreporting of AI/AN race on State death certificates.

The Effects of Alcohol Abuse

According to a 2008 report by the Centers for Disease Control and Prevention (CDC), almost 12% of deaths among the AI/AN populations are alcohol-related, more than three times the percentage of the general population.⁸ In addition, AI/AN individuals are five times more likely than whites to die of alcohol-related causes.⁹ Motor vehicle accidents and alcohol-related liver disease lead the list of alcohol-induced deaths among AI/ANs, followed by homicide, suicide, and accidental injuries.

AI/AN individuals are five times more likely than whites to die of alcohol-related

Another significant effect of alcohol misuse is seen in the high rates of fetal alcohol spectrum disorders (FASD) in the AI/AN population. According to a 2007 report by the FASD Center, AI/ANs have some of the highest rates of FASD in the U.S.¹⁰ FASD is an umbrella term that covers a range of effects that can occur in an

individual whose mother consumed alcohol during pregnancy. The consequences of FASD vary from physical, mental, behavioral, and/or learning disabilities with possible lifelong implications,¹¹ highlighting the tragic generational consequences of alcohol abuse for AI/AN communities.

Alcohol abuse also plays a prevalent role in AI/AN violence and crime. According to analysis of national data by the Bureau of Justice Statistics (BJS), 4 in 10 violent victimizations and 4 in 10 fatal motor vehicle accidents involved the use of alcohol.¹² The BJS also reports that alcohol and/or drugs are involved in 35% of violent AI/AN crimes.¹³ In the 10-year period from 1992 to 2002, approximately 62% of violent offenses against AI/ANs victims were completed by offenders under the influence of alcohol, as compared to only 42% in the general population during the same period.¹⁴

Alcoholism has clearly affected all generations of the AI/AN community and in multiple ways. As seen through these statistics, AI/AN alcohol abuse is powerfully interconnected with AI/AN health, suicide, and instances of violence and accidental injuries.

DRUG ABUSE

High rates of alcohol abuse in Indian Country are coupled with similarly high rates of drug abuse. At 21.1%, AI/ANs aged 12 and up are more likely than any other race/ethnicity to have an illicit drug use disorder in the past year.¹⁵ According to a 2009 report, nearly 20% of AI/AN adults needed treatment for drug or alcohol abuse—higher than any other race. Yet, only a fraction of this need was met during the same period of time, with reports showing that only about 12% of AI/ANs who needed treatment in a specialty facility actually received it. According to the most recently published *IHS Trends* data, the AI/AN rate of drug-related deaths has skyrocketed by 206% since it began to be reported in 1979.¹⁶

Data from 2002-2005 show that AI/AN use of marijuana, cocaine, hallucinogens, inhalants, and stimulants was significantly higher than use by members of other racial groups during the same time period.¹⁷ The use of one particular stimulant—methamphetamine—by AI/ANs is particularly alarming and represents one of the leading health and social concerns facing AI/AN communities today. According to testimony given before the U.S. Congress by the National Congress of American Indians (NCAI), “The destruction caused by methamphetamine threatens to dwarf the problems we have seen caused by alcohol.”¹⁸

The Spread of Methamphetamine in Indian Country

The IHS' 2008 Annual Report describes the serious concern of methamphetamine (meth) use among AI/ANs, stating —AI/AN people have a meth use rate that is over three times the rate for the general population.”¹⁹

The problems reported by individual Tribes are particularly troubling, demonstrating that the meth crisis is significantly more pronounced in some AI/AN communities than the straightforward —three times higher” rate would suggest. For example, in 2006, the

White Mountain Apache Tribe in Arizona testified to Congress that their Tribal employees had meth use rates of 30%.²⁰ The San Carlos Apache Tribe also described the prevalence of meth use during testimony before the U.S. Senate, citing that 25% of the patients administered drug tests in the San Carlos Apache emergency room tested positive for meth, and 64 out of the 256 babies (25%) born to Tribal members in 2005 tested positive for meth.²¹ Other reports share that meth use in the Navajo Nation increased by more than 100% in a 5-year period.²² These examples are just a sample of the problems Tribes are reporting as meth distribution, use, and addiction spreads.

“The destruction caused by methamphetamine threatens to dwarf the problems we have seen caused by alcohol.”

—Jefferson Keel, National Congress of American Indians

The Effects of Methamphetamine in Indian Country

Methamphetamine abuse in Indian Country has serious consequences and, according to the NCAI, —In particular, it is taking a severe toll on those most vulnerable in our community, our children.”²³ This claim is echoed in a 2006 report commissioned by the BIA that describes the results of the *National Methamphetamine Initiative Survey* submitted to Indian law enforcement agencies. Notably, 74% of respondents cited meth when asked, —What drug poses the greatest threat to your reservation?” Respondents were also asked whether certain crimes increased —because of the presence of methamphetamine” in their area. The crimes that were most often cited by respondents included:

- domestic violence (64% of respondents);
- assault/battery (64%);
- burglary (57%);
- child neglect/abuse (48%); and
- weapons violations (31%).²⁴

Other reports suggest that meth use is correlated with suicide risk. Among the most chilling anecdotal reports are those provided by the San Carlos Apache Tribe, citing in 2006 that 8 out of the past 10 suicide attempts had been made by individuals who were using meth.²⁵ While the extent to which the correlation between meth use and suicide risk is not fully understood in either the AI/AN population or the general population, a 2005 study conducted by the University of Utah found that —the prevalence of methamphetamine in suicide completers is unexpectedly high and requires further investigation.”²⁶

The Rise of Prescription Drug Abuse

Meth is a recognized threat in Indian Country, and current public health efforts are working diligently to increase awareness and curb its spread. Less recognized and less quantified at this time is the growing issue of prescription drug abuse in Indian Country. Prescription drug abuse includes the non-medical use of prescription-type pain relievers, sedatives, stimulants, and tranquilizers.²⁷

In a 2009 national survey, 6.2% of AI/ANs reported engaging in current non-medical use of prescription drugs, more than twice the rate of whites and the highest rate of all races nationally.²⁸ Some reservations report prescription drug abuse at epidemic levels among their communities. Tribal governments such as

the Red Lake and Ojibwe bands have declared public health emergencies to draw attention to the problem, reporting that the number of people treated for prescription drug addiction in Tribal health facilities tripled between 2007 and 2008.²⁹ National studies indicate that prescription drug abuse appears to strongly correlate with alcohol use disorders and found AI/ANs to be at particular risk for this combination of conditions.³⁰

MENTAL HEALTH DISORDERS

Mental health disorders are widely understudied among the AI/AN population according to the Surgeon General's Report on Mental Health.³¹ This assertion is echoed by the National Alliance on Mental Illness (NAMI), which explains in a mental health fact sheet that the two major studies conducted on depression did not report data on AI/ANs.³² Despite gaps in data, several sources reveal that AI/ANs are at higher risk for certain mental health disorders than other racial/ethnic groups.³³ For example, the Office of Minority Health reports that AI/ANs experience higher rates than all races in the following areas:

- serious psychological distress;
- feelings of sadness, hopelessness, and worthlessness;
- feelings of nervousness or restlessness; and
- suicide.³⁴

AI/ANs are also overrepresented among high-need populations requiring mental health services (e.g., people who are homeless, incarcerated, drug and alcohol abusers, and exposed to trauma as well as children who are in foster care).³⁵

Treating Mental Health Disorders in Indian Country

Despite widespread risk factors for and symptoms of mental health disorders in Indian Country, significant access barriers to treatment exist. In his testimony before the Senate Committee on Indian Affairs, Coloradas Mangas, a 15-year-old Tribal member and survivor of teen suicide on the Mescalero Apache Reservation, explained that cultural stigmas against talking about death and seeking psychological help often prevent AI/ANs from accessing the mental health services they need.³⁶

Even when AI/AN individuals do decide to see a psychologist, reservation hospitals simply lack the mental health resources needed to serve them. Indeed, the Surgeon General's Report on Mental Health reveals the availability of approximately 101 AI/AN mental healthcare professionals per 100,000 AI/ANs in contrast to the 173 available per 100,000 white persons.³⁷ This workforce shortage may explain the low rates among AI/ANs for accessing mental health counseling and treatments, including prescription medicine for mental health disorders.³⁸

Another issue is ensuring the provision of culturally competent services that recognize the needs and challenges of the AI/AN community. It is critical that mental healthcare professionals understand the stress and anxiety associated with AI/AN identity, the AI/AN acculturation and deculturation that trigger mental health disorders, and the need for traditional and cultural practices as a part of the treatment and prevention process.^{39 40 41}

The Effects of Mental Illness on the AI/AN Community

Multiple studies have found a correlation between AI/AN rates of depression or other mental health disorders and AI/ANs' overrepresentation among people who are incarcerated, die by suicide, or who suffer from alcohol and drug use disorders.⁴² Concerning suicide, Dr. Paula Clayton, in her testimony before the Senate Committee on Indian Affairs, indicated that 90% of suicide victims suffered from mental health disorders at their time of death.⁴³ Likewise, *The Surgeon General's Report* suggests that some behavioral risk factors, such as alcoholism and violence, are in actuality expressions of depression or other mental health disorders.⁴⁴ Regardless of the causal link between these risk factors and mental illness, the overall health and well-being of AI/AN communities are undoubtedly affected by mental health disorders.

90% of AI/AN suicide victims suffered from mental health disorders at their time of death.

SUICIDE

Suicide in Indian Country is a significant behavioral health issue affecting AI/ANs. The suicide rates for AI/ANs are even more alarming than the rates for the general population, at 1.7 times higher than the U.S. rate for all races and ages.⁴⁵ It is the second leading cause of death for Indian youth between the ages of 15 to 24 (3.5 times higher than the national average).⁴⁶ Alaska Natives die by suicide at rates four times the national average. For Alaska Native males, the suicide rate is six times higher than the national average, with teen suicide rates almost as high—nearly six times the rate of non-Native teens.⁴⁷

The suicide rate among AI/AN young men is alarmingly high. Special attention to the situation of AI/AN teenagers and young adult men is needed in order to heal and address the risk factors for suicide, as well as to determine supports that would allow young men at risk to successfully receive help. While recognizing the serious risk factors for AI/AN young men, suicide and suicidal behavior are also concerns that affect AI/AN people of both genders and across the life cycle. For example, while AI/AN males ages 15 to 24 are at highest risk for suicide completion, the group at the highest risk for suicide attempts is females of the same ages,⁴⁸ indicating the prevalence of the same troubling risk factors in the lives of young women—drug and alcohol use, violence, trauma, abuse, and depression and other mental illness. In addition, young people between ages 15 and 24 make up 40% of all suicide deaths in Indian Country. In the discussion of suicide as a behavioral health problem, it is important to recognize risk factors at all ages and the need for comprehensive and integrated solutions across communities and generations, even as strategies for suicide prevention and appropriate treatment may also be specially adapted for relevance to certain groups, such as AI/AN teenagers and young adult men.

Suicide Contagion and Suicide Clusters in Indian Country

In some communities, the suicide rate may be pushed higher by a phenomenon called suicide contagion. In her September 2009 Statement before the Senate Committee on Indian Affairs, IHS Director Dr. Yvette Roubideaux explained, "Indian Country has communities each year where suicide takes on a particularly ominous and seemingly contagious form, often referred to as suicide clusters."⁴⁹ Specifically, *suicide contagion* is when exposure to suicide, suicidal behaviors, or other unexpected deaths influence others to attempt or complete suicide, while *suicide clusters* are the occurrence of more suicide attempts or deaths by suicide in a given time period than would be expected for a community.⁵⁰ It is important to note that suicide clusters can be sparked by unintentional deaths that are not the result of suicide and may instead be caused by accidents or violence. Teenagers and young adults are at highest risk for suicide contagion, and experimentation with drugs or alcohol can increase their vulnerability. These connections reveal additional implications of the issues discussed in this section and show the overlap and interconnectedness of many behavioral health concerns.

“Our young people live in great despair—witnessing the extreme emotional and social impact of high rates of infant deaths, living with poverty and often within abusive households, and watching other young people taking their own lives.”

**—Robert Moore, Councilman,
Rosebud Sioux Tribe**

The devastating trend of suicide contagion continues to be the experience of many Tribal communities. In recent years, Tribes that have been severely affected by suicide deaths have faced dozens of deaths by suicide in short spans of time. Often, these tragic deaths can be followed by hundreds of suicide attempts that are documented by local healthcare facilities.⁵¹ The Tribal chairman of the Rosebud Sioux Tribe testified before Congress in February 2009, saying that —~~or~~ young people live in great despair—witnessing the extreme emotional and social impact of high rates of infant deaths, living with poverty and often within abusive households, and watching other young people taking their own lives. The result is that we tend to see

clusters of youth suicides in many of our communities.”⁵²

Addressing Suicide in Indian Country

Dealing with—and healing—the effects of suicide can be daunting. When a person dies by suicide, it adversely affects the lives of many other individuals and can lead to permanent consequences on the productivity, self-esteem, or physical and mental health of affected individuals. Tribal leaders and members alike describe the hopelessness they feel when their people turn to suicide and the contagious nature of this hopelessness.^{53 54 55}

In her September 2009 testimony before the Senate Committee on Indian Affairs, IHS Director Dr. Roubideaux said, —~~S~~icide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including urban communities. The pain only deepens when those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts, are unable to access adequate care.”⁵⁶ Services and resources necessary to address suicide for at-risk individuals and survivors of suicide are not always available in AI/AN communities. Navigating complex or fragmented combinations of Tribal, Federal, State, local, and community-based services can be confusing and discouraging, making it difficult to access care even if it is available. In addition, severe provider shortages are common.⁵⁷ Especially regarding services for children and young adults, research reports that AI/AN youth ~~may~~ be more likely to receive treatment through the juvenile justice system and in-patient facilities than non-Indian children; encounter a system understaffed by children’s mental health professionals; encounter systems with consistent lack of attention to established standards of care for their population; and experience high levels of unmet need.”⁵⁸



In addition to clinical care, the importance of public health and community-based interventions is becoming more widely recognized.⁵⁹ This perspective is transforming suicide prevention strategies and has increasingly brought innovative and culture-based programs, such as Native Aspirations, to the forefront. One factor that makes community- and culture-based interventions especially important is the role of historical trauma in the increased risk of suicide among AI/AN people. *Historical trauma* describes the cumulative effects of the massive group trauma experienced by AI/AN peoples and nations since the arrival of European settlers on the American continent.⁶⁰ This trauma has taken various forms, from outright violence of wars and forced relocation to damaging prohibitions on

Native languages and cultural and religious practices. Historical trauma has many dimensions, but one important aspect is that, as with any trauma situation, parents and caregivers who have been traumatized often pass on trauma response patterns to their children. This means that the effects of historical trauma in AI/AN communities include not just past or present acts of oppression and racism that AI/AN people have been victimized by, but also the ways that trauma response behaviors are internalized, repeated, and passed on within AI/AN families and communities. Historical trauma is linked to increased suicide risk not only through depression, despair, and helplessness felt because of cultural oppression, but also because anger, aggression, and violence felt in response to experiences of victimization can be turned against oneself.⁶¹

Stigma and Other Obstacles to Delivering Behavioral Healthcare

It is important to consider obstacles that may stand in the way of AI/ANs seeking and receiving behavioral healthcare. The goal in doing this is to investigate the complex factors that affect both problems and opportunities in this area and to ensure that solutions are wisely crafted and do not replicate problems with past mental and behavioral health approaches.

Cultural stigma against talking about death, the shortage of mental and behavioral health providers across Indian Country, and unmet needs for culturally relevant care all add to the difficulty of delivering appropriate behavioral healthcare, including suicide prevention, to AI/AN populations. Another important factor that can pose an obstacle is that stigma against accessing behavioral healthcare services is very high. As with most AI/AN health issues, the topic is under-researched, but a review of available data suggests that AI/ANs access community mental health facilities far less frequently than other races. A 1999 study indicated that 44% of AI/AN adults surveyed who had experienced any type of mental health problem did not seek any help, and those who did seek help did not choose to contact mental health agencies. A second study reported that 55% of AI/AN patients did not return after initial contact with mental health facilities, a significantly higher rate than other races.⁶² The impact of this stigma can be life-threatening, as described in a presentation at the IHS/BIA 2010 National Behavioral Health Conference, where Michael Gomez reported IHS data indicating that 96% of individuals who had attempted suicide stated they would not seek professional help.⁶³



While provider shortages and access factors, such as distance to health facilities, do affect these figures, stigma plays a defining role. Stigma related to behavioral healthcare for AI/AN people has multiple dimensions. First, it has been reported that AI/ANs have felt that mental and behavioral healthcare services have not been relevant to their needs and situation.⁶⁴ The perception and reality of this situation are certainly changing as outreach and awareness efforts targeted toward AI/AN populations increase and as the behavioral health field becomes more aware of the key role of culture in providing appropriate care. However, the perception that mental and behavioral healthcare lack relevance to AI/AN needs remains, and efforts to develop mental health services within AI/AN communities can be negatively associated with historic attempts to transform Native culture.⁶⁵ Second, prejudice and misinformation on the part of the behavioral health field—that is, its disregard or even hostility toward AI/AN traditional healing practices—also discourage AI/ANs from seeking behavioral healthcare services. As many as 2/3 of AI/ANs choose to use traditional healers, occasionally in conjunction with mental healthcare

providers.⁶⁶ Due to a lack of understanding, Western perspectives portray traditional and cultural practices as incompatible with behavioral healthcare, as a result some AI/AN people choose not to access behavioral health services.

A final barrier in delivering appropriate behavioral healthcare in AI/AN communities is a focus on individualized analysis and treatment in the mental health field that obscures the role of community and historical factors. To fully understand suicide, mental health disorders, alcohol and substance abuse, and even domestic violence and sexual assault, we must view these issues within the context of the AI/AN experience. A history of forced relocation, the removal of children from their homes and into harsh boarding schools, the prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices has resulted in intergenerational impacts, known as historical trauma. The effects of historical trauma, as well as racism and victimization that continue in the present day, must be acknowledged. Historical trauma is experienced by and rooted in communities. Because of this, community-based interventions can recognize and address historical trauma in a way that treatments focused on the individual may not. Many culturally based suicide prevention programs that include traditional practices and engage entire communities are currently underway, as described in Chapter 4, IHS Area Profiles and Behavioral Health Program Spotlights.

Available data and analysis describe the role of stigma and cultural factors in complicating access to mental healthcare, including suicide prevention services. Behavioral healthcare offered for alcohol and substance abuse, domestic violence, and behavior-related chronic diseases may face similar obstacles. While addressing access and resource shortages throughout the AI/AN behavioral health system is critical, it is necessary to go beyond addressing care availability and delivery systems and to critically examine the type and paradigm of care that is provided. For successful behavioral healthcare efforts, we must ensure that care offered in AI/AN communities is culturally relevant and takes its cues from successful Tribally managed behavioral health efforts, including evidence-based, cultural, and traditional practices. Successful behavioral healthcare must also allow the lingering Western model of individualized disease and treatment to be challenged and transformed by alternate understandings.

VIOLENCE

Violence is another serious problem in Indian Country. Violent deaths—deaths from unintentional injuries, homicide, and suicide—account for 75% of all mortality among AI/ANs in their 20s.⁶⁷ Age-adjusted death rates among AI/ANs in 2002-2004 for unintentional injuries were 2.5 times higher, and the homicide rate was two times higher, than the U.S. all-races rate in 2003.⁶⁸ Even when violence is non-fatal, its effects are damaging to individuals and communities, and its scope in Indian Country is widespread.

Bullying and Its Effects

An important but sometimes unrecognized aspect of violence is bullying that occurs among AI/AN youth. Bullying describes overt acts of violence between peers, but it can also include a variety of other negative or threatening behaviors such as name-calling, teasing, spreading lies or rumors, ignoring or social exclusion, stealing, or threats of physical harm.⁶⁹ Studies indicate that AI/AN youth experience bullying at rates higher than youth of other races. There are 27.5% of AI/AN students in grades 6 through 12 who reported being a victim of bullying, compared to 20.1% of students nationally. In addition, 30.9% of AI/AN students in grades 6 through 12 reported being a bully (i.e., participating in bullying behaviors), compared to 18.8% of students nationally.⁷⁰

Bullying can be—and until recently, often has been—dismissed as situational behavior that youth outgrow over time. But changing perspectives and new research present a different story. Research reports that victims of bullying are at risk for depression, low self-esteem, health problems, and poor

grades.⁷¹ Students who bully their peers are more likely to participate in a wide variety of anti-social behaviors: they more frequently get into fights, vandalize or steal property, drink alcohol, smoke, skip school, drop out, and carry weapons.⁷² Suicidal ideation and suicide attempts are higher among targets of bullying, *as well as among bullies*.⁷³ Especially among AI/AN youth, where suicide risk factors are higher than average, high rates of bullying should be viewed with special concern.

The effects of bullying extend beyond youth who are victims and bullies. Bullying creates an environment where violence and aggression are accepted, and bystanders learn to align with dominant individuals for protection and status.⁷⁴ Concretely, bullying behavior in schools is linked to an increase in violent behavior, weapons carrying, and gang membership.⁷⁵ Over time, in adolescence and adulthood, behavior patterns learned from bullying translate into other serious problems such as sexual harassment, dating violence and sexual assault, child abuse, and elder abuse.⁷⁶ Bullying can also be understood as an expression of lateral violence related to historical and intergenerational trauma.⁷⁷ Violence, anger, or aggression that cannot be expressed toward an oppressor is turned against the self or others, as is seen with suicide. These violent acts then serve to repeat and reinforce trauma, victimization, and trauma responses.

As in other areas of behavioral health, more research that is specific to AI/AN youth and communities is needed. However, available research suggests connections between the occurrence and impacts of bullying and other behavioral health concerns, including mental health disorders, suicide, alcohol and substance abuse, and domestic violence and sexual assault.

The Rise of Domestic and Sexual Violence in Indian Country

The statistics on domestic violence and sexual assault against AI/AN women are also bleak. According to the CDC, 39% of Native women have experienced intimate partner violence—the highest percentage in the U.S.⁷⁸ In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,⁷⁹ and AI/AN women are more than five times as likely to die from domestic violence-related injuries than women of any other race.⁸⁰

One out of every three AI/AN women will be sexually assaulted in her lifetime.



As with suicide and bullying, it is important to acknowledge the role that historical and intergenerational trauma has played in the high levels of domestic violence and sexual assault against AI/AN women. Colonization brought significant changes for AI/AN people—changes that have been attributed to the high levels of violent crime in Indian Country and particularly the violence against women.^{81 82 83 84} In colonizing Native people, the U.S. government sanctioned horrific acts of violence against them, now acknowledged by the Department of the Interior as “the cowardly killing of women and children.”⁸⁵ There are countless stories of soldiers raping Indian women in a violent display of power.⁸⁶ This oppression and domination continued even after relocation, most notably during the boarding school era, when children as young as five were forcibly removed from their homes and sent to live in military-like dormitories for cultural assimilation purposes.

As was discussed briefly in the issue profiles on alcohol and substance abuse, substance abuse has also played a significant role in the rise of

violent crime and violence against women and children in Indian Country. Alcohol abuse is indisputably linked to violence. For example, the Bureau of Justice Statistics reports that in violent crimes against AI/ANs, 62% of victims reported the offender was under the influence of alcohol.⁸⁷ The rise of methamphetamine abuse has been cited by Tribal law enforcement as responsible for increases in domestic violence, assault and battery, and child abuse and neglect.⁸⁸ In addition, the Deputy Director of the Office of Justice Services for the Bureau of Indian Affairs stated in an interview that rape — was a problem long before methamphetamine, but methamphetamine is making it worse.”⁸⁹

The Effects of Domestic Violence and Sexual Assault on Public Health and Safety

Violence such as intimate partner violence and sexual assault has been correlated with adverse health conditions and health risk behaviors.⁹⁰ The effects of violence and assault go beyond the short-term injuries such as cuts, bruises, and broken bones received by victims. For example, intimate partner violence has been linked to increases in heart disease, asthma, and stroke as well as migraines and fibromyalgia.⁹¹ Victims also experience negative emotional and mental health problems such as stress, depression, anger, self-hatred, and post-traumatic stress disorder.⁹²

Domestic violence and sexual assault have also been correlated with an increase in high-risk health behaviors. People who have been victimized are more likely to smoke cigarettes, drink alcohol, and use drugs.⁹³ They are also more likely to engage in risky sexual behaviors, which can lead to an increased risk of contracting sexually transmitted infections. Increased risk for drug use and increased likelihood of engaging in risky sexual behaviors have been documented among AI/AN physical and sexual assault victims, as well as among victims of domestic violence.^{94 95}

The Violence Against Women Act of 1994 (reauthorized in 2000 and 2005) has provided some discretionary grants to Tribes to address domestic violence and sexual assault. However, domestic violence and sexual assault have remained serious public safety concerns, partially because responding to and prosecuting these cases is problematic. In his testimony before the Senate Committee on Indian Affairs in June 2007, the President of the National Congress of American Indians explained that the combination of jurisdictional complexity, lack of commitment from Federal and State authorities, and insufficient resources dedicated to law enforcement in Indian Country is leading to increased criminal activity and creating fear in victims to come forward.⁹⁶ He went on to say that —criminal activity is encouraged when ‘routine’ crimes such as domestic violence and drug and alcohol offenses are unaddressed.”⁹⁷ Indeed, Federal Indian law precludes Tribal governments from prosecuting non-Indians. This law creates a serious problem given the high rate of sexual assault against AI/AN women by non-Indian men (nearly 90%) and the resulting high rate of assault cases that go unprosecuted.⁹⁸

The Tribal Law and Order Act (TLOA) of 2010 addresses these significant legal and jurisdictional loopholes. Along with strengthening Tribal law enforcement and increasing Tribal court prosecution and sentencing authority, two sections of the TLOA specifically address domestic violence and sexual assault procedures within IHS. Section 263 addresses the process of obtaining testimony from IHS healthcare providers for legal proceedings and Section 265

requires the development of IHS standardized sexual assault response procedures, in order to ensure that patient care is culturally sensitive, patient-centered, and the community response is coordinated. Taken together, these measures promise to increase the rate of domestic violence and sexual assault conviction,



which may increase the reporting of domestic violence and sexual assault incidents and ultimately change the climate surrounding violence against women in AI/AN communities. There is, however, clearly also a need for prevention, intervention, treatment, and services at the level of behavioral health treatment for both victims and offenders.

BEHAVIOR-RELATED CHRONIC DISEASES

With regard to chronic diseases and behavior-related chronic conditions, numerous health disparities exist in AI/AN populations. According to the CDC's Office of Minority Health and Health Disparities, the top 10 causes of death among AI/AN individuals are listed below.⁹⁹

- | | |
|--|---|
| 1. Heart disease | 6. Stroke |
| 2. Cancer | 7. Chronic lower respiratory disease |
| 3. Unintentional injuries | 8. Suicide |
| 4. Diabetes | 9. Nephritis, Nephrotic syndrome, and Nephrosis |
| 5. Chronic liver disease and cirrhosis | 10. Influenza and Pneumonia |

When comparing death rates for all races with those for AI/AN populations, significant disparities exist. The IHS reports that AI/AN individuals have a 750% greater incidence of tuberculosis, 524% greater incidence of alcoholism, 193% greater incidence of diabetes, and 47% greater incidence of pneumonia and influenza.¹⁰⁰ The CDC also reports that AI/AN individuals are 2.3 times more likely to be diagnosed with diabetes and 1.6 times more likely to be obese when compared with rates among white adults.¹⁰¹ Closely echoing CDC reports on health disparities, Cynthia Manuel, National Indian Health Board Member, noted in her testimony at the Fourth Annual CDC Tribal Consultation, that Tribes consistently identify the following as National Tribal Health Priorities.¹⁰²

- | | |
|--|----------------------------------|
| 1. Diabetes | 6. Injury Prevention |
| 2. Cancer | 7. Maternal and Child Health |
| 3. Behavioral Health* | 8. Dental Health |
| 4. Cardiovascular Disease** | 9. Water and Sanitation |
| 5. Health Promotion/Disease Prevention | 10. Respiratory/Pulmonary Health |

*Including alcohol/substance abuse and mental health

**Including heart disease and stroke

In its overview on Chronic Diseases and Health Promotion, the CDC indicates that four “modifiable lifestyle factors” contribute to most of these causes of death, including: “lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption.”¹⁰³ Indeed, fully 7 of the top 10 causes of death in Indian Country could be favorably impacted by health promotion activities focusing on these four modifiable risk factors.

National Indian Health Board Member Cynthia Manuel's testimony supports this assertion stating, “Tribal communities experience health disparities in multiple forms, and many of the chronic diseases that affect AI/ANs are preventable.”¹⁰⁴

As such, because so many of the leading causes of death in Indian Country and the top National Tribal Health Priorities are preventable, efforts that integrate behavioral health and health behavior modification strategies (e.g., health promotion/disease prevention) into primary care and community settings may have particular benefit for AI/AN populations.

SUMMARY

Each issue profiled in this chapter demonstrates the seriousness of the problems facing our Tribal communities. When read in aggregate, the combined gravity of these issues can become overwhelming, but the efforts to address these problems nationally, regionally, and locally offers hope. The next two chapters of this Briefing Book will explore the work being done to address existing disparities, beginning with a chapter on financing and resources dedicated to behavioral health prevention and treatment, and followed by a chapter profiling behavioral health programs in the 12 IHS Areas.



3. BEHAVIORAL HEALTH FINANCING AND RESOURCES

The purpose of this chapter is to educate and inform about various funding programs that can offer financial support for efforts to reduce the impact of behavioral health issues on AI/AN people and communities. This chapter provides an overview of the funding available to pay for behavioral health programs. It also describes the complexities, challenges, and opportunities in funding AI/AN behavioral health programs. The discussion of funding sources includes an overview of the IHS budget, Medicaid funding for behavioral health services, State and local funding, and Federal discretionary funding. It is followed by a review of other efforts and resources dedicated to advancing integrated behavioral health approaches.

BEHAVIORAL HEALTH FINANCING

Behavioral health services for AI/ANs have many payers. Although specific breakdowns vary among IHS Areas, a combination of Medicaid, IHS, State and local funds, time-limited Federal discretionary grant funding, and Tribal funds make up nearly all behavioral health funding. In addition, the BIA provides funding for Indian Child Welfare and Alcohol & Substance Abuse programs, with most decisions on spending through those programs determined at the Tribal level. Unfortunately, many AI/ANs still receive behavioral health services in correctional institutions.

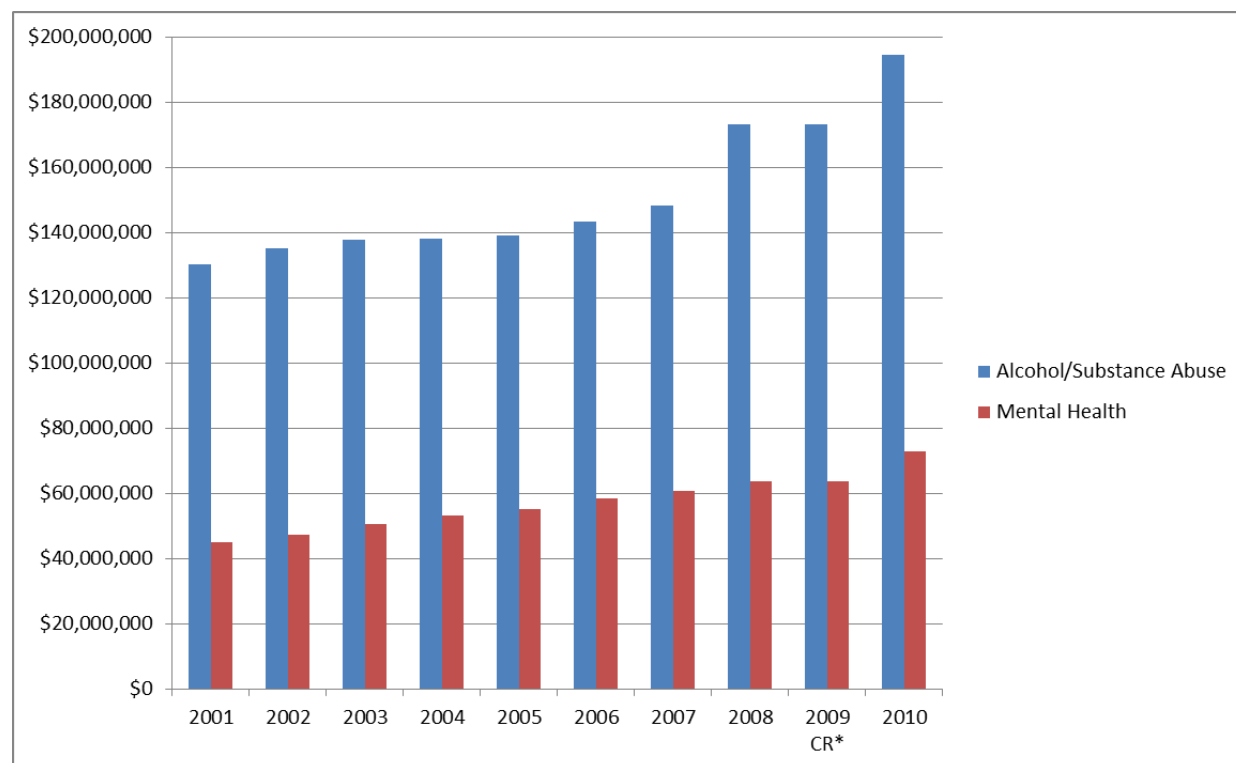
IHS Budget for Behavioral Health

The IHS budget allocates funding for behavioral health services in two line items: mental health and alcohol and substance abuse. In addition, the contract health service (CHS) line item in the IHS budget can fund purchased behavioral health specialty and hospital services. The actual amount of CHS funds spent on behavioral health services is not systematically reported or tracked. Since most contract health programs and mental health and alcohol and substance abuse IHS line items are contracted by Tribes (including most direct service Tribes), Tribes are able to set their own priorities for spending on behavioral health.

Figure 1 depicts the funding for the mental health and alcohol and substance abuse line items in the IHS budget over the past decade.¹⁰⁵ In absolute terms, these line items have increased steadily from year to year. However, these increases have not kept pace with medical cost inflation over the same period. Between 2002 and 2007, medical cost inflation was approximately 8% per year.¹⁰⁶ When compared to behavioral health budget increases, which ranged between 1.7 and 3.9% yearly over the same period, we can see that the actual purchasing power of the IHS behavioral health budget has generally been losing ground against medical costs. In addition, this calculation of the erosion of the IHS behavioral health budget does not include increases in the IHS user population, a second factor that necessitates yearly budget increases to maintain parity of service over time. The overall IHS budget, which includes the CHS line item, has followed a similar pattern in the 2001-2010 decade: while absolute increases have been steady from year to year, the increases have not kept pace with medical inflation and the overall purchasing power for health services has eroded.¹⁰⁷

This overall trend of erosion makes accessing financial support or reimbursement through other payers and programs critical to maintaining services for a growing user population. In addition, it is currently unclear how legislative changes such as the ACA and the Mental Health Parity Act will affect healthcare costs, availability, and inflation for AI/ANs and for the U.S. population overall.

Figure 1. 10-Year Funding History of IHS Behavioral Health Budget Line Items



*CR indicates that the 2009 budget was based on a continuing resolution that matched 2008 appropriations.

Medicaid Payments for Behavioral Health

Medicaid is another significant source of income for behavioral health programs. Each year, Medicaid pays well over \$2 billion for healthcare services provided to AI/ANs, but the exact amount paid for behavioral health services is unknown. Medicaid is by far the largest payer of mental health and substance abuse services, paying for counseling including residential treatment and, in most States, required detoxification services.

An important factor in Medicaid funding for AI/AN healthcare is the Federal Medical Assistance Percentage (FMAP) reimbursement. The cost of any Medicaid services provided by States is eligible for reimbursement by the Federal government at a certain percentage. This percentage is calculated yearly and ranges from 50% to 75% based on a State's per capita income. However, services provided to AI/AN patients in IHS or Tribally operated facilities are always reimbursed at 100%, as mandated in the Indian Health Care Improvement Act of 1976. This legislation was designed to increase access to healthcare services available to AI/AN patients through Medicaid, but it does not protect AI/AN Medicaid patients from service cuts in State Medicaid programs. Reimbursable services for the State's entire Medicaid population may be reduced to address State budget concerns. AI/AN Medicaid patients then lose access to these services, despite the fact that such services may be available through IHS or Tribally operated facilities and that Federal funding would cover those services at 100% reimbursement for AI/AN patients. Cuts like these can dramatically reduce AI/AN access to behavioral health services.

There is no national aggregated estimate of spending by Medicaid or Medicare for behavioral health programs for AI/ANs. Thus, to better understand how Medicaid pays for behavioral health services, it is instructive to review two States where data is available: Alaska and Washington.

Medicaid Behavioral Health Payments in Alaska and Washington

Although neither Alaska nor Washington can be generalized to represent the spending in all States with a large AI/AN population, examining Medicaid's well-documented spending on behavioral health services in these States can help demonstrate Medicaid's importance in augmenting IHS spending and reveals a better estimate of the overall spending on AI/AN behavioral health. It is important to recall, however, that the estimates provided do not include the unknown amount of CHS funding that is spent on the behavioral health services that Tribes cannot provide in their own programs.

In Alaska, AI/ANs made up about 35% of all behavioral health Medicaid beneficiaries and about 41% of all Medicaid payments in 2008. In that year, Alaska Medicaid paid \$50.6 million toward the behavioral health services of Alaska Natives (plus an additional \$1.5 million for American Indians). This compares to FY 2009 IHS payments of about \$33 million combined for mental health and alcohol and substance abuse services. Medicaid paid approximately \$4 million directly to Alaska Native health programs, and the balance was paid to non-Tribal providers. The State has recently worked with Tribes to increase their capacity to deliver behavioral health services in Tribally owned facilities, allowing the State to be reimbursed at the 100% FMAP. It also allows Tribes and the State to achieve their goals of providing service in the patient's home community in order to provide more culturally relevant services.

Notably, Alaska Medicaid has been a leader in seeking approval by the Centers for Medicare & Medicaid Services (CMS) for payment for tele-health services, including tele-behavioral health. Telemedicine has become a tool in Alaska for increasing AI/AN access to psychiatric services with links to remote locations across the State through three key programs: the tele-behavioral health program based at the Alaska Psychiatric Institute, and the tele-behavioral health network based at the Alaska Native Tribal Health Consortium. Alaska was the first State to establish the right to bill Medicaid for behavioral health services delivered electronically via telemedicine.

In Washington State, Medicaid paid more than \$13.6 million to Indian health programs (IHS and Tribal) for mental health services in the fiscal year 2008, as well as an unreported amount to non-Tribal programs. A conservative estimate of the total amount spent by Medicaid on behavioral health services for AI/ANs is approximately \$20 million, with \$13.6 million paid directly to Tribal programs and an estimated \$6.4 million to other providers for detoxification services, residential treatment, and hospitalizations. During the same time frame, the IHS Portland Area distributed a total of approximately \$19 million for behavioral health services in the States of Idaho, Oregon, and Washington, with Washington's share totaling about \$13 million. This review illustrates again the point that Medicaid is a larger payer of behavioral health services than the IHS.

State and Local Funding of Mental Health Services

States and counties also provide funding for behavioral health services. Most of this funding comes from State and local taxes ranging in importance from California's 1% tax on income over \$1 million (dedicated to mental health services) to the small but significant sales tax increases that provide revenues often tied to public safety and other social services (as is seen in King County of Washington State). In Alaska, the State's Mental Health Trust has been a very important source of funding for capital projects as well as for supporting innovations in service delivery.

Figure 2 is a depiction of State Mental Health Authority (SMHA)-managed revenues. The chart depicts mental health funding in a typical State and demonstrates the importance of Medicaid, State own-source funds, and the proportionately smaller amount of funding from other sources like Medicare and Federal grants.¹⁰⁸

Federal Discretionary Funding

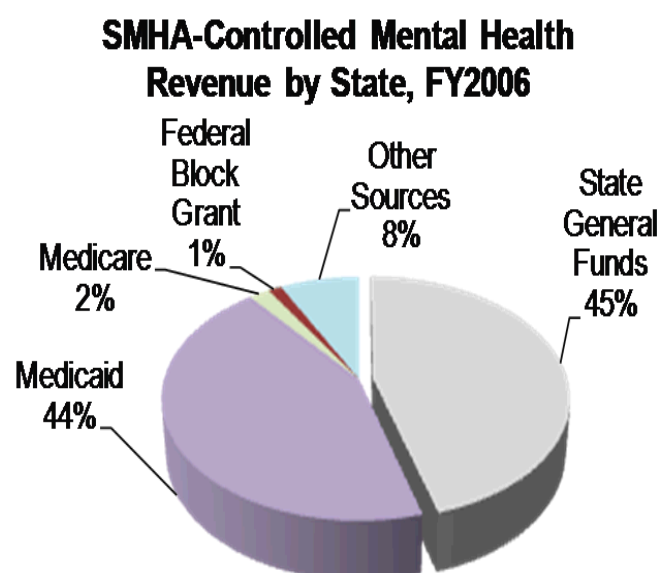
A broad range of discretionary funds are available to augment the basic mental health and alcohol and substance abuse resources available through the IHS budgets, CHS, Medicaid, State, and local funding. Although grants pay just a fraction of the costs for behavioral health efforts in Indian Country, they are an important funding stream for spurring the development or enhancement of innovative programs. The following are examples of grants and funding available to address the behavioral health issues described in the Issue Profiles, including alcohol and substance abuse, suicide, violence, and mental health disorders.

IHS Funds

The IHS disbursed millions of dollars in 2009 and 2010 to address behavioral health issues through the **Methamphetamine and Suicide Prevention Initiative (MSPI)**. MSPI is a comprehensive, coordinated program that provides much-needed, targeted meth abuse and suicide prevention and intervention resources for Indian Country. MSPI funds were dispersed using a demonstration project model through which Area Directors distributed funds to Area Tribes and Tribal organizations using Self-Determination contracts, Self-Governance compacts, and related funding agreements. These funds were also used for projects awarded to IHS programs. In addition, the IHS used MSPI funds to make a limited number of grant awards, primarily to Urban Indian health programs. This initiative promotes the development of culturally appropriate evidence-based and promising practices for prevention and treatment approaches for meth abuse and suicidal behaviors in a community-driven context. Local communities are participating in a national evaluation of the Initiative and developing a local process to measure specific outcomes.

Like MSPI, the **Domestic Violence Prevention Initiative (DVPI)** funds were dispersed in 2010 using a demonstration project model through which Area Directors distributed funds to Area Tribes and Tribal organizations using Self-Determination contracts, Self-Governance compacts, and related funding agreements. Funds were also awarded to IHS programs. Urban Indian health programs were awarded through the grant mechanism. The DVPI is focused on providing targeted domestic violence and sexual assault prevention and intervention resources to communities in Indian Country. The DVPI expands outreach and increases awareness by funding programs that provide outreach, victim advocacy, intervention, policy development, community response teams, and community and school education programs. The funding is also being used for the purchase of forensic equipment and training of medical personnel in responding to sexual assault and domestic violence. The awarded projects will report program data and evidence-based outcome measures.

Figure 2. SMHA-Controlled Mental Health Revenue



Substance Abuse and Mental Health Services Administration Grants

The Substance Abuse and Mental Health Services Administration is a strong advocate and important funding source for AI/AN behavioral health needs. Indeed, between 2006 and 2008, SAMHSA has more than doubled the resources awarded to Indian Country through competitive grants, which in 2008 totaled \$74 million. A sample of SAMHSA's grants that support Tribal behavioral health efforts are summarized below.

Circles of Care (CoC) is a 3-year infrastructure grant funded through the Center for Mental Health Services under the **Systems of Care (SoC)** initiative. CoC began in 1998 as a discretionary demonstration program solely for AI/AN grantees. The goal of the CoC program is to give Tribal grantees the opportunity to develop the infrastructure and capacity to compete for the SoC cooperative agreements or other funding to implement their model system of care. To achieve this goal, CoC funds AI/AN grantees with the tools to plan, design, and assess the feasibility of implementing a culturally appropriate system of care model through community involvement. The CoC program focuses on AI/AN children with or at risk of severe emotional disturbances and their families.

The **State/Tribal Youth Suicide Prevention Grant Program**, often referred to as the —Garett Lee Smith grants,” are an important source of suicide prevention funding for Tribes. The program funds suicide prevention efforts focused on developing and implementing youth suicide prevention and early intervention strategies that are grounded in public/private collaboration.

The **Access to Recovery Program** also provides grants to Tribes. The program uses a voucher system designed to provide clients with choices among substance abuse clinical treatment and recovery support options. To that end, grantees are tasked with developing a network of treatment and recovery providers through which clients may use vouchers to access a range of appropriate community-based clinical treatment and recovery support services.

The **Strategic Prevention Framework State Incentive Grants** provide funding to States and Tribes to assist grantees in developing the infrastructure necessary to deliver and sustain effective substance abuse services.

Other Federal Discretionary Grant Programs

The **Safe Schools/Healthy Students Program** is jointly administered by the Departments of Education and Health and Human Services, and partners with the Department of Justice. The program provides funding to schools, including BIA-funded schools, to implement and enhance community-wide plans that create safe and drug-free schools, and promote healthy childhood development. Programs are expected to develop broad partnerships between local educational agencies, public mental health authorities, law enforcement, and juvenile justice entities.

The Department of Justice's Office of Juvenile Justice and Delinquency Prevention provides grants to current Safe Schools/Healthy Students grantees under the **Mentoring for the Safe Schools/Healthy Students Initiative**. These grants provide funding for community-based mentoring programs between adults (or trained peers) and youth.

Tribes are also eligible to apply for the Department of Education's **Grants for the Integration of Schools and Mental Health Systems**. This program seeks to increase student access to high-quality mental healthcare by developing innovative approaches that link school systems with the local mental health system.

The Department of Justice's Office on Violence Against Women provides grants to Tribes to address and prevent domestic violence and sexual assault. The **Grants to Indian Tribal Governments Program** enhances the ability of Tribes to respond to violent crimes against Indian women, enhance victim safety, and develop education and prevention strategies. The **Tribal Domestic Violence and Sexual Assault Coalitions Grant Program** focuses on increasing awareness of domestic violence and sexual assault against AI/AN women; enhancing the response to violence against women at the Tribal, Federal, and State levels; and providing technical assistance to coalition membership and Tribal communities to enhance access to essential services.

OTHER EFFORTS TO ADDRESS BEHAVIORAL HEALTH

A range of other efforts exist to address behavioral health issues in Indian Country, including the following examples.

Indian Country Methamphetamine Initiative

The Indian Country Methamphetamine Initiative is a collaborative effort to address the problem of methamphetamine in Indian Country. Federal partners included the IHS, Office of Minority Health, SAMHSA, Department of Justice, National Institutes of Health, and the Corporation for National and Community Service. Tribal partners include the Chippewa-Cree Tribe, Choctaw Nation, Crow Nation, Gila River Indian Community, Navajo Nation, Northern Arapaho Tribe, Salt River Pima-Maricopa Indian Community, San Carlos Apache Nation, Winnebago Tribe, and Yakama Nation. These partners are joined by national organizations (Association of American Indian Physicians and One Sky Center) and Tribal organizations (National Congress of American Indians, Northwest Portland Area Indian Health Board, and United South and Eastern Tribes, Inc.).

Native American Center for Excellence (NACE)

An initiative of the SAMHSA, NACE is a national resource center for up-to-date information on AI/AN substance abuse prevention programs, practices, and policies. NACE provides training and technical assistance support for urban and rural prevention programs serving AI/AN populations. NACE recognizes that AI/AN interventions are most often designed within the context of the Tribal culture it is serving, based on the notion that AI/AN communities have the answers to AI/AN challenges. These culture-based interventions (CBIs) are designed for the culture they serve. NACE has set out important opportunities for CBIs through the AI/AN Services to Science Academies, which matches promising AI/AN practices with indigenous evaluators to show —whatworks in Indian Country.”

Native Aspirations

Another SAMHSA initiative, Native Aspirations, works with Tribal communities to address the serious issues of youth violence, bullying, and suicide. Communities are invited to participate in this initiative based on a needs assessment process. By 2013, 65 communities will be working with Native Aspirations to develop and implement Community Prevention Plans. One significant aspect of the Community Prevention Plan is the involvement of multiple community sectors, including the community's youth. Through Native Aspirations, participating communities receive ongoing training, technical assistance, and community prevention funds as they develop and implement these plans as well as ongoing support to ensure the sustainability of their efforts.

Integrating Behavioral Approaches into Primary Care

As was discussed in the Issue Profile on Behavior-Related Chronic Diseases, most causes of death, disability, and diminished quality of life in Indian Country are preventable, whether they are conventionally defined behavioral health issues (e.g., depression, suicide, and drug/alcohol abuse) or associated with specific health behaviors that cause or exacerbate chronic diseases (e.g., nutrition,

physical inactivity, tobacco use, and excessive alcohol consumption contributing to cancer, diabetes, and heart disease).¹⁰⁹ These issues have also been noted as “National Tribal Health Priorities” by the National Indian Health Board.¹¹⁰

In their publication, *Integrating Mental Health Into Primary Care: A Global Perspective*, The World Health Organization (WHO) and World Organization of Family Doctors (Wonca)¹¹¹ clearly articulate the importance, cost-effectiveness, and enhancements to patient outcomes when behavioral health efforts are appropriately integrated into primary care settings.

The IHS Improving Patient Care Initiative (IPC) will be proactively addressing this need in the coming year. The IPC seeks to improve both quality of and access to care using a patient- and family-centered approach to care that also focuses on the continuity of care with a well-coordinated healthcare team.¹¹² According to Dr. Yvette Roubideaux in her *Director’s Update for the Indian Health Service/Bureau of Indian Affairs Behavioral Health Conference* in July 2010, the integration of behavioral health into the IPC Initiative will be “a new focus this year.”¹¹³

Several innovative approaches to addressing behavioral factors associated with health status are showing promise in decreasing the risk of premature death and chronic disease in Indian Country, including (but not limited to) integrating behavioral health with primary care. For instance, best practices within IHS have been identified for the identification and treatment of co-morbid depression and diabetes. Since a diagnosis of diabetes doubles the odds of co-morbid depression, 1/3 of people diagnosed with diabetes will be diagnosed with depression, and AI/AN individuals with diabetes are more than three times more likely than other populations to also carry a diagnosis of depression. As such, new programs train providers to screen for and treat depression in conjunction with teaching health behavior practices associated with managing diabetes.¹¹⁴

Another example is seen in efforts to integrate domestic violence prevention into healthcare settings. As profiled in *Building Domestic Violence Healthcare Responses: A Promising Practices Report*, “the healthcare setting offers a critical opportunity for early identification and primary prevention of abuse.” The report also indicates that, as a result of the Government Performance Results Act (GPRA), which required all IHS facilities to institute policies and procedures regarding domestic violence, there was a 12-fold increase in the percentage of women screened by their providers for domestic violence between the years 2004 and 2008.¹¹⁵

Outcomes from programs like these that integrate primary healthcare and behavioral health approaches in innovative, patient-centered ways point toward the significant impact that can be made on both behavioral health issues and the health behaviors that contribute to chronic diseases and death.

COOPERATION IN BEHAVIORAL HEALTH CARE DELIVERY

In addition to the programs and funding sources described above, there have been recent cooperative initiatives at the Federal level that promise to improve behavioral healthcare access, delivery, and research by building partnerships between Federal agencies. These cooperative efforts are often initiated and defined by Memoranda of Understanding (MOUs), Memoranda of Agreement (MOAs), and Interagency Agreements (IAAs) between agencies.

The first MOA, signed in October 2009 between the IHS, BIA, and BIE, defines the goal of cooperating with Tribal governments in developing a systemic approach to substance abuse, including collaboration on data collection, resources, and programs. Tribes will take the lead in identifying service needs and best practices, but the IHS, BIA, and BIE will work with Tribes towards comprehensive cooperation in substance abuse prevention and treatment, as well as mitigating the effects of controlled substances on

communities. Pursuant to the MOA, ongoing collaborative efforts will address adult and juvenile detention centers and related substance abuse services, resources to support YRTCs, health services available for students and families through residential schools, program development for community-based adult services, child welfare services for drug-endangered children, and data collection needs. In addition, Section 703 of the IHCA provides new authorities that permit the DOI and HHS, acting through the IHS, to develop and enter into a MOA, or review and update any existing MOAs, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 United States Code 2411). DOI and IHS have developed an amendment to the 2009 MOA that includes language consistent with the new IHCA provision. The MOA amendment was signed in March 2011.

A second MOU between the U.S. Department of Health and Human Services and the Canadian Department of Health for 2007 to 2012 focuses on cooperating to improve health for the First Nations and Inuit in Canada and AI/ANs in the U.S. By working together to exchange information and personnel, and to conduct workshops, conferences, and other joint gatherings, the agencies of both countries hope to share knowledge, improve their approaches to Native health, and identify and reinforce best practices. Special areas of focus under this MOU include suicide prevention, prevention and treatment of alcohol and substance abuse, health research, maternal and child health, and urban and community health.

A third MOU related to behavioral health services, new as of October 2010, is an MOU between IHS and the Department of Veterans Affairs (VA) that increases cooperation in service delivery, promising to increase access to medical benefits, including mental health and substance abuse services for AI/AN veterans. The MOU requires the establishment of an implementation task force, the engagement of VA and IHS leadership to set priorities for action among the topics identified, and an annual report of progress. It also makes clear the necessity and importance of Tribal consultation.

A final cooperative initiative is the signing of an IAA, in August 2010, between the IHS and Department of Justice Office for Victims of Crime (OVC) to provide training and technical assistance to address the needs of sexual assault victims. The OVC has established a coordinated, multidisciplinary project, the Sexual Assault Nurse Examiner (SANE) and Sexual Assault Response Team (SART) AI/AN Initiative, which will involve multiple agencies. The overall goal of the Initiative is to restore the dignity, respect, and mental and physical health of victims of sexual assault and ensure more effective and victim-centered investigations and prosecutions. The Initiative will support victim recovery, satisfaction, and cooperation with the Federal criminal justice system, as well as support victims' of sexual assault and Tribal communities' need for justice.

4. IHS AREA PROFILES AND BEHAVIORAL HEALTH PROGRAM SPOTLIGHTS

This chapter describes the behavioral health efforts that are currently conducted in each IHS Area. To further illustrate the innovative, culturally relevant behavioral health activities being conducted across the IHS Areas, this chapter also describes in greater detail one or more significant behavioral health efforts from each Area in a program spotlight that follows the Area profile.

INTRODUCTION TO THE IHS AREA OFFICES

The IHS has a service population of approximately 2 million from 565 different Federally recognized Tribes and 34 urban Indian communities; about 1.5 million are considered IHS active users (i.e., persons who have received care in the most recent three-year period). The mission of the IHS is to raise the health status of the AI/AN people to the highest level possible. Efforts toward achieving this mission include the administration of direct healthcare services through a system of 12 Area Offices and 163 IHS and Tribally managed service units. A map of the IHS Areas is provided below. The pages that follow provide a profile of behavioral health services and resources in each Area, along with a program spotlight that details a featured behavioral health program.

Figure 3. Map of IHS Areas



ABERDEEN AREA PROFILE

The Aberdeen Area covers the four States of North Dakota, South Dakota, Nebraska, and Iowa. As of 2009, it serves a user population of 121,903 that includes approximately 104,000 Indians living in rural areas and on reservations located in the four States of the Area, as well as the urban Indian population of Rapid City, SD. Tribes located in the Aberdeen Area service territory include the Mandan, Hidatsa, Arikara, Winnebago, Omaha, Chippewa, Ponca, Sac and Fox, and Sioux.

The Area Office, located in Aberdeen, SD, works in conjunction with 13 Service Units including nine hospitals, eight health centers, two school health stations, and other smaller health stations and satellite clinics. Tribal involvement is a priority for the Area, and several Tribes provide partial or full management for their own healthcare programs through contractual arrangements with the IHS.

Overview of Behavioral Health Efforts and Resources in the Aberdeen Area

The Aberdeen Area currently has 15 mental health/social service programs and 29 substance abuse programs. The Area has one YRTC, an Adult Drug Dependency Unit (DDU), and an Inpatient Psychiatric Unit. The administration of these three facilities, as well as direction for the Area Behavioral Health Program, occurs under the supervision of the Deputy Area Director for Behavioral Health, Aberdeen Area Office. Personnel for these programs include psychologists, social workers, mental health specialists, alcohol and drug counselors, psychiatric nurse practitioners, mental health technicians, social service representatives, and support staff.

The Inpatient Psychiatric Unit is a nine-bed, co-ed facility located at the Rapid City Service Unit that includes tele-psychiatry consultation, step-up and step-down treatment strategies, intensive outpatient therapy, and mid-range services that are severely needed in the Area. The facility does not currently provide any inpatient treatment due to a reorganization that will place it directly under the Aberdeen Area Division of Behavioral Health. It is scheduled to begin providing inpatient care in 2011. Outpatient behavioral health services are currently offered at the facility.

The DDU is a 16-bed, medically based, co-ed facility adjacent to the IHS hospital in Winnebago, NE. The DDU will offer residential treatment and partial hospitalization services to eligible AI/ANs who live within and outside the Area. It combines traditional and evidence-based practices in treatment.

The YRTC, accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and the State, is an 18-bed, co-ed facility located on the Standing Rock Reservation near Wakpala, SD. The treatment center is for adolescents ages 13 to 18 diagnosed with primary substance abuse treatment needs or who have concurrent mental health treatment needs. YRTC treatment integrates a strong cultural and spiritual approach within a structured residential treatment program. Families are encouraged to be active partners in the residents' recovery process and often stay onsite to promote holistic recovery.

In addition to these three facilities, the Aberdeen Area also administers an involuntary civil commitment program to pay hospital charges for American Indians in North and South Dakota who require involuntary psychiatric hospitalization, usually for short stays of one week or less. Patients eligible to receive payment from this program must reside on reservation land, have no alternate resources, and have a primary psychiatric diagnosis. The program's budget is \$1.8 million and was created as a result of the *White vs. Califano* case that addressed psychiatric healthcare needs within the jurisdictional issues unique to North and South Dakota.

Along with these treatment programs and facilities, the Aberdeen Area employs a wide range of approaches to provide suicide prevention. The Aberdeen Area has the second highest suicide rate in the IHS system (next to the Alaska Area). The Area uses Question, Persuade, and Refer (QPR) and has a Master Trainer who provides requested training for this approach. The Area also teaches Applied Suicide Intervention Skills Training (ASIST) and has a certified trainer for this method of suicide intervention. The Area has used the Takoja (Grandchild) Program and safeTALK, to provide for a wide range of behavioral health needs including suicide prevention and intervention and substance abuse prevention services. The Aberdeen Area maintains one of the most comprehensive suicide databases in the nation. The template used in the current Electronic Health Record to report suicidal behaviors is modeled on Aberdeen's data form, which collects detailed information on suicidal behaviors including attempts, ideations, and completions. Many suicide data collection systems only count completed suicides retrospectively through searching death certificates.

Program Spotlight: Aberdeen Area Annual Behavioral Health Conference

The Aberdeen Area hosts an annual behavioral health conference each spring. The conference provides updates on clinical skills, introductions to new treatment modalities, networking for all program staff who attend, and an opportunity for all disciplines to earn continuing education credits and continuing medical education for physicians. It also provides an opportunity to recognize the outstanding work of the mental health and substance abuse programs and staff of the Area. Attendance is usually well over 100 participants and includes behavioral health providers from other Areas and outside agencies.

A multidisciplinary conference committee, including representatives from the Alcohol and Mental Health/Social Services program, actively participates in the year-long planning process that begins immediately following the completion of each conference. The conference activities are determined with input from different sources, including an annual needs assessment and recommendations or requests gathered from conference evaluations. The conference theme is drawn from the behavioral health priorities of the Aberdeen Area and developed by the planning committee. Past themes have included gang activity prevention, violence and bullying, traditional healing, suicide prevention, critical incident stress management, children's mental health needs, needs of the elderly population, and methamphetamine prevention, to name a few. The conference is also used to disseminate information on all Tribal consultations that have occurred since the last conference.

In conjunction with the annual behavioral health conference, other important programs in the Aberdeen Area support the education and training of behavioral health professionals. For example, the Area is a leader in helping to establish and maintain a cultural competency course for State and private agencies that also serve the Area's user population. The course is called, "The Native American Cultural Curriculum," and it provides education on AI/AN culture, history, programming, counseling skills, and other dynamics associated with serving AI/AN persons in a health setting.

ALASKA AREA PROFILE

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of over 30 Tribes, Tribal organizations, and regional health corporations providing health services to AI/ANs in Alaska through a self-governance compact (\$574 million in FY 2010) with IHS. Each of the Tribal health organizations (THOs) within the ATHS is managed and operated independently, while remaining interconnected through the system's sophisticated pattern of referrals and their primary mission of improving the health status of Alaska's AI/AN population. The ATHS served 138,298 active users in 2009, representing 231 Federally recognized Tribes. The mission of the ATHS is to provide excellent healthcare to Alaska's AI/AN population, more than half of whom live in remote communities across Alaska's immense 586,412 square miles of mostly roadless land.

Overview of Behavioral Health Efforts in the Alaska Area

Currently in Alaska, there is not a coordinated single system of behavioral healthcare for AI/ANs. Each THO provider of behavioral health services functions independently and determines the types and amounts of services to be made available in each region. The service level in different geographic areas of the State reflect the different capacities of various THOs, including individual funding capacity, different opportunities to maximize economies of scale, and the stability and vision of individual THO leadership.

Even so, most THOs operate multi-layered and complex behavioral health programs within their regions. Specific services offered in each geographical location are varied depending on regional needs, desires, funding, and capacities of individual THOs. They administer programs for mental health and substance abuse education and prevention, as well as outpatient mental health and substance abuse treatment, and residential treatment centers. In general, THOs provide behavioral health services across all levels of a community (e.g., small village communities, sub-regional centers, regional hubs, and urban areas), but not every village, sub-regional, or regional location offers all of the services described.

Limitations to service provision are often related to issues of financing and regulatory processes. For example, funding for services is challenged by inconsistent grant opportunities, performance-based funding, and inflexible financing processes (e.g., requirements for prior authorization). Furthermore, some of the most significant financial barriers are related to medical coverage and reimbursement for services. Across the continuum of care, particularly for those individuals who have high needs, there is a range of behavioral services that are not reimbursable (e.g., prevention and early intervention services). Throughout the ATHS, reimbursements are often limited to Medicaid-recognized providers, yet Medicaid reimbursement rates tend to be minimal and frequently restrict access to best practice models.

In addition to limited reimbursements for patient services, growth of the behavioral health workforce is limited by restrictions on reimbursable services for workforce staff (e.g., clinical supervision). Furthermore, despite attempts to increase the number of behavioral health workers serving in the ATHS, recruitment and retention efforts are regularly hindered by limited access to training, inadequate financial resources, and insufficient technological equipment needed to provide behavioral health services to individuals in rural communities. The organizational capacity of the ATHS behavioral health workforce is further strained by inadequate billing systems, non-integrated documentation policies, and the need to strengthen partnerships with external resources and organizational systems.

Overview of Behavioral Health Resources

While Tribes provide a large variety and scope of behavioral health services, very little of their funding for behavioral health services is IHS funding designated for behavioral health services. Instead, Tribes use the authority under their compacts with the Federal government to reprogram IHS funds and merge them with funding from other sources, including State grants, third-party reimbursements, and private grants, to

carry out comprehensive behavioral health programs. The State of Alaska, Department of Health and Social Services (DHSS) is a critical source of financial support for behavioral health services in Alaska, including services provided to AI/AN beneficiaries. The State finances these services through a variety of funding mechanisms including grants to behavioral health service providers and Medicaid reimbursements to enrolled providers (both of which include Tribal providers), as well as direct services provided to AI/AN persons at the Alaska Psychiatric Institute, a State-operated inpatient psychiatric hospital.

Grant funding to urban THOs for mental health services is not proportionate to the number of Native people residing in those areas. Increasing in-migration of Alaska Native people from villages to more urban areas causes a greater cost burden not covered by reimbursement and grants to THOs in order to meet the primary healthcare demands of the population. The strain on IHS funds, in conjunction with inadequate State mental health grants and services reimbursement, creates serious shortfalls in the ability to meet patient needs.

Program Spotlight: Behavioral Health Aide Program

The Behavioral Health Aide (BHA) Program is unique to Alaska and was developed to address behavioral healthcare needs within the AHS in communities with limited access to behavioral healthcare. The BHA Program promotes healthy individuals, families, and communities in rural Alaska by training local people (e.g., village-based individuals) to provide a full range of behavioral health services. The BHA Program has established standards and procedures for development, implemented a certification process, and developed assessment processes for ongoing training needs of BHAs. The program places emphasis on foundational knowledge and skills for working with clients of diverse ethnic or racial heritage, age, gender, lifestyle, or socioeconomic status. BHA certification is a multi-level provider model composed of a BHA trainee (non-certified), certified BHA I & II (offering primary function services), and the certified BHA III & BH Practitioner (who offer services for more complex behavioral health services).

BHAs are an integral part of the rural behavioral healthcare delivery system. This special group of workers is critical to rural behavioral health service delivery and to support prevention and early intervention activities to avoid more costly and higher-acuity of care. Rather than the approach that requires a diagnosis before treatment, this program promotes an approach that intervenes early and disrupts the cycle of maladaptive behaviors and poor choices that can lead to health problems. Most BHAs come from the community where they are providing services and are trusted by community members. BHAs make a lasting impact by providing culturally appropriate care where an entire family can be involved if needed. Culturally based care combined with family involvement is often the most effective way of treating Alaska's AI/AN clients.

ALBUQUERQUE AREA PROFILE

The Albuquerque Area is responsible for the provision of health services to 27 different Tribal groups and 85,948 active users in 2009. In New Mexico, the Tribes served are the 20 Pueblos, the Jicarilla and Mescalero Apaches, and the Alamo, Canoncito, and Ramah Chapters of the Navajo Nation. Located in Southern Colorado are the Southern Ute and the Ute Mountain Ute Reservation (extending into a small portion of southern Utah). In Texas, the Ysleta Del Sur Reservation is served. In addition, numerous Tribal members from throughout the U.S. who live, work, or go to school in the urban centers of the Albuquerque Area are provided services in IHS health facilities.

Overview of Behavioral Health Efforts in the Albuquerque Area

Behavioral health services within the Albuquerque Area are a joint venture between the IHS, Tribes, and urban programs. Within the Area, there are 21 Tribal programs providing behavioral health services. Two urban programs in Albuquerque and Denver provide services to AI/ANs located in the largest cities within the Area. Approximately 85% of substance abuse services are provided by Tribal and urban programs. IHS provides behavioral health services through six behavioral health departments within service units and health clinics. Approximately 80% of mental health services are provided by IHS. The IHS New Sunrise Regional Treatment Center provides residential substance abuse treatment services for AI/AN youth from all over the Southwest.

The Area behavioral health program has focused on providing better access to behavioral health services through numerous partnerships. These partnerships have primarily focused on youth. For example, the Area funds the Model Dorm Project at the Santa Fe Indian School. This project focuses on substance abuse prevention for high school students residing on campus. Substance abuse prevention services are also provided to students attending the Southwest Indian Polytechnic Institute (SIPI) in Albuquerque. A revised Interagency Agreement (IAA) will allow for expanded mental health services at SIPI. Through a new IAA, behavioral health services will be provided to the Albuquerque Job Corps. This high-need, high-risk student population currently has very limited access to behavioral health services, and it is expected that this agreement will significantly improve the success of the students there.

The Area behavioral health program also houses the IHS Tele-Behavioral Health Center of Excellence. These funds along with a long-standing partnership with the University of New Mexico Center for Rural and Community Behavioral Health has allowed the Area to provide child psychiatry and addictions psychiatry services to rural and frontier areas. The Center is currently providing services to four IHS sites and will soon be providing services at two Tribal sites and two urban sites. This program has significantly increased the access to care in high-need areas. It is planned that the Center will offer these services on a regional and national basis. Along with direct patient care, services such as education, consultation, psychotherapy, and resources such as group support and supervision will soon be offered via tele-video.

Program Spotlight: Zuni Recovery Center

The Zuni Recovery Center is an intensive outpatient clinic for substance abuse treatment. It is located on the Zuni Reservation, a reservation of 450,000 acres in New Mexico and Arizona, and serves the reservation's 10,000 Zuni residents. It serves all ages of clients, including children ages 10 and younger. Ages 10 and 11 are about the youngest ages at which the center sees kids beginning to experiment with substances. Treatment for this age is critical because young children who use controlled substances have a five times greater chance of developing an addiction or further complications than people who begin using substances in their 20s. The center receives approximately 2,000 referrals per year. Every person served has an individualized treatment plan, and a varied menu of group therapies are also available offering self-enrichment, therapeutic and confidential support groups, communication and stress

management skills, arts and crafts (a curriculum that is partly Zuni cultural education), and cultural education classes.

The Zuni Recovery Center addresses many different substance abuse issues within the community. The primary substance currently causing major health problems is alcohol, and the second is marijuana. The center is also witnessing an increase in gambling addictions and the abuse of prescription drugs. Methamphetamine addiction is seen only rarely, in large part because of concerted prevention efforts. The Tribe received MSPI funding and started a prevention campaign in 2008, and the Recovery Center has seen only one meth case in treatment since that time. Dr. Robert Currier, the Center's Director, estimates that after an additional year of prevention work, the community will be 90% meth free. "The kids are kind of scared of it, and they don't like the meth teeth," he explains.

The Recovery Center focuses on culturally specific and innovative approaches, as well as making a bridge between traditional medicine and modern clinical practices. Six licensed Zuni practitioners on staff play a key role in making that connection. There are also three cultural educators who teach Zuni history, dance, arts and crafts, and language. Along with teaching at the center, they offer educational and social programs in the community and in other cities. This emphasis on Zuni culture dovetails with the Recovery Center's integrated approach that looks at psychological, social, biological, and spiritual factors for all people served. Because of its geographic isolation, the Zuni Tribe has been able to maintain its language, religious practices, and ancestral location more so than almost any other Tribe in the country, which offers a unique level of cultural continuity. Program participants at the Zuni Recovery Center can make visits to sacred religious sites and travel to the Grand Canyon, the place of the Tribe's ancestral beginnings. The inclusion of culture in substance abuse therapy has had many positive results.

An especially important aspect of the Zuni Recovery Center's success is that their staff works as a healthy, functional team, with open communication, trust, and respect. The positive culture they have built among themselves translates directly to their work with clients and helps to form a therapeutic and healing environment. Staff culture is holistic in that it promotes and is founded on self-respect and self-care. Staff are not allowed to work more than 40 hours per week and are given an hour for exercise three times a week. Along with building healthy and cooperative relationships in their organization, they serve the community by being available for consultation to assist other programs.

One challenge that the Zuni Recovery Center faces is addressing the continuum of care for their clients. Because the Center offers only outpatient care, there are limitations for people who need more. While some local inpatient substance abuse programs are available, the biggest challenges are patients with chronic alcoholism who may need a minimum of 6 months of inpatient treatment, which local inpatient facilities cannot provide. Achieving meaningful sobriety, addressing family dysfunction, and confronting second or third generation alcohol addiction within a family are ongoing trials. Additional challenges are similar to those faced by other behavioral health programs, including maintaining an adequate budget, getting clinicians from the Tribe licensed, and dealing with community denial and stigma about receiving treatment.

BEMIDJI AREA PROFILE

The Bemidji Area Office is located in Bemidji, MN, and provides funding and healthcare support services for approximately 102,782 active users living in Minnesota, Wisconsin, Michigan, Indiana, and Illinois. There are 34 Federally recognized Tribes within the region. The IHS operates two short-stay medical hospitals, three ambulatory health centers, and five health stations. Under the 1976 Indian Self-Determination Act (PL 93-638), 25 Tribes operate their healthcare programs pursuant to PL 638 Title I contracts, and nine Tribes have Title V self-governance compacts.

Overview of Behavioral Health Efforts in the Bemidji Area

The Bemidji Area Alcohol and Substance Abuse (A/SA) Program consists of the Area Office-managed adolescent treatment program, a decentralized system where youth are referred to inpatient treatment programs throughout the region, and four Tribally operated adult inpatient treatment facilities with a total of 43 beds. Thirty-four outpatient programs are operated by Tribes and four by urban centers. In addition, 30 Tribes and the urban centers have aftercare programs. Seven halfway houses operate on Tribal lands while three are in urban locations, totaling 60 beds, and most programs have prevention components.

Counseling services are provided by professionals with a range of educational degrees, certifications, and experience, including certified alcohol counselors and licensed addiction specialists. The Bemidji Area Office provides multidisciplinary behavioral health training approximately once a quarter to meet professional needs, specific initiatives, and advances in best practices. Availability of sufficient AI/AN behavioral health professionals, especially psychologists and child/adolescent and adult psychiatrists, remains a significant challenge throughout this rural region.

The “~~Bridge~~ Bridge Program” project is an example of an innovative approach that was undertaken in the Bemidji Area to meet behavioral health needs. The program ran for 3 years (2006-2009) under a collaborative agreement between the Red Lake IHS Hospital in northern Minnesota and the Minnesota Psychiatric Society (MPS). The program consisted of a group of MPS member volunteer psychiatrists, both a child/adolescent and an adult specialist, who were scheduled together on a rotating basis to perform evaluations and respond to emergency consults in the Emergency Department/Urgent Care on weekends, thereby extending valuable coverage. Another key partner was the “~~Angel~~ Angel Flight” organization—pilots who volunteered their airplanes and services to bring psychiatrists to and from the nearest airport in Bemidji, MN.

The Bemidji Area has two Tribal MSPI projects underway since 2009 to address youth substance abuse, treatment, and suicide prevention. These programs are funded for 2 years at a total of \$1.4 million. Additionally, an IHS hospital received a DVPI Demonstration Project award for \$216,000 for expansion of their Sexual Assault Nurse Examiner and Sexual Assault Response Team program.

Overview of Behavioral Health Funding/Resources

Funding for the Bemidji Area A/SA Program totals \$10,373,267 from appropriated funds and is distributed to Tribal, Urban, and contracted programs. Tribal dollars are a substantial supplement to IHS and Medicaid payments for A/SA services provided to patients. In addition, grants and some county funding are utilized to support these programs. Of FY 2010 total recurring bases allocations, \$7,750,659 or 75% was allocated to Tribal programs and \$244,706 or 24% to Urban programs. Remaining dollars fund the Area Office-operated adolescent treatment program at \$1 million per year and contracted programs at \$1,035,504.

Program Spotlight: Fond du Lac Behavioral Health, Miikanaake Program

The Fond du Lac Behavioral Health Department is a part of the Human Services Division, located on the Fond du Lac Reservation about 15 miles west of Duluth, MN. The Fond du Lac Reservation has more than 3,700 enrolled members, and approximately 9,120 active users from over 30 Tribes use its Human Services programs. The Behavioral Health Department offers a full range of individual and family counseling; school counseling; EMDR (eye movement desensitization and reprocessing) therapy, a specialty service that is especially effective in treating post-traumatic stress disorder; and long-term and mid-term outpatient chemical dependency treatment programs that they run on the reservation. They also have partnerships with three outpatient treatment programs in Minneapolis and St. Paul.

Balance and harmony have always been prized values in Ojibwe culture. In order to rebalance patients' thinking and improve health and well-being, Fond du Lac Behavioral Health has made a new treatment option available through the Miikanaake Program, named in Ojibwe *to make a new road or trail.* This innovative program is showing amazing results for treating behavioral health issues, including long-term methamphetamine, stimulant, and prescription drug abuse, as well as depression and anxiety. The Miikanaake Program provides brainwave optimization sessions to its patients using high-resolution, relational electroencephalic (EEG) mirroring. The Miikanaake Program integrates cutting-edge technology, training and certification, ambient sounds from nature, and techniques similar to traditional meditation and prayer to provide a service that helps patients move back into balance and harmony.

Participation in the Miikanaake Program starts with an introductory session, during which the patient and certified practitioner review the patient's goals. The practitioner conducts an assessment, using EEG sensors attached to specific scalp sites, to gather brainwave data from different parts of the brain. Using this data, the practitioner individualizes the treatment plan for each patient. Treatment sessions consist of at least once-daily brainwave optimization sessions involving computer translation of brainwaves into sounds that represent optimum patterns for a specific patient's brain. The sounds vary, allowing the patient's brain a means of observing itself at optimum levels. Patients are also led through visualization exercises that help them find a more balanced state. The sensors gather data in real time based on the patient's experience, which allows the sessions to evolve over time. Brainwave optimization is an intensive process, requiring daily participation for one week followed by maintenance sessions as needed. Patients are also encouraged to participate in traditional counseling sessions throughout the process. In order to take part in the program, patients need to be actively engaged in outpatient chemical dependency treatment or a smoking cessation plan, or they must have a referral from a Fond du Lac primary care provider.

The Miikanaake Program is having astounding success rates. A study of about 20 long-term substance abuse patients has shown approximately a 50% success ratio 6 months out from treatment. Moreover, patients being treated for long-term depression, anxiety, and insomnia are also experiencing incredible results. One participant suffering from major depression said of the Miikanaake Program, *“At first I thought it sounded way _out there_ by description, but I was willing to try anything. What did I have to lose? So I was hooked up, literally, and the amazing result is that I no longer suffer from depression.”*

BILLINGS AREA PROFILE

The Billings Area is responsible for the delivery of health services to the American Indian Tribes of Montana and Wyoming. Its user population was counted in 2010 at 71,487 and includes members of Plains Tribes living on eight reservations in the two-State area and in surrounding communities. The Tribes served are the Blackfeet, Crow, Confederated Salish & Kootenai (CSKT), Assiniboine, Gros Ventre, Sioux, Northern Cheyenne, Northern Arapaho, Eastern Shoshone, Chippewa, and Cree. Five urban programs are located in each of the major cities in Montana; these include the Indian Health Board of Billings, North American Indian Alliance in Butte, Missoula Indian Center, Helena Indian Alliance, and Indian Family Health Center in Great Falls.

Overview of Behavioral Health Efforts and Resources in the Billings Area

There are multiple behavioral health programs in the Billings Area. The Blackfeet, Crow, Fort Belknap, and Wind River programs are operated through the IHS. The Northern Cheyenne program is contracted, and the CSKT and Rocky Boy programs are fully compacted Tribal programs. All these programs employ licensed Ph.D. or Psy.D. psychologists, licensed clinical social workers, and master's-level licensed professional counselors. All Tribal and urban programs provide chemical dependency counseling services by licensed mental health professionals or licensed addiction counselors. When addiction counselors hired for these programs are not yet licensed, programs work to help them obtain licensure quickly. Services provided include substance abuse treatment modeled on a co-occurring model of assessment and treatment, psychological evaluation and treatment, psychosocial assessment, crisis intervention, trauma intervention, case management, medication management, traditional healing methods, and community prevention and education.

The Billings Area Office works to provide leadership for Area behavioral health programs and to foster a spirit of cooperation among the network of programs managed by Tribes, State offices, and urban groups. The Area Office recently made a commitment to providing tele-behavioral health services to remote locations, assisted by a Behavioral Health Consultant who is experienced in telemedicine and its hardware and software tools. In 2010, conference call phone stations were purchased for all remote behavioral health offices in the Area and four dedicated office spaces in the Area Office were designated for telemedicine and tele-psychiatry. The Area also recognizes the value of prescriptive authority for psychologists. Several Area providers are pursuing master's degrees in Clinical Pharmacology, and a prescribing psychologist on the Crow medical staff has greatly enhanced integrated services and has brought many drugs of abuse into compliance with accepted treatment standards. Finally, the Area encourages all chemical dependency programs to hire a mental health professional on staff because it is estimated that 80% of new clients have co-occurring disorders.

The Billings Area Office has developed partnerships that are important in providing behavioral health resources to the Area. The Billings Area Office collaborates with the Montana-Wyoming (MT-WY) Tribal Leaders Council leadership and staff for various grant awards they have received dealing with chemical dependency treatment, methamphetamine treatment, suicide prevention, and suicide epidemiology. The Tribal Leaders Council also plays a key role in identifying problems, designing education, and bringing Tribal action forward, including holding conferences that support staff training and leadership development, and building relationships across different fields such as behavioral health, Tribal Council, law enforcement, traditional healers, social services, and others. The Montana Department of Health and Human Services has partnered with the Tribes and IHS to resolve barriers in access to services, most recently during a suicide cluster. Finally, the University of Montana Native American Children's Trauma Center is involved with IHS and school systems to address secondary trauma, provide case management for at-risk youth, and to provide community training.

Program Spotlight: Northern Arapaho Tribe Methamphetamine and Suicide Prevention Initiative Program

The Northern Arapaho Tribe MSPI program was built on the foundation laid by a SAMHSA grant awarded to the MT-WY Tribal Leaders' Council called Planting Seeds of Hope. In 2009, the MSPI program expanded to include Tribal elders, the Area Behavioral Health Office, the Fremont County Suicide Prevention Task Force, Wind River Tribes Alcohol and Drug Court program, White Bison Alcohol and Drug Treatment program, reservation public schools, and Lander and Riverton, WY, schools, among other partners. This program has created a unique safety net for highly suicidal clients that were previously under-identified.

One of the most important accomplishments of this program is the integration of traditional cultural practices with all aspects of treatment and prevention of suicide. The Wind River Service Unit, in conjunction with IHS Behavioral Health, produced a protocol on the supplementation of clinical practices with traditional practices, a treatment modality that has been effective and widely accepted for clients at risk for suicide. To implement this protocol, sweat lodges were built at Arapaho and Fort Washakie, the two IHS clinic locations, and are used for clinic patients who request the inclusion of traditional practices in their treatment, returning warriors (men and women veterans), and others. To bring additional support to youth, the Wind River Tribal Youth Program, in conjunction with a new Planting Seeds of Hope grant, has implemented talking circles for youth. Strengthening Families, an evidence-based program, also uses talking circles and sweats to bring families together for healing and rebuilding family relationships. In the case of completed suicides, elders help bereaved families by setting up tepees for wakes and helping to get wood. They find sources of food and are there to support the family in whatever form is needed. They have assisted families by cleaning, bringing in an elder or traditional healer to cedar and bless the home, offering prayer, and talking to families to help them with their trauma and be part of their healing process.

The Northern Arapaho Tribe MSPI program has also partnered with other programs. In collaboration with the Fremont County Suicide Task Force, community-wide suicide awareness and prevention efforts have been launched, including Lifeline information billboards, public service announcements, and displays at health fairs. The ASIST evidence-based training has been provided across the Wind River reservation. Other prevention initiatives on the reservation include the NATIVE H.O.P.E. (Helping Our People Endure) program, Responsible Fatherhood, and The Good Road of Life by Dr. Clayton Small. These initiatives have partners in WIC programs, youth services, court-based diversion programs, and substance abuse treatment. The Northern Arapaho Tribe MSPI program demonstrates the successful integration of a strong practice-based cultural component into many aspects of service programs across the reservation.

CALIFORNIA AREA PROFILE

The California Area Indian Health Service (CAIHS) does not administer direct service programs. All Area healthcare services are delivered through PL 93-638 self-determination contracts (Title I) or PL 93-638 self-governance compacts (Title V). California is home to the largest population of AI/ANs in the country, numbered at nearly 800,000. There are 107 Federally recognized Tribes within the State; however, most AI/ANs represent Tribes from outside the State. California Tribal health programs had 78,682 active users in 2009.

Overview of Behavioral Health Efforts in the California Area

There are presently 31 California Tribal health programs operating 57 ambulatory clinics under the authority of the Indian Self Determination Act. In addition, there are eight urban Indian health programs that operate under the authority of the Indian Health Care Improvement Act. The CAIHS works in collaboration with these programs to support access to mental health services. Most of the ambulatory care clinics have a Behavioral Health Department and/or employ Certified Alcohol Counselors. California also has three adult residential treatment centers to address substance abuse and alcohol issues.

The Youth Regional Treatment Center Network in the CAIHS provides inpatient substance abuse and alcohol treatment to eligible AI/AN youth. The primary responsibility of the Network is to help California Tribal youth find healthy directions in their life. The Network supports youth by offering inpatient care, as well as technical assistance, training, and consultation to Tribal alcohol program counselors. In FY 2010, the Network provided resources to assist approximately 40 youth with residential inpatient treatment. Urban and Tribal partners assist their youth by participating in the Network and by providing continuing services (often called “aftercare”) once youth return to the community.

The CAIHS has begun using telemedicine as a new and innovative approach to increase behavioral health services. In December 2009, the CAIHS hired a tele-health professional to assist and expand current tele-health services. Currently, the CAIHS has nine ambulatory clinics receiving specialty care using telemedicine services. The Tribal clinics utilize 30 hours a month for child and adult psychiatric care delivered by a board-certified psychiatrist through the University of California-Davis. CAIHS has also begun to use tele-health for addiction medicine. By partnering with a pain management clinic, Tribal clinics are able to effectively diagnose and treat drug addictions using experts located in Lafayette, CA. In June 2010, the CAIHS hosted a pain management treatment program for providers. As a result of this effort, medical staff and providers are able to identify and prescribe alternative medications to address addictions.

A portion of the funding received through MSPI was used to purchase and install additional tele-video equipment at an additional seven Tribal sites throughout the State and a teleconferencing bridge that is housed at the Area Office. This will expand the capacity at CAIHS and allow the Area Office to broadcast to or video conference with multiple Tribal sites at one time.

Overview of Behavioral Health Resources

Chief Medical Officer, David Sprenger, M.D., Board Certified in Child Psychiatry, and Behavioral Health Consultant, Dawn M. Phillips, RN, M.P.A., work closely to collaborate with CAIHS’s Tribal and urban behavioral health professionals within the State. The YRTC Network consists of about eight professionals licensed in social work (LCSW); licensed marriage family counseling (LMFC); and/or certified alcohol consultants. CAIHS, however, lacks a board-certified psychiatrist, which creates a significant barrier. The State of California prohibits billing the State for behavioral health interventions and treatments provided to adult patients unless those services are provided by a medical doctor (psychiatrist). This was a huge loss of revenue for the Tribal and urban health clinics within California. Moreover, due to the budget

deficit, in 2009 the State cut reimbursements through MediCal, California's Medicaid program, to Tribal and urban Indian health clinics unless the clinic was designated as a Federally qualified health center, which the majority of Indian health clinics are not. The results of this change have been devastating because programs may no longer bill for mental health services provided by the LCSW or LMFC. These reimbursement barriers have increased the rationale to advocate to CMS to standardize and expand billing for telemedicine services. Using tele-health is one option for the Tribal and urban ambulatory clinics to seek reimbursement as the patient actually sees the specialist using tele-video and receives appropriate mental healthcare. This is extremely beneficial to the patients and to the overall clinic budgets.

Program Spotlight: Toiyabe Indian Health Project

Toiyabe Indian Health Project is a nonprofit organization providing behavioral health, primary care, diabetes prevention, a dialysis unit, and dental services to the AI/AN people living in the Eastern Sierra region of California. Toiyabe represents seven Federally recognized Tribes and two Indian communities. The geographic service area is very rural and isolated including 13,277 square miles of mountainous, narrow valleys and desert terrain.

Substance abuse continues to be a significant concern to Toiyabe Indian Health Project. Receiving MSPI funding from the IHS has allowed the program to enhance and expand the capacity of several of their prevention and treatment programs. They now operate an intensive outpatient program (IOP) for alcohol and substance abuse treatment programs based on the Matrix Model. To create a more culturally relevant IOP, Toiyabe Indian Health Project includes talking circles and has integrated Red Road to Wellbriety 12-Step Groups into their approach. Infusing their IOP with these and other culturally appropriate practices like sweat lodges and family groups creates a recovery environment that is focused on a Native tradition of healing.

The MSPI grant also supports their Warrior Down program, which provides community-based support to individuals coming out of treatment and jail. This culturally based mentor program helps people stay clean and sober as they re-integrate back into the community by linking them with social services, job opportunities, and other recovery supports they need to remain in a spirit of healing.

To address suicide prevention, Toiyabe Indian Health works closely with the schools to present the American Indian Life Skills curriculum. Behavioral health staff have also been trained in ASIST and are working toward training other agencies, including school personnel, on the ASIST model. They are also working on a protocol within the community to address suicide, including creating a crisis response team.

Toiyabe Indian Health Project continues to face challenges related to the stigma of drug and alcohol abuse, mental health issues, and suicide. They work with their community to raise awareness and to get people to talk about the pain and trauma so that healing can begin. They try to host a Gathering of Native Americans (GONA) for their community every year, during which the community works together on healing so that people in recovery have the support of a community that is getting well along with them.

NASHVILLE AREA PROFILE

The Nashville Area is composed of 16 Title I (contracted) Tribal programs, nine Title V (compacted) Tribal programs, four IHS-direct service unit programs, two Federal CHS programs, and two urban programs. These programs are dispersed over 14 States, although the Nashville Area assists patients in a total of 28 States in the eastern, southeastern, and middle U.S. The Area's FY 2009 user population was 5,149 and represented the following Tribes: Alabama-Coushatta Tribe of Texas, Aroostook Band of Micmac Indians, Catawba Indian Nation, Cayuga Nation, Chitimacha Tribe of Louisiana, Coushatta Tribe of Louisiana, Eastern Band of Cherokee Indians, Houlton Band of Maliseet Indians, Jena Band of Choctaw Indians, Mashantucket Pequot Tribal Nation, Mashpee Wampanoag Tribe, Miccosukee Tribe of Florida, Mississippi Band of Choctaw Indians, Mohegan Tribe of Connecticut, Narragansett Indian Tribe, Oneida Indian Nation of New York, Onondaga Nation of New York, Passamaquoddy Tribe Indian Township, Passamaquoddy Tribe Pleasant Point, Penobscot Indian Nation, Poarch Band of Creek Indians, Seminole Tribe of Florida, Seneca Nation of Indians, St. Regis Mohawk Tribe, Tunica-Biloxi Tribe of Louisiana, Tonawanda Seneca Nation, Tuscarora Nation, and Wampanoag Tribe of Gay Head (Aquinnah).

Overview of Behavioral Health Efforts in the Nashville Area

Of the 33 Nashville Area health programs, 22 provide direct behavioral health services on an outpatient basis. The remaining 11 health programs refer patients to private practitioners for behavioral health services through CHS. Two Nashville Area programs provide residential substance abuse services: Unity Healing Center and St. Regis Partridge House. Both the Catawba and Micmac health programs provide behavioral health services that meet Accreditation Association for Ambulatory Health Care (AAAHC) standards, and Cherokee Hospital, Choctaw Hospital, and Unity Healing Center are accredited by the Joint Commission.

Nashville Area behavioral health programs offer a full spectrum of diagnostic, intervention, and prevention services to children, adolescents, adults, and families presenting with a wide range of psychological and psychiatric disorders and problems of daily living. Licensed and/or certified professionals (e.g., psychiatrists, psychologists, clinical social workers, professional counselors, and alcohol and drug counselors) provide all services, using a variety of clinically acceptable and culturally appropriate assessment and treatment strategies, according to individual patient needs and preferences. Some of the specific types of behavioral health intervention and prevention services provided include comprehensive biopsychosocial assessments; mental health and substance abuse treatment; specialized trauma care; specialized sex-offender care; crisis management; case management; medication management; psychoeducation; support groups; community outreach, aftercare (currently being expanded to include the use of telemedicine devices); court liaison services; a limited amount of transportation; and financial assistance for food, shelter, clothing, and respite. Frequently diagnosed conditions that require behavioral health services are anxiety, depression, post-traumatic stress disorder, and alcohol use/dependence. Interpersonal relationship problems and school-behavior problems are also prevalent. A coordinated, collaborative, and interdisciplinary approach to patient care is encouraged and embraced throughout the Nashville Area.

Obstacles that currently confront Nashville Area behavioral health programs include maintaining engagement with patients past the crisis point, recruiting and mainlining trained and skilled providers to rural areas, finding space to continue program growth, and addressing transportation problems.

Overview of Behavioral Health Resources

The Nashville Area is the most geographically diverse and widespread Area within the IHS; thus, Area health programs rely heavily on long-distance communication to share information and learn from one

another, exchanging frequent informational emails and phone calls. Moreover, the Area recently established a “learning community” for behavioral health providers through a series of scheduled continuing education calls or tele-seminars. While these calls/tele-seminars are primarily aimed at behavioral health staff, they are open to all Area healthcare providers. The goal of these calls is to provide information and tools for implementing new ideas and best practices in behavioral healthcare and to accelerate improved and sustainable outcomes in the management of patients with chronic conditions. The Matrix Model, Motivational Interviewing, and Trauma-Focused Cognitive Behavioral Health Therapy (TFCBT) are three examples of evidence-based practices that Nashville Area behavioral health programs successfully implement. The Nashville Area Health Summit is another continuing education opportunity for Area behavioral health providers. Recognizing the importance of patient education, the Nashville Area also brings patients with diabetes (and their support networks) together, within the context of a conference designed to assist these patients in identifying and overcoming personal and psychosocial roadblocks to good diabetes self-care. Participant follow-up or a progressive evaluation is an added component of this conference.

Funding sources for Nashville Area behavioral health programs include IHS, city and State governments, Medicaid, Medicare, private insurance, and SAMHSA.

Program Spotlight: Choctaw Behavioral Health

Choctaw Behavioral Health serves the Mississippi Band of Choctaw Indians in eight communities throughout East Mississippi. The population of these communities ranges from approximately 100 to 3,000 individuals, and the Tribal enrollment is approximately 10,000. Choctaw Behavioral Health provides services to address an array of substance-related, emotional, and behavioral issues. They have a staff of about 25 providers, including a psychiatrist 2 days per week, a full-time RN, master’s-level therapists, bachelor’s-level specialists, a State-certified alcohol/drug abuse counselor, prevention staff, and case managers. Because trauma is such a problem for their community, all of their master’s-level therapists are trained in trauma-focused cognitive behavioral therapy.

Choctaw Behavioral Health provides extensive support to children and adolescents in their community. Among the adolescent population, there has been a tremendous spike in self-injury, especially among teens who do not feel equipped to talk about or deal with their problems. The program is seeing that these kids significantly reduce or stop self-harm when they engage in the therapeutic process and talk about emotional stressors they are experiencing.

To further support youth in and around the surrounding communities, Choctaw Behavioral Health and the Choctaw Community Planning Coalition (an active group with approximately 40 representatives from multiple sectors across the reservation) sponsor an annual Choctaw Youth Leadership Conference. In 2010, more than 700 youth attended this 2-day conference that included workshops on facts about stimulants and marijuana use, the dangers of “sexting,” safety in social networking (Facebook, Twitter), suicide prevention, and ways to handle bullying. In addition, they have implemented the Olweus Bullying Prevention Program at the elementary and high schools as well as in the Boys & Girls Club. To address the ongoing challenges with teenage alcohol, marijuana, and other drug abuse, they have implemented two evidence-based prevention programs in the schools: Project Northland and Reconnecting Youth.

Ensuring a culturally appropriate approach is of vital importance to Choctaw Behavioral Health. Before they refer clients out for contracted services (e.g., residential treatment), Choctaw Behavioral Health visits the site and provides orientation on providing culturally appropriate care. This approach has helped improve retention rates for people in contract care services and has led to an increased understanding of Choctaw culture among non-Tribal programs.

NAVAJO AREA PROFILE

The Navajo Area Indian Health Service (NAIHS) is responsible for the delivery of health services to AI/ANs in portions of the States of Arizona, New Mexico, Utah, and Colorado (a region known as the Four Corners). NAIHS is primarily responsible for healthcare to members of the Navajo Nation and Southern Band of San Juan Paiutes, but care to other AI/ANs (e.g., Zuni, Hopi) is also provided. The area had 242,331 active users in 2009, second in population only to the Oklahoma Area. The Navajo Nation is the largest Indian Tribe in the U.S. and has the largest reservation, which encompasses more than 25,000 square miles in Northeast Arizona, Northwest New Mexico, Southern Utah, and Colorado.

Overview of Behavioral Health Efforts in the Navajo Area

NAIHS behavioral health programs offer a wide range of diagnostic care, therapeutic counseling services, intervention, and prevention services to children, adolescents, adults, and families presenting with a wide range of psychological and psychiatric disorders, co-occurring health conditions, and life challenges. Licensed and/or certified professionals (e.g., psychiatrists, psychologists, clinical social workers, professional counselors, and alcohol and drug counselors) provide the multi-disciplinary services, utilizing a variety of clinically acceptable and culturally competent assessment and treatment modalities, with respect to individualized patient needs. Specific types of behavioral health intervention and prevention services provided include comprehensive bio-psychosocial assessments; mental health and substance abuse treatment; Native healing methods, faith-based counseling services, specialized trauma care; crisis management; case management; medication management; psycho-education; support groups; outreach and aftercare; court liaison services; and limited patient transportation services. A coordinated, collaborative, and interdisciplinary approach to patient care is strongly encouraged and supported throughout the Navajo Area.

Issues common in rural areas, such as workforce recruitment and transportation barriers, are among the challenges in behavioral healthcare faced by the Navajo Area. Moreover, across the continuum of care, there are a range of behavioral health services that are not reimbursable (e.g., prevention, intervention, and indigenous traditional healing services). Reimbursements are often limited to Medicaid-recognized and approved providers, with reimbursement rates at a minimal level. Such restrictive reimbursement processes can limit patient access to best practice models that are available and accessible within their regional and rural areas. Such limitations to service provisions are often related to issues of funding and financing of State, CMS, and/or other funding regulatory processes. Another significant barrier in the behavioral health field is the lack of a unified credentialing process and/or reciprocity process for behavioral health providers among the current national and State credentialing boards. Presently, certain States will only honor the certification or the licensure behavioral health service providers possess and will limit them in providing the comprehensive services that a rural area client needs.

Overview of Behavioral Health Resources

As of March 12, 2000, the disciplines of Alcohol and Substance Abuse, Mental Health, and Medical Social Services merged under the umbrella of the NAIHS Division of Behavioral Health Services, which provides monitoring and consultation services. There currently are five Federal (IHS) service units and four regional 638 Health Care Corporations that provide Alcohol and Substance Abuse, Mental Health, and Social Services counseling services to all-age populations. Ft. Defiance Indian Hospital, a 638 Health Care Corporation, manages and operates a sub-acute co-ed adolescent residential treatment center in Ft. Defiance, AZ.

Navajo Nation Department of Behavioral Health Services under the Navajo Division of Health provides a wide range of alcohol and substance abuse prevention, intervention, and counseling services to adolescents, adults, elderly, and families in outpatient, residential treatment, intensive outpatient and

aftercare program settings. They have five agency programs, five sub-offices, and have their central administrative office located in Window Rock, AZ. In addition, they work with sub-contractors who provide these and other specialized behavioral health services. The Navajo Nation Department of Behavioral Health Services manages and operates a residential adolescent treatment center in Shiprock, NM, and an adult, co-ed short-term residential treatment program in Page, AZ. Soon to open will be another adult co-ed residential treatment center (Navajo Regional Behavioral Health Center) located in Shiprock, NM.

Within the past two to three years, the various geographical rural areas of the Navajo Nation have begun to rely on telemedicine and tele-psychiatry in treating hospital and clinic patients due to many obstacles to care in rural areas, including the difficulty of recruiting psychiatrists and/or psychologists and retaining licensed clinical behavioral health providers, transportation difficulties, and the unpredictability of weather conditions.

Other information sharing occurs through quarterly teleconferences, WebEx training sessions, e-mails, postal service, and in-house routing of mail service. Furthermore, Navajo Area has also become involved in learning opportunities for behavioral health providers through a series of webinar training sessions coordinated and sponsored by the Arizona Division of Behavioral Health Services, or tele-seminars coordinated by outside entities such as IHS Headquarters Division of Behavioral Health, SAMHSA, and other organizations. While these forms of telecommunication and information sharing are primarily aimed at behavioral health staff, they have been made available and accessible to all Area-wide healthcare providers, including Diné traditional practitioners. The goal of these forms of communication and collaboration is to provide information on new techniques, counseling skills, and necessary tools to implement new ideas and best practices in behavioral healthcare. It also serves as a means of follow-up regarding implementation of various behavioral health assessment and/or screening tools in the emergency room, treatment rooms, and hospital or clinic departments.

Program Spotlight: Traditional Practitioners

Integrative blending of indigenous Native American practices alongside mainstream methods of healing and treatment modalities are encouraged and supported by the Navajo Area. To support this blend of treatment modalities, traditional practitioners have been hired to work as part of the service delivery systems in the following agencies in the Navajo Area: Chinle Service Unit – Native Medicine Program; Gallup Indian Medical Center – Native Medicine Program; Shiprock Service Unit – Community Health Services Program; Ft. Defiance Indian Health Care Corporation (638 HCC); Winslow Indian Health Care Corporation (638 HCC); Chinle Department of Behavioral Health Services (Navajo Nation), AZ; Dilcon Department of Behavioral Health Services (Navajo Nation), AZ; Navajo Regional Behavioral Health Center (Navajo Nation), Shiprock, NM; Shiprock Department of Behavioral Health Services – Outpatient Program; and Shiprock Adolescent Treatment Center. These facilities include two Navajo Area IHS Service Unit programs; two of the 638 Health Care Corporation Programs; and four Navajo Nation Department of Behavioral Health Services Programs.

OKLAHOMA CITY AREA PROFILE

The Oklahoma City Area covers the States of Oklahoma, Kansas, and portions of Texas, serving the largest IHS user population in the U.S., with 317,840 active users in 2009. The majority of patients reside in urban settings. The Area consists of eight service units with Federally operated hospitals, clinics, and smaller health stations. In addition, the Area is home to more than 39 Tribes and Tribal organizations, and many Tribes operate their own health programs, from full-scale hospitals to smaller preventive care and behavioral health programs.

Overview of Behavioral Health Efforts and Resources in the Oklahoma City Area

The Oklahoma City Area Indian Health Service Behavioral Health Program includes IHS, Tribal, and urban Indian mental health, social work, and substance abuse programs. Two hospitals and nine clinics are IHS-operated. Tribal programs operate four hospitals, 31 clinics, five in-patient substance abuse treatment centers, 18 substance abuse outpatient facilities, one halfway house, and one YRTC. There are five facilities in urban settings that offer medical and substance abuse services. Behavioral health services available within the Area include a full range of medical care, substance abuse treatment and counseling, mental healthcare, and social work services. Providers who offer this care include social workers, psychologists, psychiatrists, licensed alcohol and drug counselors, certified alcohol and drug counselors, licensed professional counselors, and licensed marriage and family therapists. Approximately 350 professionals and paraprofessionals working in close to 100 programs provide a wide range of services ranging from case management to psychiatric treatment.

The Oklahoma City Area Office (OCAO) has the distinction of being the first Area Office that has also been designated as a clinic, the OCAO Clinic. The Area behavioral health staff consists of one half-time psychiatrist and two contract psychiatrists, along with the Office Director. Through the OCAO Clinic, tele-psychiatry services are provided to two outlying clinics, with two more sites that may be added to the network soon.

Behavioral health funding in the Oklahoma Area comes primarily from IHS mental health and alcohol and substance abuse budgets. Several other programs are funded by Federal grants from various sources, including MSPI and DVPI grants and awards, as well as grants from SAMHSA and DOJ. Some programs have been certified by the State of Oklahoma and can bill the State for services offered. Some Tribes also match program funds with Tribal general revenue funds.

Program Spotlight: Choctaw Nation of Oklahoma Sexual Assault Nurse Examiner Program

The Choctaw Nation of Oklahoma Sexual Assault Nurse Examiner (SANE) program is administered under a larger program for sexual assault response called Project Holitopa, which means “~~a~~sacred” in Choctaw. The project’s name emphasizes the desire to renew an understanding of the Choctaw people, and particularly women, as sacred and worthy of respect and honor. The SANE program serves a geographic area in southeast Oklahoma that covers 10.5 counties, equal in size to the State of Vermont. It serves a population of 100,000 Tribal members, along with non-Natives who live in the same geographic area. The SANE program is the only such program available in the area. Prior to its launch on October 1, 2010, sexual assault victims had to travel to facilities several hours away, sometimes into another State, to receive exam services.

The SANE project was fortunate to become the recipient of an IHS DVPI award recently, but the start of the project was planned even before funding was awarded. Demonstrating their support for this much-

needed program, the Choctaw Nation assisted five nurses in receiving training through the International Association of Forensic Nursing (IAFN) to become certified sexual assault nurse examiners for adolescents and adults (age 14 and older). These five IAFN-certified nurses are now on call to provide SANE services throughout the entire Choctaw Nation service area. The nurses are also working toward completing additional training that would certify them to offer sexual assault examination services for pediatric patients (under 14 years old), a designation that requires separate certification. The SANE program is investigating how to incorporate their services into the Choctaw Nation health system, so that services will continue even if grant dollars are not available.

Project Holitopa and the SANE program are part of a larger network of related projects that include domestic violence response and advocacy services (Project United Voice) and dating and intimate partner violence prevention programs (Project United Action). Project Holitopa and the SANE program connect the people they serve with three victim advocates in the nursing program. These advocates are located strategically within the Tribal area to offer coverage for the entire region. Unlike SANE services, advocacy services are for Natives only, but advocates provide referrals to outside advocacy agencies for non-Natives.

This network of related projects on domestic violence and sexual assault extend throughout the infrastructure of the Choctaw Nation. Two factors have prompted this rapid growth in sexual assault response capacity. First, there has been a push from several areas within the Tribe to develop comprehensive response and prevention services. DOJ-funded legal programs, Tribal justice efforts, and medial programs, all initiating efforts separately, have had the opportunity to come together in establishing new frameworks for sexual assault response with strong collaboration from the ground up. Second, a recent Oklahoma court decision significantly affected funding throughout the State, so many different response programs are in the process of investigating new ways to collaborate for better services and coverage on a tighter budget. As a result, comprehensive and cooperative sexual assault response procedures have been established for many agencies—for law enforcement, for SANE examinations, and for advocacy services, frequently in cooperation with non-Native agencies. These procedures are potentially a model for other Tribes working to create similar procedures.

A noteworthy aspect of the development of these sexual assault and domestic violence programs is their priority on building relationships with the local non-Native community. Because the Choctaw Nation is not a reservation Tribe and spans multiple counties within Oklahoma, jurisdictional issues related to sexual assault response involve many players. The sexual assault response team has collaborated with Tribal law enforcement, Federal and State law enforcement, and many different county and city law enforcement groups. One planned point of collaboration is to station a victim advocate from Project United Action in a non-Native children's advocacy center within the area because it was discovered that the center works with a very high number of Native children—approximately 50% of the center's clients are Native, in an area where Natives are 18% of the general population. The collaboration between Project United Action's Native advocates and a well-established non-Native advocacy center is an exciting prospect and a good way to connect Native children who need services with the new and growing Project United Action. Deciding who needs to be at the table to form collaborative sexual assault response plans has been an ongoing challenge, but building working relationships among these team members will certainly be among the programs' greatest strengths.

PHOENIX AREA PROFILE

The Phoenix Area covers IHS, Tribal, and urban programs in the States of Arizona, Nevada, and Utah, serving approximately 43 Tribes in the tri-State area and 159,166 active users. The services for alcohol/substance abuse are 98% Tribally run either by 638 contract or compact. The mental health services are approximately 50% Tribally run and 50% IHS-managed.

Overview of Behavioral Health Efforts and Resources in the Phoenix Area

The Phoenix Area behavioral health program is unique and integrated. The Phoenix Area Office has retained all three behavioral health consultant positions, which are the Alcohol/Substance Abuse Program Director (A/SAP), the mental health consultant, and the social work consultant. In addition to the behavioral health consultants, the A/SAP employs a substance abuse program specialist, a substance abuse technician, and a behavioral health program specialist.

The behavioral health program operates within the Office of Health Programs. The three consultants work within their designated disciplines but are diversified and cross-trained. This diversification provides the unique opportunity for the three disciplines to be integrated in working together, communicating information to each program, and collaborating on many projects. An example of a collaborative project was the team's joint efforts in planning the Seventh Annual Phoenix Area Integrated Behavioral Conference in Scottsdale, AZ. The conference was held May 4 through 6, 2010, and was attended by more than 130 attendees—the largest attendance for this conference to date.

Two Title V urban programs also serve the area: Nevada Urban Indians, Inc. located in Reno, NV, and Native Health located in Phoenix, AZ. Two additional urban programs are currently on a Buy-Indian Contract and are awaiting Title V status. These programs include Native American Connection, Inc., located in Phoenix, AZ, which provides out-patient care, residential care for adult males, and residential care for women and children and the Indian Walk-In Center, located in Salt Lake City, UT, which operates an intensive outpatient program.

There are two youth residential treatment centers in the Phoenix Area. The Desert Visions Youth Wellness Center, a 24-bed co-ed residential program, is located in Sacaton, AZ. Nevada Skies Youth Wellness Center, a newly formed satellite program of Desert Visions in Nixon, NV, is a 16-bed co-ed residential program. Desert Visions is Joint Commission-accredited and Nevada Skies is working on accreditation either by Joint Commission (JC) or Commission on Accreditation of Rehabilitation Facilities (CARF). Desert Visions is directed by a governing board composed of Tribal representatives from the three-State Area, along with representatives from the Inter Tribal Council of Arizona (ITCA), the Indian Health Board of Nevada (IHBN), and the Utah Tribal Leaders. Nevada Skies is governed under the same governing board, along with its own advisory group of Tribal representatives from Nevada.

Area staff members serve on the ITCA Involuntary Commitment Working Group, which focuses on resolving jurisdictional issues in Tribal court involuntary commitment orders so that Tribal members can receive treatment in State-operated facilities such as the Arizona State Hospital. Area staff have also worked with Tribal liaisons at the Arizona Department of Health Services, the Division of Behavioral Health Services, and the State Medicaid agency to increase outreach about jurisdictional issues. Together they are working to educate and cross-train Tribal, IHS, and State behavioral health staff and court officials, as well as to formulate new policies to simplify the referral process so American Indian clients referred by Tribal courts can be better served by the State public behavioral health system.

The three programs continue working closely together in training, programming, and IHS headquarters projects such as the recent MSPI and DVPI projects. The Phoenix Area Behavioral Health Program has a unique team and is grateful that the Phoenix Area IHS leadership has retained all three disciplines for an integrated behavioral health program that is committed to fulfilling the mission of IHS and the IHS Behavioral Health Program.

Program Spotlight: Phoenix Area Suicide Prevention Program

The Phoenix Area Suicide Prevention Program was developed around the framework created by the IHS Suicide Prevention Initiative. The program selected three national best practice gatekeeper programs that could be used successfully in Indian Country: Assessing & Managing Suicide Risk (AMSR); Applied Suicide Intervention Skills Training; and Question, Persuade, Refer. In cooperation with the Area Director, several behavioral health staff participated in —Train the Trainer” workshops for these programs. Each of these individuals is now certified to train others in their respective models. By the summer of 2010, the area trainers had conducted more than 31 workshops, training more than 700 participants in suicide prevention and intervention skills that they can take home to their communities and programs.

The Phoenix Area Suicide Prevention Program recognized at its inception that fighting suicide provides their communities with an opportunity to join forces and work together. This collaborative model of suicide prevention promotes cooperation and partnerships among IHS, Tribal, and urban communities with the inclusion of local, State, and national programs. As a result, the Area Suicide Prevention Program has strengthened relationships with the Suicide Prevention Resource Center, Arizona Department of Health Services/Department of Behavioral Health Services, the Arizona Suicide Prevention Coalition, the Indian Health Board of Nevada, and the Indian Walk-In Center of Utah.

The program has also been successful in reinvigorating the Native American Suicide Prevention Coalition (NASPC). The NASPC holds a monthly teleconference addressing the suicide prevention, intervention, and postvention needs of the communities it serves. The NASPC has representatives from Arizona, Nevada, Utah, and California. The group has many dedicated and energetic participants working together to share their skills and experiences to improve suicide prevention activities in Indian Country.

The Area Suicide Prevention Program is currently working on the development of a suicide cluster response strategy, as well as developing a series of postvention activities for communities in need.

PORTLAND AREA PROFILE

The Portland Area serves 43 Federally recognized Tribes in Washington, Oregon, and Idaho, with 104,097 active users in 2009. There are six service units in the Portland Area: five in Tribal communities and one that shares a campus with the Chemawa Indian School in Oregon's Willamette Valley. The majority of health services provided in the Area are managed and administered through the Tribes under the Indian Self-Determination and Education Assistance Act (PL 93-638). Twenty-four Tribes and Tribal organizations contract services under Title I, and 23 Tribes are fully compacted under Title V. Over 74% of the Area budget is administered through self-determination contracts or self-governance compacts. The Area also has three urban Indian health programs.

Overview of Behavioral Health Efforts and Resources in the Portland Area

Like all health services in the Portland Area, the majority of behavioral health services are provided through Tribes and Tribal programs. The service unit at the Chemawa Indian School is the only Federal site that offers behavioral healthcare. There are no Federally managed behavioral health facilities in the Area. Many different Tribal programs offer behavioral health services for adults. There are also two YRTCs that offer inpatient drug and alcohol treatment for adolescents, as well as mental health counseling and treatment for co-occurring disorders.

In the Portland Area, IHS personnel work to assist Tribes in their provision of behavioral healthcare by offering a variety of supportive services. Area staff offer training, technical assistance, consultation, and work cooperatively to address barriers to treatment or to locate appropriate services when requested. They may share information on best practices or grant opportunities among Tribes or assist with projects such as data gathering or development of new health programs.

IHS personnel also encourage licensure for Tribal behavioral health professionals, where appropriate, to access increased billing opportunities (such as billing through Medicaid). In addition, many Tribes employ behavioral health providers who are traditional practitioners and elders. Tribes and Tribal organizations in the Portland Area are working for increased recognition for traditional practitioners and evidence-based practices, again, because such recognition increases available public funds to provide these services. Oregon is a forerunner in recognition of Tribal best practices by the State's Department of Health Services as a result of advocacy by many Tribal organizations.

Challenges confronted by Portland Area behavioral health services are similar to those faced by programs across the country. Funding and resources fall far below what is needed. Frequently, even if dollars are available to purchase treatment, capacity in local facilities cannot accommodate new patients. Many programs have long waiting lists. Tribally operated programs frequently focus on a holistic approach to behavioral health issues, meaning that while working with individuals, they also address families, employment, social services, and other issues. While more integrated than treatment-focused approaches, these holistic approaches are also more resource intensive. Finally, accessibility is an ongoing concern. Because many eligible users live in remote locations, they may not be able to access far-away health services, even when services are available.

Tribes in the Portland Area are passionate about addressing the behavioral health concerns faced by their people and have taken great ownership of their behavioral health programs and administer them in concert with other health and social service programs. Portland Area Tribal health organizations frequently work in partnership with other prevention or healthy lifestyle organizations, like school programs, Head Start, and others, to maximize scarce health resources. Tribes also cooperate with State

and county governments. For example, Tribes in Washington worked with a State suicide prevention initiative to bring ASIST training to their areas.

Program Spotlight: Spokane Tribe Health and Human Services Behavioral Health Program

The Spokane Tribe Health and Human Services Behavioral Health Program serves the approximately 1,000 American Indian people living on the Spokane Indian Reservation, as well as Spokane Tribal members living off-reservation in Spokane, Stevens, and Pend Oreille Counties in Washington State. The program provides a range of behavioral health services, addressing substance abuse needs and providing mental health services for children, families, and adults. The program also employs a mental health geriatric specialist who makes weekly visits to the senior program and is available onsite for services.

During the summer of 2010, the Behavioral Health Program began working together with a registered dietician to develop a community garden. The dietician works with alcohol/substance abuse and mental health clients to help them develop strategies for eating a proper diet, and this community garden is one way to ensure that behavioral health clients and other Tribal members are eating healthy, fresh, locally grown produce. Funding for seeds came from the WIC program, and youth from the community center work in the garden. They sell the produce at the garden's weekly farmer's market. This is just one of the innovative community-based projects that the Behavioral Health program has implemented to increase the integration of health-related efforts.

In response to a tragic suicide cluster in 2010, three behavioral health staff members attended an ASIST suicide prevention training. As a result, they have launched a community suicide prevention effort, training over 100 kids in suicide warning signs and prevention during just a one week period of time. Over the next couple of years, they plan to train every child on the reservation.

The Spokane Behavioral Health Program has also been seeing increased success with their drug and alcohol program when they are able to reach out to the whole family. Recently, seven members of a local family came through the program, starting with the dad, then the children, and also an uncle. Getting the whole family involved helps create the supportive environment necessary for sustained sobriety, and the staff is excited to see the healing that has been happening through these efforts.

Workforce shortages have been a significant problem for the Spokane Tribe's Behavioral Health program, which is located in a geographically isolated area. To help address this issue and work toward attracting and retaining a greater number of qualified behavioral health workers, the program has recently implemented two workforce development strategies. First, they have created an "upward mobility" position, which they fill with a Tribal member who has an MSW. Over a 2-year period, she/he will receive salary and training to become the manager of the mental health program. They have also recently applied for and received approval to become a site for the National Health Service Corps Loan Repayment Program. This program provides student debt reduction and elimination to medical, dental, and behavioral and mental health clinicians who take a position at an approved site to serve underserved populations. The Spokane Behavioral Health program believes that being an approved site will be instrumental in attracting psychiatrists or psychologists to take a job with the Tribe.

TUCSON AREA PROFILE

Serving a user population of 25,562 in 2009, the Tucson Area Office-Behavioral Health (TAO-BH) office is small and has a unique and efficient approach to providing behavioral health services. The IHS Tucson Area Office works with two Tribes, the Tohono O'odham Nation and the Pascua Yaqui Tribe of Arizona, and provides liaison and support for one urban Indian program (a NIAAA program) in the area, the Tucson Indian Center.

Overview of Behavioral Health Efforts and Resources in the Tucson Area

Behavioral health services offered in the Tucson Area are contributed to by the Tucson Area Office of Behavioral Health, two major Tribally managed programs that serve each major Tribe in the Tucson Area, and one urban Indian program in the city of Tucson.

Most of TAO-BH's recurring funding is used for contracted behavioral health vendors. TAO-BH has one staff member, an MD boarded by the American Board of Psychiatry and Neurology in psychiatry and addiction psychiatry and the Board of the American Society of Addiction Medicine. The TAO-BH consultant provides consultation, training, and technical assistance to the two major Tribal behavioral health programs. The consultant offers referrals to outside vendors, including medical detoxification and inpatient substance abuse rehabilitation; outpatient counseling; court-ordered DUI, domestic violence, sexual offender assessments and required groups/classes; and pain management and wellness-enhancing services such as auricular acu-detox. Inpatient psychiatric admissions are funded by Sells Service Unit (a combined effort of the IHS and Tohono O'odham Health Department) or Pascua Yaqui Contract Health Service. Beneficiaries include clients of Tucson Indian Center. The TAO-BH consultant also provides direct clinical psychiatric/substance abuse services for Sells Service Unit patients and rapid-turnaround psychiatric consultations with Sells Service Unit medical providers. Finally, the consultant provides psychiatric consultation for the TOBH program and participates with other providers/agencies in TOBH TEAM efforts (child/school/Head Start/jail). To increase behavioral health services in the Tucson Area, the Tucson Division of Information Technology is currently collaborating with the Tohono O'odham Nation and TAO-BH consultant to provide the Electronic Health Record system for Tribal behavioral health programs and to develop a tele-behavioral health program.

Tohono O'odham Nation's Division of Behavioral Health (TOBH) provides a full spectrum of behavioral health services for a Tribal population of 29,000. Services include inpatient psychiatric referrals/aftercare, outpatient counseling, an intensive outpatient substance abuse program, aftercare sobriety campouts, Alcathons on and off reservation, Personal Growth, and GONAs; walk-in acu-detox and acupuncture clinics, and ASIST (suicide prevention) workshops in the community. Program staff and some TOBH vendors provide sweat lodges and other sacred healing and cleansing ceremonies for outpatients and incarcerated individuals. TOBH contracts to provide a full spectrum of behavioral health services including acupuncture, art therapy, traditional medicine, court-ordered evaluations and treatment, substance abuse detox and rehabilitation, and outpatient counseling. TOBH operates a successful MSPI program and has excellent crisis intervention and community response teams.

Pascua Yaqui Tribe's Centered Spirit Program (PYT CSP) has been CARF-accredited for over a decade. They have an Intergovernmental Agreement with the State of Arizona to operate as a Tribal Regional Behavioral Health Authority. This agreement provides additional funding and a great deal of flexibility regarding resources for referrals to a full spectrum of behavioral health services for a Tribal population of over 6,500. PYT CSP provides adult services, child and family services, New Beginnings (methadone) Clinic, Yoeme Kari Group Home (youth residential program), inpatient psychiatric admissions and aftercare, Men's Pascua Assessment Treatment Healing (PATH) (a residential substance

abuse program), and a transitional treatment home. PYT CSP operates a successful MSPI program. The program excels at prevention programs and gathering information from their community.

The **Tucson Indian Center (TIC)** is a Title V Urban Program. TIC provides wellness and social services for the Tucson urban American Indian population comprising members of Tribes throughout Arizona and the U.S. TIC has an estimated 10,000 annual service contacts. Referrals include all available behavioral health resources including detox, inpatient substance abuse rehabilitation, outpatient therapy, and psycho-educational assessments upon request. In addition, TIC distributes the monthly *Native Wellness Voice* newsletter to promote wellness in all spheres and to inform the local Indian community about the rich variety of services available at the TIC, including but not limited to wellness, acu-detox, and White Bison Native American 12-Step meetings.

Program Spotlight: PYT CSP Child and Family Team

The PYT CSP Child and Family Team has been in existence since 2001 when three programs—Social Services, Mental Health, and Alcohol and Substance Abuse—were merged to become the Behavioral Health Program. The Child and Family Team was developed by upper management and the Tribal council to eliminate confusion and create easier access for Tribal families who were being seen by one or more of the programs. The Child and Family Team serves the children and families of the Pascua Yaqui communities in Tucson and in the Maricopa areas of Arizona.

The Child and Family Team provides the Pascua Yaqui Tribe with services for those experiencing mental health, alcohol/substance abuse, behavioral, and school issues. The Team currently serves 300 children between the ages of birth and 17 with a staff of nine, including therapists, in-school counselors, and case managers. The team utilizes culturally compatible services for Pascua Yaqui members and provides individual, group, family, and play therapy, in-home services, Love and Logic parenting groups, and counseling at neighborhood feeder schools. The Child and Family Team is unique because it reaches out to the feeder schools where children attend school and provides in-school counseling directly at the school. It also facilitates team meetings involving direct support services, connection to natural supports, and strength-based and culturally sensitive therapy. Challenges faced by the team include a high turnover of therapists. The team has been short-staffed for about 2 years now, but they continue to strive to provide appropriate services to the children and families of the community.

The Child and Family Team has changed lives and supported positive changes for the families it serves. Clients who have attended the Love and Logic parenting courses have given very positive feedback, including “This Love and Logic parenting class has taught me things that I would never have thought of. I do believe that it has bettered me in all the six classes that I have attended here at behavioral health,” and “I would like to let other people on the reservation and also family members know about the group. It really helps in the long run.”

5. SUMMARY

The descriptive Area profiles of the previous chapter outline behavioral health efforts currently underway in every Area of the Indian Health System and identify challenges in behavioral healthcare in each Area. The program spotlights, which describe one particular behavioral health initiative in each Area, demonstrate a widespread commitment to innovative and culturally relevant approaches to addressing behavioral health issues. Transcending the limited concept of “treatment,” these approaches are focused on healing for individuals, families, and communities that are affected.

These varied approaches to behavioral health, in their innovation, their demonstrable successes, and strong cultural grounding, are points of hope that stand in stark contrast to the daunting evidence about prominent behavioral health issues. Alcohol and substance abuse, mental health disorders, suicide, violence, including domestic and sexual violence, and behavior-related chronic diseases continue to adversely impact AI/AN communities at rates disproportionately higher than the general population.

Demonstrating IHS commitment to a holistic approach to health and wellness, two groups have recently taken a role at the national level to identify strategic steps toward addressing behavioral health concerns in AI/AN communities. The National Tribal Advisory Committee on Behavioral Health (NTAC) serves as a policy and advocacy body on behavioral health issues for the IHS. The IHS Behavioral Health Work Group (BHWG), convened in 2007, is a technical group of experts in the field of behavioral health and/or substance abuse charged with providing guidance to the IHS in the development of programs and services for behavioral health for AI/AN communities. These groups have worked together within the IHS Headquarters Division of Behavioral Health to develop the AI/AN National Strategic Plans on Behavioral Health and Suicide Prevention. Both plans incorporate the input of Tribal leaders and behavioral health professionals working in Indian Country. Both plans are living documents, intended to be flexible and responsive to current developments in behavioral health as concerns and solutions evolve within AI/AN communities. Continued input from Tribal leaders, behavioral health professionals, and others is invited throughout the 5-year duration of the strategic plans. In an era of increased Tribal consultation between Federal agencies and AI/AN governing bodies, the behavioral health and suicide prevention strategic plans also communicate IHS priorities to partner agencies and highlights the critical importance of behavioral health issues in the IHS mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level.

In disseminating the strategic plans on behavioral health and suicide prevention, along with this accompanying Briefing Book, the IHS hopes to take leadership in the critical area of behavioral health, to foster strong collaboration across the Indian Health System and with other Federal partners, and to recognize the innovative and tireless work of IHS, Tribal, and urban Indian healthcare professionals as they address the continuing needs of AI/AN communities.

The gravity of the behavioral health issues impacting AI/AN communities calls for an equally serious focus on addressing these problems. The documented connections between behavioral health issues such as mental health and suicide, or sexual violence and chronic diseases, among other examples, underscore the need for holistic and integrated solutions. Finding solutions will require sustained collaboration between Federal, Tribal, and urban Indian health programs, and policymaking bodies, as well as a willingness to thoughtfully engage deep issues in the field, including historical trauma, cultural renewal, and a readiness to include entire communities in healing work. The importance of integrated perspectives that include culture, cultural and traditional practices, and community-wide healing and wellness must not be underestimated.

We are at a historic moment where health policy bodies are increasing their recognition of the value of traditional and holistic approaches. Just as the IHS mission represents the IHS's commitment to addressing health and wellness holistically, the recently passed Indian Health Care Improvement Act specifically authorizes the use of cultural and traditional approaches, recognizing the importance of such approaches to overall AI/AN health. It can be hoped that these legislative and policy changes represent an ongoing shift in understanding toward a more integrated perspective and an acknowledgement of culture's key role in both prevention and treatment. This long-overdue recognition aligns with AI/AN historic and continuing reliance on elders, languages, community, and cultural and traditional practices as protective factors that restore balance and health. The behavioral health approach embraces the strength and resiliency of Native people and so must those of us who have dedicated ourselves to creating a shared vision for behavioral health and wellness.

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