American Indian/Alaska Native Behavioral Health Briefing Book

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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 ―sesential 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 IHCIA, 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 destruction caused by methamphetamine threatens to dwarf the problems we have seen caused by alcohol.”**
> ***—Jefferson Keel, National Congress of American Indians***

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 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]