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Behavioral Health Among American Indian and Alaska Natives: An Overview

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Summary

Behavioral health problems (e.g., mental disorders, substance use disorders, and suicide) among the American Indian and Alaska Native (AI/AN) population have been the subject of multiple congressional hearings, introduced bills, and Administration initiatives in recent years.

Research on AI/AN behavioral health demonstrates three key points: Relative to the general U.S. population, the AI/AN population has (1) a high prevalence of risk factors for behavioral health problems, (2) a high prevalence of behavioral health problems, and (3) limited access to care for behavioral health problems. Improving behavioral health among the AI/AN population is a challenging task that requires collaboration among federal agencies, tribal governments, other organizations, communities, and individuals, especially in a resource constrained budget environment.

Within the U.S. Department of Health and Human Services (HHS), two key agencies conduct activities designed to improve AI/AN behavioral health: the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). IHS is the lead federal agency on health care (including behavioral health care) among the AI/AN population. SAMHSA is the lead federal agency on behavioral health care among the general population (including the AI/AN population).

This report describes IHS and SAMHSA programs (listed below) that specifically target behavioral health in the AI/AN population; it does not include every IHS or SAMHSA program available to support behavioral health in the AI/AN population.

IHS Programs

- Fetal Alcohol Spectrum Disorders
- Integrated Substance Abuse Treatment in Primary Care
- Methamphetamine and Suicide Prevention Initiative
- Youth Regional Treatment Centers
- Behavioral Health Integration with Primary Care
- Telebehavioral Health and Workforce Development
- Zero Suicide Initiative

SAMHSA Programs

- Systems of Care
- Circles of Care
- Garrett Lee Smith (GLS) Youth Suicide Prevention—Campus
- GLS Youth Suicide Prevention—State/Tribal
- Native Connections
- Project LAUNCH
- Strategic Prevention Framework–Partnerships for Success
- Drug Courts

Understanding the relationship between AI/AN behavioral health problems and related federal programs may help policymakers consider policy options affecting the AI/AN population.

Policymakers could amend, eliminate, or create programs; require different types of coordination or information; and/or provide additional oversight.

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About This Report

This report provides background information and a summary of federal programs related to behavioral health among the American Indian and Alaska Native (AI/AN) population. Both Congress and the Administration have demonstrated an interest in addressing AI/AN behavioral health. Congressional hearings have focused on behavioral health problems such as alcohol use disorders, drug use disorders, and youth suicide in the AI/AN population.[1] Members have introduced legislation containing behavioral health elements as part of larger efforts to improve the health of the AI/AN population. For example, some bills would call for recommendations to improve behavioral health (among other things)[2] or fund demonstration projects addressing behavioral health (among other things).[3] In 2014, the President specifically mentioned behavioral health problems such as substance abuse and suicide in his remarks when he announced the creation of Generation Indigenous (Gen-I), a federal initiative that collaborates with organizations such as the Aspen Institute[4] to assist tribal youth through programs, policies, and leadership opportunities.[5]

This report begins by clarifying the scope of information covered. It then provides background information about AI/AN behavioral health—including the high prevalence of risk factors, the high prevalence of specific behavioral health problems, and limited access to care. The report then summarizes each of the programs that meet criteria for inclusion. It concludes with a brief discussion of how an understanding of the scope and limits of existing programs might inform certain policy decisions.

Behavioral health among the AI/AN population is a broad and potentially amorphous topic. This report limits the scope by setting parameters for (1) the definition of behavioral health used, (2) the definition of the AI/AN population used, (3) the federal agencies included, and (4) the types of programs included.

Behavioral Health Defined

The term "behavioral health" is defined differently in different contexts; however, it is generally used to include both mental health disorders (e.g., depression) and substance use disorders (e.g., alcohol or drug use disorders).[6] This report describes programs that support prevention and

[1] See, for example, U.S. Congress, Senate Committee on Indian Affairs, Oversight Hearing on *Examining the True Costs of Alcohol and Drug Abuse in Native Communities*, 114th Cong., 1st sess., July 29, 2015, and U.S. Congress, Senate Committee on Indian Affairs, Oversight Hearing on *Demanding Results to End Native Youth Suicides*, 114th Cong., 1st sess., June 24, 2015.

[2] In the 114th Congress, the Alyce Spotted Bear and Walter Soboleff Commission on Native Children Act (S. 246, H.R. 2751) would establish a commission, which would be required to (among other activities) "make recommendations [that] will result in ... improvements to the mental and physical health of Native children, taking into consideration the rates of suicide, substance abuse, and access to nutrition and health care."

[3] In the 114th Congress, the Tribal Early Childhood, Education, and Related Services Integration Act (S. 2304, H.R. 5072) would (among other activities) fund demonstration projects, the applications for which must include "a description of how programming funded under the demonstration project will address child and family mental health issues, including issues relating to violence and substance abuse."

[4] Center for Native American Youth at the Aspen Institute, "Gen I-Youth Challenge," press release, http://cnay.org/Gen-I_Challenge_Youth.html.

[5] The White House, "Remarks by the President at the Tribal Nations Conference," press release, December 3, 2014, https://www.whitehouse.gov/the-press-office/2014/12/03/remarks-president-tribal-nations-conference.

[6] The Indian Health Care Improvement Act (IHCIA, 25 U.S.C. §§1601 et. seq.) provides general authorization for

treatment of mental health disorders, alcohol or drug use disorders, and suicide or attempted suicide. It does not include programs specifically focused on tobacco use.[7]

American Indian and Alaska Native (AI/AN) Population Defined

The overall AI/AN population—that is, individuals who self-identify as AI or AN—differs from the population who are members of Indian Tribes (ITs), which is generally the population targeted by federal programs (see **Table 1**). The self-identified AI/AN population, according to the U.S. Census Bureau in 2014, was 5.2 million—including 2.6 million people who considered themselves to be only AI or AN and 2.7 million people who considered themselves to be AI/AN in combination with another race.[8]

Both of these numbers are larger than the number of individuals who are members of federally recognized tribes, estimated at 2.0 million by the Bureau of Indian Affairs in 2010.[9] Note that Native Hawaiians are not included in this report because they are not considered to be members of an IT (see **Table 1**) and are generally not eligible for federal programs that target tribal members.

Table 1. Selected AI/AN-Related Definitions

Term and Abbreviation	Definition
Indian (American Indian/Alaska Native or AI/AN)	"any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102 and 103, such terms shall mean any individual who (A), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (B) is an Eskimo or Aleut or other Alaska Native, or (C) is considered by the Secretary of the Interior to be an Indian for any purpose, or (D) is determined to be an Indian under regulations promulgated by the Secretary.... "
Indian Tribe (IT)	"... any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians."

many federal activities related to AI/AN health and defines behavioral health as "(A) In general: the term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services; and as (B) Inclusions: the term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach." (25 U.S.C. §1603(2)).

[7] Although IHS provides resources to its providers and beneficiaries for tobacco cessation there are no specific programs that target tobacco use. In addition, while SAMHSA provides resources on tobacco cessation it does not sponsor AI/AN specific programs related to tobacco cessation.

[8] These numbers do not sum due to rounding. Data on AI/AN population obtained from the U.S. Census Bureau, ACS Demographic and Housing Estimates, "2014 American Community Survey 1-Year Estimates," http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP05&src=pt. For discussion of the AI/AN population, see Appendix A in CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[9] U.S. Department of the Interior, Bureau of Indian Affairs, "Population Indictors by State, for Federally Recognized Tribes, 2010."*2013 American Indian Population and Labor Force Report,* http://www.bia.gov/WhatWeDo/Knowledge/Reports/index.htm.

Term and Abbreviation	Definition
Tribal Organization (TO)	"the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.... "
Urban Indian Organization (UIO)	"a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a)." [Contracts and Grants for the Provision of Health Care and Referral services].
Contracts/Compacts	Legal arrangements under which ITs and TOs contract to operate government program to serve a defined Indian population that would otherwise be operated by a federal agency (e.g., the Indian Health Service). Both kinds of arrangements are authorized under the Indian Self-Determination and Education Assistance Act (ISDEAA), but the authorities for each kind of arrangement derives from different ISDEAA sections. There are also some limited differences in program scope and requirements for the IT and TO that is entering into the contract or compact.

Source: Section 4 of the Indian Health Care Improvement Act (IHCIA, 25 U.S.C. §1603) and the Indian Self Determination and Education Assistance Act (ISDEAA, 25 U.S.C. §450b).

Federal Agencies Included in This Report

Designing and implementing programs to improve AI/AN behavioral health is a challenging task that requires collaboration among federal agencies, tribal governments, other organizations, communities, and individuals. This report, however, focuses on the activities of two agencies within the U.S. Department of Health and Human Services (HHS): the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). IHS is the lead federal agency on health care (including behavioral health care) among the AI/AN population. SAMHSA is the lead federal agency on behavioral health care among the general population (including the AI/AN population).

For More Information

CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

CRS Report R44510, *Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview*.

This report does not address other federal agencies that support—but are not focused on—behavioral health care among the AI/AN population. For example, some federal programs focus on improving the well-being of AI/AN children either exclusively or as part of a larger program focus. Improving child well-being could include activities related to behavioral health and could ultimately result in lower rates of behavioral health conditions for the AI/AN population; however, programs that do not focus exclusively on behavioral health care are beyond the scope of this report.[10] Other programs may finance behavioral health services for the AI/AN population.

[10] For example, the Administration for Native Americans (ANA) is an office within the Administration for Children and Families (ACF) an agency within the U.S. Department of Health and Human Services (HHS). Among other

Such programs may finance health services for a population broader than the AI/AN population and pay for health services beyond those intended to treat behavioral health conditions. Although programs offering such financing are an important source of federal support for behavioral health services (see text box), they are beyond the scope of this report.

Federal Programs that Pay for Behavioral Health Services for AI/ANs

Federal programs that pay for health services may pay for services, including behavioral health services, provided to the AI/AN population who are eligible for these programs. For example, the Medicaid program may pay for services covered by Medicaid and provided to a low-income AI/AN individual who is enrolled in the program. These programs may pay for services provided to AI/ANs when services are provided at an IHS facility or when these services are provided at a non-IHS facility.

Sources: CRS Report R44040, *Indian Health Service (IHS) Funding: Fact Sheet*; and HHS, IHS, FY2017 Justification of Estimates for Appropriations Committees, p. CJ-100, https://www.ihs.gov/budgetformulation/congressionaljustifications/.

Indian Health Service (IHS)

The Indian Health Service (IHS) provides health care directly or provides funds for Indian Tribes (ITs) or Tribal Organization (TOs) to operate health care facilities (collectively referred to in this report as IHS-funded facilities). IHS serves approximately 2.2 million individuals who are primarily members of federally recognized tribes. IHS may also serve individuals who are not members of federally recognized tribes (e.g., individuals who are considered to be Indian by the community in which they live).[11] IHS provides services to individuals of all ages through a network of facilities located in 35 states. Specific services vary by facility, but generally focus on primary care, prevention, and treatment of conditions common among American Indians and Alaska Natives, including behavioral health conditions.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA supports community-based mental health and substance abuse services through various grant programs and other activities (e.g., technical assistance and data collection).[12] ITs and TOs are eligible to apply directly for certain SAMHSA grants and may benefit indirectly from grants awarded to states or other entities (e.g., if a state uses a portion of block grant funding to support programs serving the AI/AN population). Two of SAMHSA's formula grant programs are unusual in that each awards a portion of funds to a single tribal entity. One such program is the Substance Abuse Prevention and Treatment Block Grant, which distributes funds to states (including the District of Columbia and U.S. territories) and the Red Lake Band of the Chippewa. The other such program is the Protection and Advocacy for Individuals with Mental Illness program, which distributes funds to protection and advocacy systems designated by each state (including the District of Columbia and specified U.S. territories) and the American Indian Consortium.[13]

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responsibilities, ANA provides grants to promote social and economic self-sufficiency among AI/AN populations. For more information, see HHS, ACF, and ANA, "About SEDS," http://www.acf.hhs.gov/programs/ana/programs/seds/about.

[11] For a larger discussion of IHS eligibility, see the "IHS User Population" section in CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[12] For more information about SAMHSA and its programs, see CRS Report R44510, *Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview*.

[13] The American Indian Consortium represents the Navajo and Hopi Tribes in the Four Corners region of the Southwest

SAMHSA has formal mechanisms for collaborating with ITs, TOs, and other stakeholders. SAMHSA's Office of Tribal Affairs and Policy is responsible for working on behavioral health issues affecting tribal communities in collaboration with ITs, TOs, other SAMHSA offices and centers, and other federal agencies;[14] its responsibilities also include supporting agency efforts to implement the Tribal Law and Order Act of 2010 (Title II of P.L. 111-211), which seeks to reduce alcohol and illicit drug usage (among other things).[15] SAMHSA's Tribal Technical Advisory Committee, comprising 14 members from federally recognized tribes, enables tribal leadership and SAMHSA staff to "exchange information about public health issues, identify urgent mental health and substance abuse needs, and discuss collaborative approaches to addressing these behavioral health issues and needs."[16]

IHS and SAMHSA Programs Included in This Report

This report includes IHS and SAMHSA programs that specifically target behavioral health in the AI/AN population; it does not include every IHS or SAMHSA program that may be used to support behavioral health in the AI/AN population. That is, this report does not compile every program administered by IHS's Division of Behavioral Health and every SAMHSA grant for which ITs or TOs are eligible. For example, IHS offers scholarships and loan repayment to recruit providers (including but not limited to behavioral health providers) to IHS facilities.[17] These workforce programs are not discussed in this report because they do not specifically target behavioral health. Similarly, IHS programs that focus on problems such as domestic violence or sexual assault (which may cause or exacerbate behavioral health problems) are beyond the scope of this report.[18]

Both IHS and SAMHSA participate in interagency (within HHS) and interdepartmental activities related to AI/AN behavioral health (see text box); however, they generally approach AI/AN behavioral health in ways that are not directly comparable. IHS delivers health care (including behavioral health care) directly or under contracts/compacts with ITs or TOs. As such, it has specific health service programs, including facilities focused on behavioral health. SAMHSA

(i.e., Arizona, Colorado, New Mexico, and Utah).

[14] U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Administration (SAMHSA), Tribal Affairs, http://www.samhsa.gov/tribal-affairs. The Tribal Technical Advisory Committee is consistent with a 2000 executive order, a 2004 presidential memorandum, a 2009 presidential memorandum, and the HHS Tribal Consultation Policy. See Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments," *Public Papers of the Presidents of the United States: William J. Clinton* (Washington: GPO, 2000); U.S. President (G.W. Bush), "Memorandum on Government-to-Government Relationship with Tribal Governments," September 23, 2004; U.S. President (Barack H. Obama), "Presidential Memorandum on Tribal Consultation, Memorandum for the Heads of Executive Departments and Agencies," November 5, 2009; and HHS, *Tribal Consultation*, http://www.hhs.gov/about/agencies/iea/tribal-affairs/consultation/index.html. Under the HHS Tribal Consultation Policy, each division within HHS (including SAMHSA) must have "an accountable consultation process to ensure meaningful and timely input by Tribal officials in the development of policies that have Tribal implications" (among other requirements).

[15] Ibid. The Tribal Law and Order Act of 2010 distinguishes the responsibilities of federal, state, IT, and TO governments regarding crimes committed in American Indian and Alaska Native territory.

[16] HHS, SAMHSA, Tribal Technical Advisory Committee (TTAC), http://www.samhsa.gov/about-us/advisory-councils/tribal-technical-advisory-committee-ttac.

[17] For information on IHS scholarship and loan repayment programs, see HHS, IHS, "Scholarship Program," https://www.ihs.gov/scholarship/ and HHS, IHS, "Loan Repayment Program," https://www.ihs.gov/loanrepayment/.

[18] For more information on these programs, see HHS, IHS, "Forensic Healthcare," https://www.ihs.gov/forensichealthcare/ and HHS, IHS, "Domestic Violence Prevention Initiative," https://www.ihs.gov/dvpi/.

does not deliver health care services or operate health care facilities. SAMHSA primarily awards grants to support behavioral health activities of other entities (e.g., states or ITs).

Interagency Efforts on AI/AN Behavioral Health

Behavioral Health Coordination Council (BHCC): The Department of Health and Human Services (HHS) established the council in 2010 to facilitate collaboration, reduce program duplication, increase sharing of information, and encourage collaboration in accordance with the HHS behavioral health agenda.

Tribal Behavioral Health Agenda (in progress): HHS, in collaboration with other federal agencies, ITs, and the National Indian Health Board—an organization that represents tribal governments on a variety of health issues—are developing a *Tribal Behavioral Health Agenda*, as a guide to providing behavioral health care.

Generation Indigenous (Gen-I): A multidepartment government initiative, in partnership with the Center for Native American Youth at the Aspen Institute, established in 2014, that includes but is not limited to behavioral health projects. The initiative aims to assist tribal youth through programs, policy, and leadership opportunities.

Substance Abuse Memorandum of Agreement: HHS, the Department of the Interior (DOI), and the Department of Justice (DOJ) issued a Memorandum of Agreement (MOA) in 2011 to address disproportionate rates of substance abuse among AI/ANs. Under the MOA, these departments are coordinating their respective efforts to assist AI/AN communities in the prevention, intervention, and treatment of alcohol and substance abuse.

Sources: HHS/Substance Abuse and Mental Health Services Administration (SAMHSA), "Interagency Activities: Behavioral Health Coordinating Council (BHCC)," December 12, 2015; HHS, SAMHSA, Indian Health Service (IHS), and National Indian Health Board, The National Tribal Behavioral Health Agenda, Draft Overview: National Tribal Public Health Summit, April 11, 2016, p. 5; The White House, "Remarks by the President at the Tribal Nations Conference," press release, December 3, 2014; HHS, U.S. Department of the Interior (DOI), and U.S. Department of Justice (DOJ), Indian Alcohol and Substance Abuse Memorandum of Agreement, July 29, 2011, pp. 29-30; HHS, IHS, FY2017 Justification of Estimates for Appropriations Committees, p. CJ-92; and HHS, DOI, and DOJ, "Indian Alcohol and Substance Abuse Interdepartmental Coordinating Committee: FY 2015 Annual Progress Report," 2015.

Background on AI/AN Behavioral Health

Research on AI/AN behavioral health demonstrates three key points: The AI/AN population has (1) a high prevalence of risk factors for behavioral health problems, (2) a high prevalence of behavioral health problems, and (3) limited access to care for behavioral health problems.

High Prevalence of Risk Factors Among AI/AN

A wide variety of health outcomes have been found to depend on factors such as education, employment, poverty, and culture, among others—factors collectively known as "social determinants."[19] High rates of behavioral health problems (and other health problems) in the AI/AN population may be attributable to "issues rooted in economic adversity and poor social conditions," such as "inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences."[20] The AI/AN population has been found to be "poorer, less educated, less employed, less healthy ... than virtually any other demographic group in the United States."[21] For example, as of 2012, fewer AI/AN adults had at least a high

[19] James Knibb-Lamouche, *Culture as a Social Determinant of Health: Examples from Native Communities*, commissioned paper prepared for the Institute of Medicine Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities (Seattle, WA), November 14, 2012. Hereinafter cited as Knibb-Lamouche, *Culture as a Social Determinant of Health*, 2012.

[20] HHS, IHS, *Disparities*, March 2016, https://www.ihs.gov/newsroom/factsheets/disparities/.

[21] Joseph P. Gone and Joseph E. Trimble, "Native American and Alaska Native Mental Health: Diverse Perspectives on Enduring Disparities," *Annual Review of Clinical Psychology*, vol. 8 (2012), pp. 131-160.

school diploma (85%) compared to non-Hispanic whites (92%), and the median income for the AI/AN population ($37,353) was two-thirds that of the non-Hispanic white population ($56,565).[22]

Health disparities, including those in behavioral health that may result from social determinants, are not exclusive to the AI/AN population; rather they may occur in all disadvantaged populations. Social determinants, in turn, may adversely affect all types of health conditions, not just behavioral health conditions. Moreover, behavioral health conditions may exist in individuals without these risk factors.

High Prevalence of Behavioral Health Problems Among AI/AN

The AI/AN population has a higher prevalence of some behavioral health problems than many other racial or ethnic groups. For example, in 2014 the AI/AN population had the highest suicide rates among other racial ethnic groups for both the male population (27.4 per 100,000) and the female population (8.7 per 100,000), as shown in **Figure 1**.[23] Similarly, in 2014 the rate of past-year substance use disorders was higher among the AI/AN population (16%) than among other racial and ethnic groups: non-Hispanic white (8%), non-Hispanic black (8.6%), Hispanic (8.5%), Asian (4.5%), and Native Hawaiian or other Pacific Islanders (10%).[24]

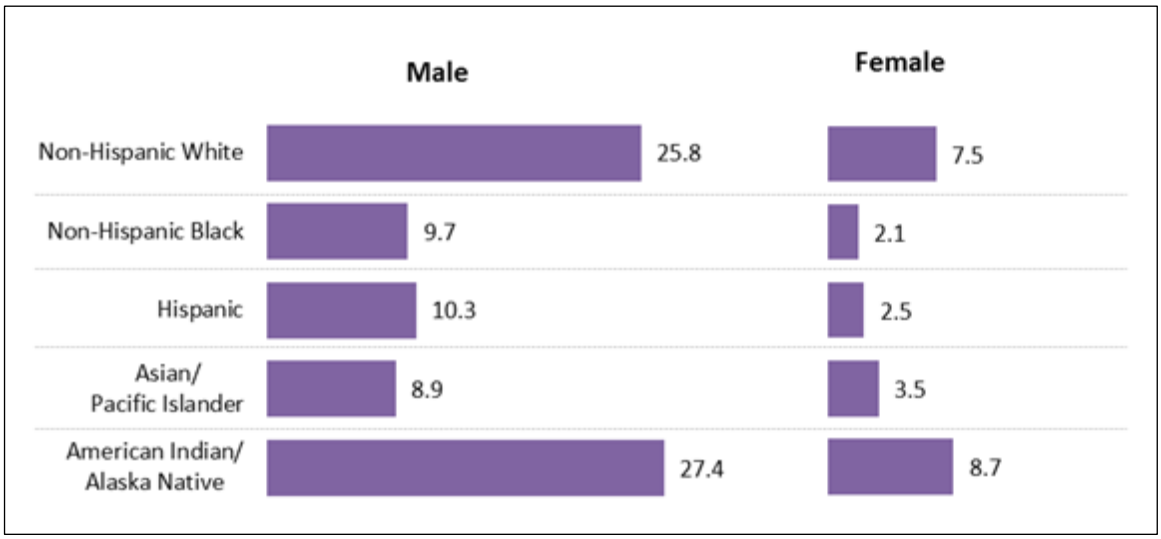
[22] HHS, Office of Minority Health, *Profile: American Indian/Alaska Native*, February 3, 2016, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62.

[23] HHS, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), *Suicide Rates for Females and Males by Race and Ethnicity: United States, 1999 and 2014*, April 2016, pp. 4-5, http://www.cdc.gov/nchs/data/hestat/suicide/rates_1999_2014.pdf. The CDC data include both members of federally recognized tribes (i.e., the population traditionally served by IHS) and individuals who self-identify as American Indian or Alaska Native who may not be eligible for IHS services. The rates of suicide are age-adjusted.

[24] HHS, SAMHSA, Center for Behavioral Health Statistics and Quality, *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables* (Rockville, MD), September 2015, p. 150406, http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf#page=1169. Rates are among the population aged 12 or older. For more information about the NSDUH, see CRS Report R43047, *Prevalence of Mental Illness in the United States: Data Sources and Estimates*.

Figure 1. Age-Adjusted Suicide Rates, by Gender, Race, and Ethnicity (2014)

(Deaths per 100,000)



Source: Data from HHS, CDC, National Center for Health Statistics (NCHS), *Suicide Rates for Females and Males by Race and Ethnicity: United States, 1999 and 2014*, April 2016, pp. 4-5.

Note: Data represent the self-identified AI/AN population; not all self-identified AI/AN are eligible for programs restricted to members of Indian Tribes.

Researchers have found that the AI/AN population has particularly high rates of certain behavioral health problems, including alcohol and marijuana use disorders. According to IHS, substance use disorders result in "devastating intergenerational social, economic, physical, mental, and spiritual health disparities" in AI/AN communities, including a rate of alcohol-related deaths (49.6 per 100,000) that is six times greater than the rate for all races (8.0 per 100,000).[25] Posttraumatic stress disorder, childhood conduct disorder, and suicidal behaviors are also present at higher rates than in other races.[26] However, these higher rates are not consistent across all behavioral health problems; for example, researchers found that major depressive disorder is less common among the AI/AN population than among the overall adult U.S. population.[27]

Despite a greater prevalence of some behavioral health disorders among the AI/AN population, collecting and analyzing data poses several challenges. First, when researchers present prevalence rates (or other data) by race or ethnicity, they often do not report data for groups of comparatively small size (such as the AI/AN population) because the samples of such groups are too small to support statistical analysis. Second, studies conducted specifically among the AI/AN population can report data for that population but lack comparisons to other groups. Third, the designation of individuals as AI/AN may not be consistent: some datasets may categorize individuals as AI/AN based on self-identification, whereas others may do so based on tribal membership. Also, an AI/AN designation does not capture variation within that population (e.g., differences between tribes).

[25] HHS, IHS, *FY2017 Justification of Estimates for Appropriations Committees*, p. CJ-100, https://www.ihs.gov/budgetformulation/congressionaljustifications/. Hereinafter cited as IHS, CJ FY2017. The rates of alcohol-related deaths are age-adjusted. The rate for the AI/AN population is a three-year average for 2007-2009, and the rate for all races is for 2008.

[26] Joseph P. Gone and Joseph E. Trimble, "Native American and Alaska Native Mental Health: Diverse Perspectives on Enduring Disparities," *Annual Review of Clinical Psychology*, vol. 8 (2012), p. 131-160.

[27] Ibid.

Limited Access to Care Among AI/AN

Preventing and treating behavioral health conditions generally requires regular access to health care providers who can screen and, if necessary, treat behavioral health conditions. AI/ANs often have difficulty accessing care because they are more likely to live in rural and remote areas than the U.S. population as a whole. A number of rural areas are designated as mental health shortage areas by the federal government thereby making these areas eligible for programs that seek to reduce provider shortages; this designation includes areas with federally recognized Indian Tribes, which are automatically designated as shortage areas.[28]

The IHS system provides access to care but has difficulty recruiting and retaining providers generally and behavioral health providers specifically. For example, IHS noted that it has approximately 1,500 vacant health care provider positions and that it has difficultly recruiting providers because of the remote locations of many of its facilities.[29]

Even when health care facilities are geographically close and health care providers are available, other factors may impede access to care that is acceptable to and appropriate for the AI/AN population. Whereas IHS-funded facilities specialize in the AI/AN population, non-IHS-funded facilities do not and may be less likely to provide culturally competent care. AI/AN patients may be reluctant to visit non-IHS-funded mainstream health care facilities due to cultural differences between the patients and the providers available to treat them.[30] For example, non-IHS health care providers typically speak in terms of "treatment," whereas the AI/AN population might relate to the concept of "healing."[31] If health care providers are not able to provide culturally competent care, AI/AN patients may feel alienated or disrespected, and they may be less compliant with treatment.[32] Another access barrier may be financial. AI/ANs receive free care at IHS-funded facilities when services are provided directly by these facilities. However, non-IHS facilities generally require AI/ANs to pay for services, and some people may not be able to afford such costs because they have low incomes or they lack insurance coverage.[33]

Program Summaries

IHS and SAMHSA have programs aimed at improving AI/AN behavioral health. In some cases, both agencies have programs with the same (or a very similar) specific focus (e.g., suicide prevention). Given the fundamental differences between the two agencies—with IHS primarily delivering health care services and SAMHSA primarily awarding grants—programs with similar

[28] For more information, see CRS Report R43255, *The Mental Health Workforce: A Primer*.

[29] IHS, CJ FY2017, p. CJ-224.

[30] Knibb-Lamouche, *Culture as a Social Determinant of Health*, 2012.

[31] Karen M. Anderson and Steve Olson, *Advancing Health Equity for Native American Youth: Workshop Summary (2016)*, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities; Board on Population Health and Public Health Practice; Health and Medicine Division; National Academies of Sciences, Engineering, and Medicine, 2016.

[32] Knibb-Lamouche, *Culture as a Social Determinant of Health*, 2012.

[33] According the U.S. Census Bureau, access to services at IHS is not considered to be insurance coverage; the Census Bureau estimated that 22.6% of the AI/AN population were uninsured in 2012 (by comparison,14.7% of non-Hispanic whites were uninsured in 2012). In addition, 26% of the AI/AN population lived below the federal poverty level in 2012 (compared to 11% of non-Hispanic whites). See HHS, Office of Minority Health, *Profile: American Indian/Alaska Native*, February 3, 2016, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62 and U.S. Census Bureau, "Table 7: People Without Health Insurance Coverage by Selected Characteristics, 2011 and 2012," http://www2.census.gov/programs-surveys/demo/tables/p60/245/table7.pdf.

names or goals may not be comparable. Programs and grants are listed separately below according to agency.

The programs in this report do not represent a comprehensive list of IHS programs that may treat behavioral health conditions and SAMHSA programs for which ITs and TOs are eligible. That is, AI/ANs may receive behavioral health services as part of IHS programs that are not focused on behavioral health, and ITs or TOs may receive funds from SAMHSA programs that have not been identified as particularly relevant to the AI/AN population. Furthermore, some of the SAMHSA programs included in this report are not limited to ITs, TOs, or the AI/AN population. For these reasons, presenting funding for the included programs would be misleading—underestimating spending in AI/AN behavioral health in some ways and overestimating it in others. This report is not intended to capture federal spending on AI/AN behavioral health and does not include funding for the programs.

IHS Programs

IHS programs are authorized by the Indian Health Care Improvement Act (IHCIA).[34] Title VII of the act specifically authorizes programs related to behavioral health. IHS has structured its behavioral health programs under two main umbrella programs: (1) the Alcohol and Substance Abuse Program, and (2) the IHS Mental Health/Social Services Program. Programs presented below are ordered alphabetically and described under their umbrella program.

The Alcohol and Substance Abuse Program

The Alcohol and Substance Abuse Program (ASAP) is an overarching program that incorporates preventive, educational, and treatment services to address the behavioral health status of AI/ANs. Program services may be delivered in conjunction with primary health services and through telehealth[35] when appropriate. Alcohol and substance abuse program services can be provided by the IHS, ITs, or TOs using funds received through two Indian Self-Determination Education and Assistance Act (ISDEAA) [36] funding mechanisms: contracts and compacts (see definitions in **Table 1**). IHS reports that 80% of alcohol and substance abuse programs are operated by ITs or TOs.[37] In addition, IHS requires that health care providers who work in IHS facilities operated by the federal government and who have the authority to prescribe opioids consult their state's Prescription Drug Monitoring Program (PDMP)[38] databases prior to prescribing and dispensing opioids for more than seven days.[39]

[34] 25 U.S.C. §§1601 et seq; permanently authorized in §10221 P.L. 111-148, as amended, for more detailed information see CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

[35] Telehealth is the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration; as defined in Section 330K(a) of the Public Health Service Act (42 U.S.C. §254c–16(a)). See, also, CRS Report R44437, *Telehealth and Telemedicine: Description and Issues*.

[36] P.L. 93-638.

[37] HHS, IHS, "Alcohol and Substance Abuse Program," https://www.ihs.gov/asap/.

[38] For a larger discussion of PDMPs, see CRS Report R42593, *Prescription Drug Monitoring Programs*.

[39] HHS, IHS, "IHS Implements Groundbreaking New Policy Regarding Opioid Prescribing," press release, July 6, 2016, https://www.ihs.gov/newsroom/ihs-blog/july2016/ihs-implements-groundbreaking-new-policy-regarding-opioid-prescribing/.

IHS programs within ASAP's scope include Fetal Alcohol Spectrum Disorders (FASD), Integrated Substance Abuse Treatment in Primary Care, Methamphetamine and Suicide Prevention Initiative (MSPI), and Youth Regional Treatment Centers (YRTCs).

Fetal Alcohol Spectrum Disorders

IHS provides funding to the Fetal Alcohol and Drug Unit (FADU) at the University of Washington's Alcohol and Drug Abuse Institute. The FADU provides consultations and referrals for evaluation and diagnosis to AI/ANs with fetal alcohol spectrum disorders (FASD) and their families. FADU offers resources, referrals, workshops, and technical support on FASD issues for service providers in Washington State, and online courses for out-of-state health care providers.[40] FADU data are collected to inform strategies for FASD prevention and treatment.[41]

Integrated Substance Abuse Treatment in Primary Care

The Integrated Substance Abuse Treatment in Primary Care program incorporates substance abuse treatment into primary care and emergency services at IHS-funded facilities. Patients identified as having substance use disorders are provided with medical advice and/or substance abuse consultations, while patients with more severe substance use-related problems are referred to treatment.[42] As part of this program, IHS promotes the Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategy, a community-based screening for health risk behaviors, including substance use.[43] The Center for Medicare and Medicaid Services (CMS) reimburses IHS-funded facilities for SBIRT provided to individuals enrolled in CMS-administered programs.

Methamphetamine and Suicide Prevention Initiative

The Methamphetamine and Suicide Prevention Initiative (MSPI) program is a nationally coordinated grant program that awards substance abuse, suicide prevention, and intervention resources to IHS-funded facilities (i.e., the entity including an IT or a TO that operates the facility). Grantee programs must address at least one of the following four purpose areas: (1) community needs assessment and strategic planning; (2) suicide prevention, intervention, and postvention;[44] (3) methamphetamine prevention, treatment, and aftercare; and (4) Gen-I Initiative support. Programs operate within a five-year period, and 128 MSPI programs were selected for the 2015 through 2020 program cycle.[45] IHS collects data from the grantee programs[46] in

[40] Fetal Alcohol Syndrome Diagnostic & Prevention Network, *Training*, https://depts.washington.edu/fasdpn/htmls/training.htm.

[41] University of Washington, "Fetal Alcohol and Drug Unit: Research Studies and Intervention Projects-IHS," June 11, 2015, http://depts.washington.edu/fadu/research-projects/list-of-projects/research-intervention-ihs.

[42] IHS, CJ FY2017, p. CJ-96.

[43] HHS, SAMHSA and HRSA, *SBIRT: Screening, Brief Intervention, and Referral to Treatment*, http://www.integration.samhsa.gov/clinical-practice/SBIRT.

[44] Postvention refers to interventions with the surviving family and friends of someone who has died by suicide.

[45] HHS, IHS, "About MSPI," https://www.ihs.gov/mspi/aboutmspi/.

[46] HHS, IHS, "MSPI Fact Sheet," https://www.ihs.gov/mspi/includes/themes/newihstheme/display_objects/documents/mspifactsheet.pdf.

conjunction with Tribal and Urban Epidemiology Centers,[47] the National Indian Health Board,[48] and the National Council of Urban Indian Health.[49]

In FY2016, MSPI and Gen-I Initiative supported a new MSPI grantee cycle that made funds available to both new applicants and current MSPI grantees. These grants were awarded to help support the overarching goals of the MSPI and Gen-I Initiative by implementing early intervention strategies and youth development programming that seek to reduce risk factors for substance abuse and suicidal behavior. If awarded a grant, new applicants are required to implement evidence-based approaches to promote development and self-sufficiency among AI/AN youth, promote family engagement, increase access to culturally appropriate substance use and suicide prevention activities for youth, and hire behavioral health staff specializing in child, adolescent, and family services. Current MSPI grantees that receive funding under the FY2016 initiative are required to hire additional behavioral health staff, and may use funds to supplement existing MSPI-related activities.[50]

Youth Regional Treatment Centers

IHS funds 11 Youth Regional Treatment Centers (YRTCs) that provide residential substance abuse and mental health treatment services to AI/AN youth.[51] These services include clinical evaluation; substance abuse education; individual, group, and family psychotherapy; medication management or monitoring; and post-treatment follow-up. These facilities are designed to provide regionalized services in each of IHS's 12 areas,[52] where patients travel to a centralized facility to obtain services. The IHS has 12 areas[53] but has fewer YRTCs because two areas have opted to contract for YRTC services.[54] An additional YRTC facility is under construction in California.[55]

IHS Mental Health/Social Services Program

The IHS Mental Health/Social Services (MH/SS) Program is an overarching program that provides preventive and clinical mental health services that are provided by the IHS or by ITs and TOs. Currently, 50% of mental health programs are operated by ITs or TOs.[56] The most common

[47] Tribal Epidemiology Centers are IHS-funded and manage the public health information systems of IHS-funded facilities, investigate diseases of concern, manage disease prevention and control programs, respond to public health emergencies, and coordinate these activities with other public health authorities. IHS, "Tribal Epidemiology Centers," https://www.ihs.gov/epi/index.cfm?module=epi_tec_main.

[48] National Indian Health Board (NIBH) represents IT and TO governments that operate their own health care systems and those that receive health care from IHS. NIHB, "About NIBH," http://www.nihb.org/about_us/about_us.php.

[49] National Council of Urban Indian Health (NCUIH) is an organization that advocates for health care services for AI/ANs in urban settings. NCUIH, "About," http://www.ncuih.org/about.

[50] HHS, IHS, "Division of Behavioral Health, Office of Clinical and Preventive Services, Methamphetamine and Suicide Prevention Initiative-Generation Indigenous (Gen-I), Initiative Support," 2016-15111 *Federal Register* 41574-41584, June 27, 2016.

[51] IHS, CJ FY2017, p. CJ-96.

[52] California is considered to be two areas for the purposes of the YRTCs. For this authority, see "Section 708. Indian Youth Program" in CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

[53] For information on these areas, see Figure 1 in CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[54] The two areas that contract for YRTC services are Bemidji (which covers Michigan, Minnesota, and Wisconsin) and the Billings area (which covers Montana and Wyoming).

[55] HHS, IHS, "California Youth Regional Treatment Center (YRTC)," press release, January 2016, https://www.ihs.gov/california/index.cfm/yrtc-project/yrtc-newsletter-winter-2016/.

[56] Meeting with Director IHS, Division of Behavioral Health, July 7, 2016.

MH/SS program model is an acute, crisis-oriented outpatient service. After-hour emergency services are typically offered by local non-IHS hospital emergency departments, some of which provide services under contractual agreements with IHS. IHS-funded facilities may also purchase inpatient services from non-IHS hospitals or these services may be provided by state or county mental health hospitals. Access to intermediate level services—such as group homes, transitional living support, and intensive case management—are typically offered through state and local resources, and are not generally reimbursable through IHS mechanisms.[57] IHS programs within MM/SS's scope are Behavioral Health Integration with Primary Care, Telebehavioral Health and Workforce Development, and Zero Suicide Initiative.

Behavioral Health Integration with Primary Care

The Behavioral Health Integration with Primary Care program incorporates behavioral health treatment into primary care. Primary care support enables health care providers to identify and provide interventions for high-risk individuals before their behavior becomes more clinically significant.[58] The program integrates the medical home model, a partnership between the patient, family, and primary provider in cooperation with specialists and support from the community.[59]

Telebehavioral Health and Workforce Development

The IHS Telebehavioral Health Center of Excellence (TBHCE) was developed in partnership with the University of New Mexico Center for Rural and Community Behavioral Health.[60] TBHCE provides televideo clinical services to patients at IHS-funded facilities. Clinical services include addiction medicine, adult psychiatry, and child/adolescent psychiatry as well as family, adult, and child/adolescent therapy. TBHCE provides continuing education courses by webinar to personnel at IHS-funded facilities.[61]

Zero Suicide Initiative

IHS launched a suicide prevention initiative, called the Zero Suicide Initiative, in FY2015.[62] This initiative is based on a model developed by the Education Developmental Center, Inc. (EDC)[63] and the Suicide Prevention Resource Center (SPRC),[64] both of which receive funding from SAMHSA.[65] The Zero Suicide Initiative involves educating health care providers (e.g., how to conduct suicide screening and risk assessment) and supporting evidence-based practices. In

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[57] HHS, IHS, *FY2016 Justification of Estimates for Appropriations Committees*, p. CJ-84.

[58] IHS, CJ FY2017, p. CJ-89.

[59] HHS, Health Resources and Services Administration, "What is a Medical Home? Why is it Important?" http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html.

[60] Telebehavioral health is a form of telehealth where telehealth technologies (as defined in footnote 35) are used to provide behavioral health services. For example, where a social worker provides counseling using skype or similar technologies.

[61] HHS, IHS, "Clinical Services," https://www.ihs.gov/telebehavioral/index.cfm/clinicalservices/.

[62] IHS, CJ FY2017, p. CJ-88.

[63] Education Developmental Center, Inc. is a non-profit organization that designs, implements, and evaluates programs and services relating to suicide prevention, among other areas.

[64] Suicide Prevention Resource Center is a project in the Education Development Center's Health and Human Development Division. It offers information on resources and online trainings pertaining to suicide prevention. See http://www.sprc.org/.

[65] For more on Health Resources and Services Administration (HRSA), IHS, and SAMHSA cross-agency suicide prevention efforts, see http://www.samhsa.gov/sites/default/files/combined_suicide_resources_overview.pdf.

FY2016, IHS is funding 10 pilot sites that are implementing this model. IHS has also developed a suicide surveillance reporting tool to document incidents of suicide in a standardized, systematic fashion. The reporting tool gathers data, such as the method and other epidemiological information, related to specific incidents of suicide.

American Indians into Psychology Program

The American Indians into Psychology Program (INPSYCH),[66] a grant program administered by the IHS, is designed to attract AI/ANs into health professions and to ensure the availability of health professionals to serve AI/AN populations. It provides scholarships (tuition, books, fees, stipends) for AI/ANs enrolled in programs offering training in clinical psychology. Most recently in FY2014, three institutions of higher education were selected to receive grant funding over a five-year term: Oklahoma State University, the University of North Dakota, and the University of Montana.

Graduate students accepted into the INPSYCH program must work in an AI/AN community for one year for each year of funding they receive. Graduates may fulfill this commitment at an IHS-funded facility or at a private practice if the practice is situated in a federally designated health professional shortage area and addresses the health care needs of a substantial number of AI/ANs.

SAMHSA Programs

SAMHSA pursues its mission primarily by awarding grants, some of which are open to ITs and TOs.[67] As described below, several grants are specifically aimed at the AI/AN population or highly customized for that population, as identified by SAMHSA.[68] Each of the grants is administered by one of three centers within SAMHSA: the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment.

Center for Mental Health Services

Most of the programs identified by SAMHSA as particularly relevant to the AI/AN population are administered by SAMHSA's Center for Mental Health Services and focus on supporting mental health treatment or suicide prevention. Several of the programs are part of larger programs and may be commonly known by more than one name.

[66] HHS, IHS, "American Indians Into Psychology," 2014-13960 *Federal Register* 34317 -34323, June 16, 2014; and Lisa Rabasca, "Helping American Indians Earn Psychology Degrees," Monitor on Psychology, vol. 31, no. 3 (March 2000), p. 52. IHCIA Sec. 217 (25 U.S.C. §1621p)n.

[67] With the exception of the Systems of Care program, the SAMHSA grants included in this report operate under SAMHSA's programs of regional and national significance (PRNS) authority. For more detailed information, see CRS Report R44510, *Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview*. These grant programs do not necessarily have open competitions at this time. For organizations interested in competing for grant programs, information is available at http://www.samhsa.gov/grants or http://grants.gov for open grant competitions.

[68] Mirtha Beadle and Alex Thundercloud, *Tribal Behavioral Health Agenda—An Approach to Improving Wellness in Tribal Communities*, HHS, SAMHSA and IHS, presentation at National Indian Health Board (NIHB) 6th Annual Tribal Public Health Summit, Rancho Mirage, CA, April 8, 2015. SAMHSA provides an expanded list of grants that "may be of particular interest to tribes" at http://www.samhsa.gov/tribal-affairs/grants.

Systems of Care

The Systems of Care (SOC) program, also called the Children's Mental Health Initiative, provides funds to ITs and TOs (among other eligible entities) to adopt or expand the SOC approach to improve mental health outcomes for children aged 21 or younger with serious mental health conditions and their families.[69] The SOC approach aims to address children's "physical, intellectual, emotional, cultural, and social needs" by delivering evidence-based, culturally and linguistically appropriate services in the least restrictive environment.[70] In addition, the SOC program supports the development of infrastructure to provide such services.[71]

Circles of Care

The Circles of Care program supports ITs, TOs, Urban Indian programs, and tribal colleges (without competition from other entities) in implementing an SOC model of behavioral health services and supports for children and families.[72] Grantees may use funds for planning, developing infrastructure, and building local capacity.[73] They must adopt culturally appropriate methods; incorporate family, youth, and community resources; and emphasize collaboration across systems.[74] Circles of Care grantees may not use funds to provide direct services.[75]

Garrett Lee Smith (GLS) Youth Suicide Prevention—Campus

The Garrett Lee Smith (GLS) Youth Suicide Prevention—Campus program aims to improve the suicide prevention efforts of institutions of higher learning, including tribal colleges and universities.[76] GLS Campus grants support services to address problems "such as depression, substance abuse, and suicide attempts."[77] Grant-funded activities may include outreach to and services for students experiencing substance abuse and mental health issues who may be at greater risk for suicide and non-fatal attempts.[78]

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[69] HHS, SAMHSA, The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program: Report to Congress 2015, PEP16-CMHI2015, http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf.

[70] HHS, SAMHSA, *FY2017 Justification of Estimates for Appropriations Committees*, p. 127.

[71] For details of the SOC program, see HHS, SAMHSA, *System of Care (SOC) Expansion and Sustainability Cooperative Agreements Funding Opportunity Announcements*, FOA No. SM-16-009, http://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-09.pdf.

[72] HHS, SAMHSA, Tribal Training and Technical Assistance Center, *Circles of Care*, last updated May 15, 2015, http://www.samhsa.gov/tribal-ttac/training-technical-assistance/circles-of-care.

[73] Ibid.

[74] Ibid.

[75] Ibid.

[76] "Tribal colleges and universities" are institutions that (1) qualify for funding under the Tribally Controlled Colleges and Universities Assistance Act of 1978 (25 U.S.C. 1801 et seq.) or the Navajo Community College Act (25 U.S.C. § 640a note); or (2) are cited in section 532 of the Equity in Educational Land-Grant Status Act of 1994 (7 U.S.C. §301 note) per the Higher Education Act of 1965 (20 U.S.C. §10599(b)).

[77] 42 U.S.C. §290bb-36b.

[78] Further grant details are available at HHS, SAMHSA, *2015 Campus Suicide Prevention Grant: Funding Opportunity Announcements*, FOA No. SM-15-008, http://www.samhsa.gov/grants/grant-announcements/sm-15-008.

GLS Youth Suicide Prevention—State/Tribal

The GLS Youth Suicide Prevention—State/Tribal program aims to improve the suicide prevention efforts of states, U.S. territories, ITs, and TOs. Awardees may use funds for the development and implementation of statewide or tribal youth suicide prevention and early intervention strategies in order to reduce suicides and non-fatal attempts. SAMSHA requires grant recipients to collaborate with local youth-serving institutions, such as schools and foster care systems, prevention/health related programs in the recipient's community, and the Suicide Prevention Resource Center.[79]

Native Connections

The Native Connections program, also called Tribal Behavioral Health Grants, supports ITs, TOs, and IT/TO consortia (without competition from other entities) in their efforts to promote mental health and reduce substance abuse and suicidal behavior among AI/AN youth (aged 24 or younger).[80] Grantees are required to assess their current behavioral health resources; identify and address gaps using established strategies; and develop the infrastructure to collect data on suicide attempts, deaths, and substance abuse data in conjunction with SAMHSA's Tribal Training and Technical Assistance Center. Grantees must also collaborate with public and private partners, such as those managing foster care and juvenile justice. Grantees may use funds on follow-up care and support services for young community members who abuse substances or have attempted suicide.[81]

Project LAUNCH

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) aims to promote the health and well-being of children (aged eight or younger) through the coordination of child-serving agencies and organizations, and the development of policy and funding reforms to improve behavioral health services. The grants are open to states, territories, and ITs. The grants support pilot programs in communities with a demonstrably high need for service, and aim to address the physical, social, emotional, cognitive, and behavioral aspects of children's development.[82]

Center for Substance Abuse Prevention

SAMHSA's Center for Substance Abuse Prevention, which addresses behavioral health through evidence-based prevention approaches, administers the Strategic Prevention Framework-Partnerships for Success grants.

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[79] HHS, SAMHSA, *PPHF-2015 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention: Request for Applications* (Rockville, MD), 2015, p. 2.

[80] For more information, see HHS, SAMHSA, *Native Connections*, last updated January 21, 2016, http://www.samhsa.gov/native-connections.

[81] HHS, SAMHSA, *Cooperative Agreements for Tribal Behavioral Health: Funding Opportunity Announcement*, FOA No. SM-16-010, http://www.samhsa.gov/grants/grant-announcements/sm-16-010.

[82] HHS, SAMHSA, *Cooperative Agreements for Linking Actions for Unmet Needs in Children's Health*, http://www.samhsa.gov/grants/grant-announcements/sm-14-004.

Strategic Prevention Framework-Partnerships for Success

Strategic Prevention Framework-Partnerships for Success (SPF-PFS) State and Tribal Initiative grants address underage drinking (among those aged 12 to 20) and prescription drug misuse and abuse (among those aged 12 to 25). These grants are intended to prevent the onset and reduce progression of substance abuse by incorporating SAMSHA's Strategic Prevention Framework, which emphasizes strategic planning and the implementation of evidenced-based prevention.[83] To be eligible for an SPF-PFS grant, states and ITs must have completed SAMHSA's Strategic Prevention Framework State Incentive Grant (SPF-SIG), which helps grantees build a foundation for providing and sustaining prevention services.[84] SPF-PFS grantees are expected to increase infrastructure and the capacity for providing preventive services at the state, IT, and community levels. ITs may allocate grant funds to target additional substance abuse prevention priorities, such as marijuana or heroin, at their discretion.[85]

Center for Substance Abuse Treatment

SAMHSA's Center for Substance Abuse Treatment, which addresses substance abuse treatment and recovery services for individuals and families, administers the drug court grants (within a larger program for criminal justice activities).

Drug Courts

Treatment drug courts are coordinated efforts between the court, law enforcement, and mental health and social services, among others, to intervene, provide treatment, and reduce recidivism.[86] SAMHSA's Treatment Drug Court grants support substance abuse treatment services in adult drug courts, Tribal Healing to Wellness Courts (i.e., the tribal version of adult drug courts), and (tribal or non-tribal) Juvenile Treatment Drug Courts. Treatment Drug Court grant funds must serve individuals diagnosed with substance use disorder(s) as the primary condition and in need of treatment. Funds are distributed to IT, state, and local governments with direct involvement with the tribal court or drug court. Grantees may use funds to provide services for co-morbid conditions such as mental health disorders. SAMHSA Treatment Drug Court grant expenditures must remain consistent with the drug court model, which requires judicially supervised treatment, mandatory periodic drug testing, and the use of other rehabilitation services.[87]

Issues for Future Consideration

This report is intended to provide background information about behavioral health among the AI/AN population and a summary of the most relevant federal programs. The report is not intended to address policy options for modifying, eliminating, or adding such programs (and future CRS reports may explore these policies in greater detail); however, the information in this

[83] For more information on the Strategic Prevention Framework, see HHS, SAMHSA, *Applying the Strategic Prevention Framework (SPF)*, http://www.samhsa.gov/capt/applying-strategic-prevention-framework.

[84] HHS, SAMHSA, *Strategic Prevention Framework State Incentive Grant (SPF SIG)*, http://www.samhsa.gov/capt/about-capt/prevention-grants#spf-sig.

[85] HHS, SAMHSA, *Strategic Prevention Framework - Partnerships for Success*, http://www.samhsa.gov/grants/grant-announcements/sp-16-003.

[86] For a larger discussion of drug courts, see CRS Report R44467, *Federal Support for Drug Courts: In Brief*.

[87] HHS, SAMHSA, "Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts," http://www.samhsa.gov/grants/grant-announcements/ti-16-009.

report may help policymakers address a range of potential policy issues related to AI/AN behavioral health care.

For example, one challenge that IHS and SAMHSA-supported programs face is the shortage of behavioral health providers, particularly in rural areas, where much of the IHS beneficiary population resides. IHS, SAMHSA, and the Health Resources and Services Administration (which administers the majority of federal health workforce programs) are seeking to address these workforce issues. Policymakers may consider coordinating or modifying existing workforce programs to reduce the effects of workforce shortages on programs that support AI/AN behavioral health prevention and treatment.[88] However, policymakers may face fiscal constraints in doing so, as a number of these programs have more applicants than can be supported with the funding available.[89]

As another example, some research has found that improving access to culturally competent care (e.g., through integration of traditional AI/AN healing practices with mainstream health care) may lead to better health outcomes and better patient satisfaction.[90] Although some existing federal programs aim to increase the number of AI/AN behavioral health care providers (e.g., the American Indians into Psychology Program), such training may take years to complete and may train only a limited number of providers. Policymakers may consider additional approaches to increase the culturally competent workforce, such as programs teaching qualified health care providers from other racial and ethnic groups about elements of AI/AN culture.

Policymakers may consider whether current data are sufficient to determine the need for programs and to evaluate their effectiveness. As noted above, data collection is complicated by several factors: efforts to identify the AI/AN population in research may be confounded by differences between self-identification and tribal membership (or program eligibility);getting a sufficient sample size for analysis of specific behavioral health conditions and comparison with other populations is difficult because the AI/AN population is comparatively small; and mapping the rates of conditions to the AI/AN population served is an ongoing challenge. Policymakers may consider requiring additional data collection or may find that the need for services is so apparent that additional data collection is not necessary.

Finally, many of the behavioral issues that AI/ANs experience may be related to the AI/AN socioeconomic conditions. As such, policymakers may consider the balance among programs that address behavioral health directly, programs that address the socioeconomic conditions of AI/AN (which may affect behavioral health indirectly), and programs that address some combination of the two. Similarly, policymakers may consider whether they would like to see evaluations of the association (if any) between implementation of programs aimed at improving socioeconomic conditions and subsequent changes in the rates of behavioral health conditions.

[88] CRS Report R44054, *Health Resources and Services Administration (HRSA) Funding: Fact Sheet*.

[89] For example, IHS has scholarships and loan repayments available to health professionals (or health professional students) that are provided in exchange for working at an IHS-funded facility. These programs receive more applicants than can be supported with available funds. IHS estimated that it would need an additional $30.4 million to fund all eligible and qualified program applicants. IHS, CJ FY2017, pp. 138.

[90] Knibb-Lamouche, *Culture as a Social Determinant of Health*, 2012.

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