



APR 28 2009

Indian Health Service
Rockville MD 20852

TO: Area Directors

FROM: Director

SUBJECT: Area Guidance for Distribution of Fiscal Year 2008 and Fiscal Year 2009 Methamphetamine and Suicide Prevention Initiative for American Indians and Alaska Native Communities Funding Pursuant to Public Law 111-161 and the Omnibus Appropriations Act, 2009

Public Law 110-161, the Consolidated Appropriations Act of, 2008 (the Act) provided \$14,000,000 before rescission for a methamphetamine and suicide and treatment initiative, of which \$5,000,000 may be used for mental health, suicide prevention, and behavioral issues associated with methamphetamine use. After rescission, the base amount was \$13,782,000. The Act mandated that the funds be provided apart from other distribution methods and formulas at the discretion of the Director, Indian Health Service (IHS). Public Law 111-8, the Omnibus Appropriations Act, 2009 provided an additional \$2,609,000 to the fiscal year 2008 enacted level of \$13,792,000 for the methamphetamine and suicide prevention treatment initiative, bringing the total for this initiative to \$16,391,000. These funds also specifically provide that they are to be allocated "at the discretion of the Director, IHS."

The IHS will use a demonstration project model through which each Area may distribute these non-recurring funds to Tribes and Tribal organizations utilizing self-determination contracts and self-governance compacts and funding agreements (FA). These funds may also be used for projects awarded to federally operated programs.

There are certain guidelines that must be followed when Area Directors make determinations regarding which projects will receive Area-allocated funds. This guidance along with supporting information is included in the following attachments:

- Guidance for Area Directors on Distribution of FY 2008 and FY 2009 Methamphetamine and Suicide Prevention Initiative Funding Pursuant to Public Law 110-161
- EXHIBIT 1: GPRA Measures
- EXHIBIT 2: Outcomes and Output Tables
- EXHIBIT 3: 638 Contract/Compact Amendment
- EXHIBIT 4: Funding Tables Related to FY 2008 and FY 2009 Funding Distribution

Areas will exercise discretion in determining timeframes for negotiating awards, but consultation with Area Tribes and your final allocation decisions are expected to be completed no later than 60 days from transmittal of this memorandum.



Robert C. McSwain

GUIDANCE FOR AREA DIRECTORS ON DISTRIBUTION OF FY 2008 AND FY 2009 METHAMPHETAMINE AND SUICIDE PREVENTION INITIATIVE (MSPI) FUNDING PURSUANT TO PUBLIC LAW 110-161

Public Law 110-161, the Consolidated Appropriations Act of, 2008 (the Act) provided \$14,000,000 before rescission for a methamphetamine and suicide and treatment initiative, of which \$5,000,000 may be used for mental health, suicide prevention, and behavioral issues associated with methamphetamine use. After rescission, the base amount was \$13,782,000. The Act mandated that the funds be provided apart from other distribution methods and formulas at the discretion of the Director, Indian Health Service (IHS). Public Law 111-8, the Omnibus Appropriations Act, 2009 provided an additional \$2,609,000 to the fiscal year 2008 enacted level of \$13,792,000 for the methamphetamine and suicide prevention treatment initiative, bringing the total for this initiative to \$16,391,000. These funds also specifically provide that they are to be allocated “at the discretion of the Director, IHS.”

The Director has decided to use a demonstration project model through which each Area Director may distribute these non-recurring funds to Area Tribes and Tribal Organizations utilizing self-determination contracts and self-governance compacts and related funding agreements. These funds may also be used for projects awarded to federally operated programs.

In accordance with P. L. 110-161, there are specific guidelines that must be followed when Area Directors make determinations regarding which projects will receive Area-allocated funds. Specifically, the proposed projects must:

- Provide community-focused responses that enhance evidence-based or practice-based methamphetamine and/or suicide prevention or treatment services or education programming;
- Coordinate services for communities to respond to their local methamphetamine and/or suicide crises;
- Participate in a nationally coordinated program focusing specifically on increasing access to methamphetamine and/or suicide prevention or treatment related activities among the Federal partners, Areas, Tribes, States, and academic or not-for-profit programs;
- Provide communities with needed resources to develop their own community-focused programs with preference for coordinated programming that maximizes the impact across communities and Tribal groups; and,
- Establish baseline data and information related to methamphetamine abuse/suicides in the local communities.

In accordance with these project guidelines, funding recipients must:

1. Develop and submit a three (3) year action plan. This demonstration project is intended to cover three funding years subject to the availability of appropriations. Two years of funding will be provided initially to selected projects utilizing fiscal year (FY) 2008 and FY 2009 appropriations. Funding for the third year of the projects is subject to the FY 2010 appropriation and will be awarded once that appropriation is received. Funds beyond FY 2010 are subject to discussion and decision pending review. Funding recipients must document how their methamphetamine and/or suicide prevention or treatment activities will be implemented as required by the Area award process, but in no case later than six (6) months after award. The remainder of year one, year two, and year three should focus on implementation.

The primary intent of the action plan is to illustrate how the funding recipient will enhance community access to, or support community delivery of, evidence-based or practice-based methamphetamine and/or suicide prevention or treatment services. Funding recipients must report on applicable Government Performance and Results Act (GPRA) objectives and outcome/output measure requirements within established timeframes. The action plan should include appropriate key outcome measures from output tables (Exhibit 1). The action plan should describe the project implementation process. The implementation process may be guided by a community action organization, collaboration, or a group of partners to plan and implement a community-wide methamphetamine and/or suicide prevention or treatment project. If such partnerships or collaborations already exist, a description of how said partnership intends to expand its scope to include implementation of the methamphetamine and/or suicide prevention or treatment project should be provided. Relevant partnerships working closely with and developing collaborations for the MSPI may include Tribes and/or Tribal organizations, Tribal colleges or universities, colleges with more than a 51 percent American Indian/Alaska Native (AI/AN) student population, and Tribal boarding schools. "Relevant partnerships" can be defined as developing cooperative agreements and/or memoranda of agreement that clearly define how the collaboration will be conducted. Collaborations may also include other partners to share resources and information that could strengthen the program.

2. Attend one (1) mandatory MSPI meeting per year (Subject to availability of funds). The budget submitted should reflect travel costs for the project director and the local evaluator to attend this meeting. Location (city/hotel) and timeframe for this meeting will be provided after award; however, the meeting will generally last 2 to 3 days and attendance is mandatory. At these meetings, funding recipients will present the outcomes of their projects and Federal staff will be available to provide technical assistance.
3. Participate in a national evaluation of this project. Each funding recipient shall coordinate with the national MSPI project officer. The funding recipient shall work with the IHS staff and national MSPI project officer to develop a local process to measure specific outcome indicators as consistent with national GPRA and IHS Division of Behavioral Health program requirements.

4. Use a portion of awarded funds, not to exceed 20 percent, to develop or enhance funding recipients' local evaluation capacity. All funding recipients are required to use an information management system which is compatible with the Resource and Patient Management System (RPMS) and the RPMS Behavioral Health module or IHS Electronic Health Record. If a funding recipient is unable to utilize RPMS as an information management system, the funding recipient must demonstrate within the project proposal how data collection requirements will be met. Funding recipients are required to select and incorporate appropriate key outcomes from output tables (Exhibit 1) and report within established timeframes. Other costs in conjunction with the project evaluation function may include training (onsite and off-site), conference calls, and information sharing using e-mail and/or faxing materials.

5. Publicize funding recipient activities in the affected communities. Possible activities include the following:
 - Identification and documentation of one to three issues that community members have stated need to be addressed in order to promote the prevention and/or treatment of methamphetamine abuse and/or suicide. The Tribe's activities may be publicized in local newspapers, Tribal Council meetings, town hall meetings, radio programs, or other appropriate mediums.
 - Informing the community about the program, its goals, and the baseline data for the outcome indicators is recommended. The project should establish a timeframe and setting to share their progress with the community. The settings could include regular programs on local radio, monthly newspaper reports, newsletter mailings, posting graphs or "thermometer"-type billboards tracking project progress.
 - The action plan should include a community gathering that is held at the end of the project to provide an accounting of the progress by indicators and dialogue about next steps.

EXHIBIT 1

GPRA MEASURES-Use applicable measures.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 / FY 2009
10. RTC Improvement/ Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	91% (Target Unmet)	100%	100%	Maintain

For applicants that partner with a Regional Youth Treatment Center

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 / FY 2009
18. Behavioral Health: Proportion of adults ages 18 and over who are screened for depression. IHS-All	35% (Target Exceeded)	35%	44%	+9%

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 / FY 2009
18. Behavioral Health: Proportion of adults ages 18 and over who are screened for depression. <i>Tribally Operated Health Programs</i>	29% (Target Exceeded)	29%	35%	+6%

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 / FY 2009
29. Suicide Surveillance: Increase the incidence of suicidal behavior reporting by healthcare (or mental health) professionals.	1,598 (Target Unmet)	1,678	1,700	+22

EXHIBIT 2

OUTCOMES AND OUTPUTS TABLES

The following outcome/output measures and potential supporting activities were developed in consultation with the National Behavioral Health Technical Advisory Committee to describe critical elements for planning, implementing, and evaluating the IHS MSPI for Tribal communities and Federal direct service sites within the Indian healthcare system. Each program must comply with applicable outcome measures (Numbers 1-6 that follow) when establishing their local evaluation processes for the prevention, treatment, and aftercare services for methamphetamine abuse and suicide prevention among AI/AN communities. The items identified below the outcome measures are “Suggested Supporting Activities and Potential Elements for Monitoring” and a program should monitor only those measures applicable to their program. The supporting activities represent potentially important elements to the realization of the initiative’s outcome/output measures.

Each of the outcome/output measures have been designed to provide each funding recipient with demonstrable measures that are directly linked to the 2009 IHS *Congressional Justification Budget Submission*. It is important to note that any future funding decisions will be based upon demonstrated use of funds toward the achievement of the outcome considerations and measures.

Outcome Measure No. 1	FY 2008	FY 2009	FY 2010
The proportion of identified meth using patients who enter a methamphetamine treatment program.	N/A	Baseline	Baseline

Suggested Supporting Activities and Potential Elements for Monitoring

1. Develop treatment staff trained to identify, screen, and treat methamphetamine abusers.
2. Ensure clinically and culturally appropriate care.
3. Train staff in practice-based (and/or evidence-based) approaches that are proven to be effective in addressing the challenges of methamphetamine abuse.
4. Expand the knowledge base of treatment program staff on the danger that drugs present to mental and physical health, the psychological well-being of children, possible violent behavior, and the severe long-term health problems of chronic use.
5. Identify drug and family courts methamphetamine clients.
6. Expand the capacity and access to treatment using evidence- or practice-based treatment, including regional treatment facilities, particularly within Areas with limited access to substance abuse treatment options.

7. Identify individuals in the child protection system. Increase capacity to respond to the needs of drug endangered children in communities, while maintaining family unity to the extent possible. Ensure appropriate interventions to reduce the risk of harm. Expand the reach of drug endangered children protocols to all Tribal communities.
8. Develop case management interventions for re-entry of Tribal members into communities after treatment.
9. Develop data reporting that identifies the individual's reported methamphetamine treatment results such as abstinence rate, employment/education rate, criminal justice involvement, family communication and social connectivity, behavioral/health/medical consequences of methamphetamine abuse, housing stability, and treatment rate retention.

Outcome Measure No. 2	FY 2008	FY 2009	FY 2010
Reduce the incidence of suicidal activities (ideation, attempts) in AI/AN communities through prevention, training, surveillance, and intervention programs.	N/A	Baseline	Baseline

Suggested Supporting Activities and Potential Elements for Monitoring

1. Collect, analyze, and monitor local data on suicide, its consequences, and factors contributing to the local problem in a culturally appropriate and valid manner.
2. Establish a database of measures of suicidal ideation or completion risk and protective factors associated with existing knowledge surrounding best practices in psychiatric epidemiology that is evidence-based or practice-based.
3. Assess community resources and readiness to address factors contributing to suicide and its consequences.
4. Mobilize and build capacity to address the contributing factors.
5. Develop a comprehensive community-level strategic plan that enhances protective factors and reverses or reduces risk factors.
6. Implement evidence- or practice-based culturally relevant prevention programs, policies and practices based on the National Strategy for Suicide Prevention.
7. Monitor the progress of these efforts to affect contributing factors and make changes to the community strategic plan as needed.

8. Evaluate program effectiveness to sustain what has worked and to make changes to improve effectiveness.
9. Reduced risk factors associated with suicide (i.e. hopelessness, substance use problems, trauma exposure).

Outcome Measure No. 3	FY 2008	FY 2009	FY 2010
Reduce the incidence of methamphetamine abuse in AI/AN communities through prevention, training, surveillance, and intervention programs.	N/A	Baseline	Baseline

Suggested Supporting Activities and Potential Elements for Monitoring

1. Develop treatment staff trained to identify, screen, and treat methamphetamine abusers.
2. Ensure clinically and culturally appropriate care.
3. Train staff in practice-based (and/or evidence-based) approaches proven to be effective in addressing methamphetamine abuse challenges such as withdrawal issues, lack of effective pharmacotherapy, acute psychosis, protracted cognitive impairment, and paranoia.
4. Expand the knowledge base of treatment program staff on the dangers that drugs present to mental and physical health, the psychological well being of children, possible violent behavior, and the severe long-term health problems of chronic use.
5. Identify methamphetamine clients in drug and family courts.
6. Expand access to evidence or practice-based treatment, including regional treatment facilities, particularly within Areas with limited access to substance abuse treatment options.
7. Identify methamphetamine clients in the child protection system. Increase capacity to respond to the needs of drug endangered children while maintaining, to the extent possible, family unity. Implement appropriate interventions to reduce harm. Expand the reach of drug endangered children protocols to all Tribal communities.
8. Provide access to evidence- or practice-based methamphetamine treatment for pregnant women abusing methamphetamines.
9. Develop case management interventions for community re-entry after treatment or incarceration.

10. Develop data reporting that identifies methamphetamine treatment results such as abstinence rate, employment/education rates, criminal justice involvement, family communication and social connectivity, behavioral/health/medical consequences, housing stability, and retention in treatment rates.

Outcome Measure No. 4	FY 2008	FY 2009	FY 2010
The proportion of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs.	N/A	Baseline	Baseline

Suggested Supporting Activities and Potential Elements for Monitoring

1. Expand the knowledge base of treatment program staff on the danger that drugs present to mental and physical health, the psychological well being of children, violent behavior, and long-term health consequences of chronic use.
2. Identify methamphetamine clients in drug and family courts.
3. Provide access to evidence or practice-based methamphetamine treatment for pregnant women abusing methamphetamine.
4. Identify individuals in the child protection system. Increase capacity to respond to the needs of drug endangered children in communities while maintaining family unity to the extent possible. Ensure appropriate interventions to reduce the risk of harm. Expand the reach of drug endangered children protocols to all Tribal communities.
5. Publicize (if appropriate) and honor specific cultural prevention, intervention, or treatment programs that promote the healing of communities, families, and victims.
6. Create age-appropriate materials to help children identify available resources and identify resources for guidance and support.
7. Provide drug education and information for parents and care-givers that reinforce family discussions about suicide. Programs as early as preschool need to address risk factors.
8. Educational programs focused on skill development, such as self-control, emotional awareness, communication, social problem-solving and peer relationship.

9. Support educational programs aimed at preventing suicide and peer referral programs (i.e. Question Persuade and Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), and skills-based trainings).
10. Develop case management interventions for community re-entry for Tribal members after treatment or incarceration.
11. Develop training for educational systems and staff aimed at identifying and referring at-risk youth to mental health services.

Output Measures No. 5	FY 2008	FY 2009	FY 2010
Establishment of trained suicide crisis response teams.	N/A	Baseline	Baseline

Suggested Supporting Activities and Potential Elements for Monitoring

1. Mobilize and build capacity to address the contributing factors.
2. Develop a comprehensive community-level strategic plan that enhances protective factors and reverses or reduces risk factors.
3. Implement evidence or practice-based culturally relevant prevention programs, policies and practices based on the National Strategy for Suicide Prevention.
4. Develop or enhance crisis response teams for suicide events.
5. Develop treatment staff trained to identify, screen, and treat suicidal clients.
6. Train staff in practice-based (and/or evidence-based) approaches that are proved to be effective in addressing the challenges of suicide.

Output Measure No. 6	FY 2008	FY 2009	FY 2010
Increase tele-behavioral health encounters **	N/A	Baseline	Baseline

*Newly developed target for FY 2010

**Measures will be limited to funded sites only. Data from the initiative can be utilized to develop best practices and performance measures that can potentially be generalized to the population served by the IHS and national performance measures.

EXHIBIT 3

Amendment to the [Tribe]'s FY 2009 Indian Self-Determination and Education Assistance Act Funding Agreement to transfer funds appropriated pursuant to P.L. 110-161 to Support a National Methamphetamine and Suicide Prevention Initiative (MSPI)

In Public Law 110-161, Congress provided \$14,000,000 before rescission, for a methamphetamine and suicide prevention and treatment initiative (MSPI) to be allocated at the discretion of the Director of the Indian Health Service (IHS). The Omnibus Appropriations Act, 2009 provided \$16,391,000 for the methamphetamine and suicide prevention and treatment initiative. The Director of the IHS has decided to fund one-time, non-recurring demonstration projects intended to expand community-level access to effective Tribal methamphetamine and suicide prevention and treatment programming. The Director of the IHS solicited proposals from Tribes and as a consequence of that solicitation, has elected to fund the [Tribe]'s proposal. The parties to this Amendment are the [Tribe] and the IHS. Pursuant to this Amendment, the IHS and the [Tribe] agree that the total amount due under this Amendment is \$ _____.

These funds, hereinafter referred to as MSPI funds, are distributed to the [Tribe] through a modification to an existing Indian Self-Determination and Education Assistance Act (ISDEAA) compact or contract and respective Funding Agreement (FA) or Annual Funding Agreement (AFA) for programs, services, functions and activities (PSFAs).

However, notwithstanding any provision in the [Tribe]'s compact or contract and FA, or AFA, the following terms and conditions shall apply to the use of these funds. By signing this Amendment, both parties agree:

1. The MSPI funds in the FA/AFA are part of a non-recurring, one-time allocation, and the Tribe acknowledges that:
 - a. No contract support cost (CSC) funding is associated with the MSPI funds, and nothing in the FA/AFA or the associated compact/contract creates a promise on the part of the IHS to pay the [Tribe] CSC funding in connection with the MSPI funds.
 - b. The Tribe still wishes to contract for the MSPI funds and can conduct the MSPI-funded project or activity, despite the absence of CSC funding.
 - c. The IHS will include the CSC need associated with the MSPI funds in the annual CSC Shortfall Report to Congress.
2. The [Tribe] has submitted a Proposal (attached to this amendment), including a Scope of Work and 3-year action plan conforming with the requirements set forth by the IHS in [IDENTIFY GUIDANCE DOCUMENT]. Funding provided under this amendment is non-recurring and is intended to fund the first 2 years of the 3-year action plan. Funding for the third year of the Tribe's action plan is subject to availability of FY 2010 funds and

future evaluation. Nothing in this Amendment construes a right on behalf of the Tribe to any funding for its Proposal beyond the funds awarded in this Amendment. The Proposal and this amendment constitute the complete agreement between the parties with respect to the use of these MSPI funds.

3. MSPI funds must be expended for the specific purpose outlined in this Agreement and the attached Proposal. The [Tribe] may not re-budget, redesign, reallocate, or reprogram MSPI funds without written authorization from the IHS.
4. With regard to these MSPI funds, in the event of a conflict between this Amendment, the [Tribe]'s compact, contract and FA or AFA, or a provision in the ISDEAA, the parties agree that this Amendment controls.

Both parties understand that the terms and conditions in this Amendment apply only to these MSPI funds and in no way alter or modify the [Tribe]'s compact or contract with respect to other funds.

Signed:

Tribe

Indian Health Service

Dated: The _____ day of _____, _____

MSPI Appropriation		100.0%	\$ 13,782,000			
Non-Area MSPI Components		%	Amount			
Urban Projects Subtotal		8.0%	\$ 1,103,000			
National Programs Subtotal		6.0%	\$ 827,000			
Methamphetamine Initiative			\$ 67,000			
Tobacco Behavioral Health			\$ 167,000			
Suicide Prevention Initiative			\$ 67,000			
Youth Services			\$ 337,000			
NIHB Funding			\$ 126,000			
NCUIH Funding			\$ 63,000			
Other Costs			\$ -			
Support and Administrative Services Subtotal		6.0%	\$ 827,000			
HHS and Congressional Request: 3 FTEs, NTAC and BHWG Travel & Support			\$ 827,000			
Subtotal Non-Area MSPI Components		20.0%	\$ 2,757,000			
Markers for Targeting MSPI \$ Among IHS Areas		%	Amount			
1. Area Population and Age		Use Cohort	33.3% 26.7% \$ 3,675,000			
a) Users: All Ages		Yes				
b) Users: Age < 25		No				
c) Users: Age 15-34		NO				
2. Area Health Markers		Intra-marker %	33.3% 26.7% \$ 3,675,000			
a) Alcohol Abuse		20%				
b) Homicide		20%				
c) Suicide		20%				
d) Injuries / Accidents		20%				
e) Meth Related Amb Encounters		20%				
3. Area Poverty Marker			33.3% 26.7% \$ 3,675,000			
4. Area Low Funding Marker			0.0% 0.0% 0			
5. Option: Fixed Amount Per Area to Start		\$ -	0.0% 0			
6. Option: Adjust \$ for Cost/Price (COLA like)		Yes	Built-in to Markers if YES			
7. Option: Adjust \$ for Disproportionate Burden (AIAN rate > US avg rate)		No	Built-in to Markers if YES			
Subtotal Area MSPI \$		80.0%	\$ 11,025,000			
Allocations Targeted Among Areas by MSPI Markers						
Area	Fixed \$	Pop. And Age	Disease Burden	Poverty Burden	Low Funding	Total
Aberdeen	\$ -	296,000	\$ 327,000	\$ 442,000	\$ -	\$ 1,065,000
Alaska	\$ -	489,000	\$ 657,000	\$ 327,000	\$ -	\$ 1,473,000
Albuquerque	\$ -	209,000	\$ 168,000	\$ 256,000	\$ -	\$ 633,000
Bemidji	\$ -	249,000	\$ 176,000	\$ 203,000	\$ -	\$ 628,000
Billings	\$ -	178,000	\$ 217,000	\$ 230,000	\$ -	\$ 626,000
California	\$ -	204,000	\$ 328,000	\$ 177,000	\$ -	\$ 709,000
Nashville	\$ -	126,000	\$ 55,000	\$ 97,000	\$ -	\$ 279,000
Navajo	\$ -	537,000	\$ 490,000	\$ 733,000	\$ -	\$ 1,760,000
Oklahoma	\$ -	687,000	\$ 496,000	\$ 512,000	\$ -	\$ 1,695,000
Phoenix	\$ -	361,000	\$ 396,000	\$ 415,000	\$ -	\$ 1,172,000
Portland	\$ -	277,000	\$ 302,000	\$ 221,000	\$ -	\$ 800,000
Tucson	\$ -	60,000	\$ 62,000	\$ 62,000	\$ -	\$ 185,000
Area Subtotal	\$ -	\$ 3,673,000	\$ 3,674,000	\$ 3,675,000	\$ -	\$ 11,025,000
Urban Subtotal	\$ 1,103,000					\$ 1,103,000
National Programs Subtotal	\$ 827,000					\$ 827,000
Methamphetamine Initiative	\$ 67,000					\$ 67,000
Tobacco Behavioral Health	\$ 167,000					\$ 167,000
Suicide Prevention Initiative	\$ 67,000					\$ 67,000
Youth Services	\$ 337,000					\$ 337,000
NIHB Funding	\$ 126,000					\$ 126,000
NCUIH Funding	\$ 63,000					\$ 63,000
Support and Admin. Subtotal	\$ 827,000					\$ 827,000
HHS & Congressional Requesting: 3 FTEs, NTAC and BHWG Support	\$ 827,000					\$ 827,000
Grand Total	\$ 2,757,000	\$ 3,673,000	\$ 3,674,000	\$ 3,675,000	\$ -	\$ 13,782,000

**THE METHAM-
PHETAMINE &
SUICIDE
PREVENTION
INITIATIVE
(Option #10
Formula)**

**FY
2008
Funds**

MSPi Appropriation		100.0%	\$ 16,391,000
Non-Area MSPi Components			
		%	Amount
Urban Projects Subtotal	Fixed at 2008 Amount	6.7%	\$ 1,103,000
National Programs Subtotal		5.0%	\$ 827,000
Methamphetamine Initiative	Fixed at 2008 Amount		\$ 67,000
Tobacco Behavioral Health	Fixed at 2008 Amount		\$ 167,000
Suicide Prevention Initiative	Fixed at 2008 Amount		\$ 67,000
Youth Services	Fixed at 2008 Amount		\$ 337,000
NIHB Funding	Fixed at 2008 Amount		\$ 126,000
NCUIH Funding	Fixed at 2008 Amount		\$ 63,000
Other Costs	Fixed at 2008 Amount		\$ -
Support and Administrative Services Subtotal		5.0%	\$ 827,000
	HHS and Congress Reports; 3 FTE's; NTAC and BHWG Travel/Support		\$ 827,000
Subtotal Non-Area MSPi Components		16.8%	\$ 2,757,000

**THE METHAM-
PHETAMINE &
SUICIDE
PREVENTION
INITIATIVE
(Option #10
Formula)**

**FY
2009
Funds**

Markers for Targeting MSPi \$ Among Areas			
		%	Amount
1. Area Population and Age	Use Cohort	33.3%	27.7%
a) Users: All Ages	Yes		\$ 4,545,000
b) Users: Age < 25	No		
c) Users: Age 15-34	NO		
2. Area Health Markers for MSPi	Intra-marker %	33.3%	27.7%
a) Alcohol Abuse	20%		\$ 4,545,000
b) Homicide	20%		
c) Suicide	20%		
d) Injuries / Accidents	20%		
e) Meth Related Amb Encounters	20%		
3. Area Poverty Marker		33.3%	27.7%
4. Area Low Funding Marker		0.0%	0.0%
	5. Option: Fixed Amount Per Area to Staff	\$ -	0.0%
	6. Option: Adjust \$ for Cost/Price (COLA like)	Yes	Built-in to Markers if YES
	7. Option: Adjust \$ for Disproportionate Burden (AIAN rate > US avg rate)	No	Built-in to Markers if YES
Subtotal Area Based MSPi		83.2%	\$ 13,634,000

Allocations Targeted Among Areas by MSPi Markers

Area	Fixed \$	Pop. And Age	Disease Burden	Poverty Burden	Low Funding	Total
Aberdeen	\$ -	366,000	\$ 404,000	\$ 546,000	\$ -	\$ 1,316,000
Alaska	\$ -	605,000	\$ 812,000	\$ 404,000	\$ -	\$ 1,821,000
Albuquerque	\$ -	259,000	\$ 208,000	\$ 317,000	\$ -	\$ 784,000
Bemidji	\$ -	308,000	\$ 218,000	\$ 251,000	\$ -	\$ 777,000
Billings	\$ -	220,000	\$ 269,000	\$ 284,000	\$ -	\$ 773,000
California	\$ -	253,000	\$ 406,000	\$ 218,000	\$ -	\$ 877,000
Nashville	\$ -	155,000	\$ 68,000	\$ 120,000	\$ -	\$ 343,000
Navajo	\$ -	654,000	\$ 606,000	\$ 907,000	\$ -	\$ 2,177,000
Oklahoma	\$ -	831,000	\$ 614,000	\$ 634,000	\$ -	\$ 2,099,000
Phoenix	\$ -	447,000	\$ 490,000	\$ 513,000	\$ -	\$ 1,450,000
Portland	\$ -	343,000	\$ 373,000	\$ 273,000	\$ -	\$ 989,000
Tucson	\$ -	74,000	\$ 77,000	\$ 77,000	\$ -	\$ 228,000
Subtotal	\$ -	\$ 4,545,000	\$ 4,545,000	\$ 4,544,000	\$ -	\$ 13,634,000
Urban Projects	\$ 1,103,000					\$ 1,103,000
National Programs	\$ 827,000					\$ 827,000
Methamphetamine Initiative	\$ 67,000					\$ 67,000
Tobacco Behavioral Health	\$ 167,000					\$ 167,000
Suicide Prevention Initiative	\$ 67,000					\$ 67,000
Youth Services	\$ 337,000					\$ 337,000
NIHB Funding	\$ 126,000					\$ 126,000
NCUIH Funding	\$ 63,000					\$ 63,000
Support and Administration	\$ 827,000					\$ 827,000
HHS and Congress Reports; 3 FTE's; NTAC and BHWG Travel/Support	\$ 827,000					\$ 827,000
Grand Total	\$ 2,757,000	\$ 4,545,000	\$ 4,545,000	\$ 4,544,000	\$ -	\$ 16,391,000

SUMMARY - MSPI Allocations

Area	2008	2009	Total
Aberdeen	\$ 1,065,000	\$ 1,316,000	\$ 2,381,000
Alaska	\$ 1,473,000	\$ 1,821,000	\$ 3,294,000
Albuquerque	\$ 633,000	\$ 784,000	\$ 1,417,000
Bemidji	\$ 628,000	\$ 777,000	\$ 1,405,000
Billings	\$ 626,000	\$ 773,000	\$ 1,399,000
California	\$ 709,000	\$ 877,000	\$ 1,586,000
Nashville	\$ 279,000	\$ 343,000	\$ 622,000
Navajo	\$ 1,760,000	\$ 2,177,000	\$ 3,937,000
Oklahoma	\$ 1,695,000	\$ 2,099,000	\$ 3,794,000
Phoenix	\$ 1,172,000	\$ 1,450,000	\$ 2,622,000
Portland	\$ 800,000	\$ 989,000	\$ 1,789,000
Tucson	\$ 185,000	\$ 228,000	\$ 413,000
Subtotal Areas	\$ 11,025,000	\$ 13,634,000	\$ 24,659,000
Subtotal Urban	\$ 1,103,000	\$ 1,103,000	\$ 2,206,000
Subtotal National	\$ 827,000	\$ 827,000	\$ 1,654,000
Methamphetamine Initiative	\$ 67,000	\$ 67,000	\$ 134,000
TeleBehavioral Health	\$ 167,000	\$ 167,000	\$ 334,000
Suicide Prevention Initiative	\$ 67,000	\$ 67,000	\$ 134,000
Behavioral Health Initiative	\$ -	\$ -	\$ -
Youth Services	\$ 337,000	\$ 337,000	\$ 674,000
NIHB Funding	\$ 126,000	\$ 126,000	\$ 252,000
NCUIH Funding	\$ 63,000	\$ 63,000	\$ 126,000
Subtotal Support and Admin.	\$ 827,000	\$ 827,000	\$ 1,654,000
HHS and Congress Reports: 3 FTE's; NTAC and BHWG Support	\$ 827,000	\$ 827,000	\$ 1,654,000
Grand Total	\$ 13,782,000	\$ 16,391,000	\$ 30,173,000

Amounts Rounded to \$000