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Andy Joseph Testimony
11th Annual HHS Tribal Budget Consultation

SAMHSA Breakout Session
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Introduction

My name is Andrew Joseph, I serve as Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB) and am a Tribal Council Member for the Confederated Tribes of the Colville Reservation. Established in 1972, NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health care issues. I am pleased to offer my recommendations concerning alcohol and substance abuse issues and SAMHSA budget.

The Indian Health Service (IHS) behavioral health programs include community-oriented clinical and preventive services. Over the last 15 years, most of these programs have transitioned from IHS to local community control via tribal contracting and compacting. Challenges facing American Indian and Alaska Native (AI/AN) communities and programs include substance abuse, trauma, forced cultural change, poverty, lack of economic opportunity, and limited access to behavioral health services. In 2002-2005, AI/ANs were more likely to have a past year alcohol and illicit drug use disorder than members of other racial groups. Suicide rates among AI/AN adolescents and young adults age 15 to 34 are 1.9 times higher than the national average for the same age group. AI/AN women are 2.5 times more likely to be sexually assaulted than other women in the United States. Greater than one-third of the demands made on health facilities in Indian country involve visits related to mental health, alcoholism, and substance abuse.

The IHS spends approximately seven percent (in FY 2009) of its total budget on behavioral health and substance abuse and alcohol services. The system of services for treating mental health problems among American Indians and Alaska Natives is a complex and often fractured web of tribal, federal, state, local, and community-based services. The availability of these programs varies considerably across communities. Because of these complex issues and lack of funding the behavioral health needs for AI/ANs are largely unmet, services generally are lacking, and access is often difficult and can be costly. Greater integration of SAMHSA funding and program services with Tribal programs can greatly improve access to behavioral health services for AI/AN people.

I. Top Health and Human Services Priorities (SAMHSA)

1. Additional SAMHSA resources are needed to address mental health needs of Indian communities.
2. Increase HHS and SAMHSA role in addressing and preventing youth suicide in Indian Country.

3. SAMHSA must continue to urge State governments to include Tribal governments in SAMHSA block grant funding and setting up programmatic requirements of block grant programs.
4. Continue to build on success of SAMHSA and DOJ collaboration to improve Tribal capacity and infrastructure to deal with alcohol and substance abuse and law enforcement issues.

II. Description of Top Health and Human Services Priorities

1. Depression and other mental health diseases continue to destroy the sanctity of countless AI/AN families. Behavioral health services are inadequate to meet the present and growing needs of mental health disorders. Psychological services are necessary to improve outreach, education, crises intervention, the treatment of mental illness such as depression. Stronger action and intervention is necessary. To address this, additional resources are needed from SAMHSA to complement the programs and services that are provided by the Indian Health Service (IHS).

2. We recommend that HHS and SAMHSA establish an office within the SAMHSA Administrator to address the growing suicide issues in Indian country. This office would be responsible to monitor, develop policy, and coordinate collaboration in response to suicide issues in Indian Country. We also support establishing a "Tribal Suicide Task Force" to develop a comprehensive plan to prevent suicide in Indian country as part of the broader national health reform initiative. This office and task force should work to address the correlation of substance abuse and mental health disorders with suicide and the growing suicide rates among AI/AN youth.

3. Tribal leaders continue to have concerns related to the distribution of HHS funds through state block grants that may not be distributed by recipient states to Tribal programs providing services to AI/AN people. There are also requirements for matching funds that may be prohibitive for under-served groups that lack resources for the match and programs with allocation formulas based on numbers of clients or anticipated costs that may be biased against small Tribal communities with small numbers of participants and the inability to spread costs across a larger client base.

   States must also work with the Tribes in a meaningful manner to provide culturally appropriate mental health services. This issue has been brought up in previous consultations without much change. SAMHSA has hosted academies that serve to foster State/Tribal relationships and should continue to host forums that bring state and Tribes together to develop approaches to address mental health issues. These opportunities allow states and Tribes to develop a culturally appropriate system of comprehensive care for Tribal members with substance abuse and mental health disorders. SAMHSA should target those areas, like the Portland Area, that have not had an opportunity to participate in these sessions.

4. The past two years SAMHSA and DOJ collaborated to respond to Tribal leaders to improve tribal capacity and infrastructure through training and technical assistance to tribal communities. With more federal agencies committing to developing strategic solutions for American Indians and Alaska Natives, the collaboration is now a multi-agency endeavor entitled *Tribal Justice, Safety and Wellness Government-to-Government Consultation, Training and Technical Assistance Sessions.* We encourage SAMHSA and DOJ to continue to build on this very positive initiative and for HHS to commit more resources to SAMHSA to continue this work.

III. Identify Top Legislative Issues (regarding SAMHSA)

We sincerely hope that the HHS' Office of Legislation will meet with Tribal leaders to identify and include important AI/AN provisions in any health legislation that will impact behavioral health services for Indian Country and make new coverage options and programs accessible to AI/AN people. We also hope that provisions are included that protect Tribal health programs and offer them the option to fully participate to SAMHSA and other programs. Congress and the Obama Administration have made clear the importance of considering and including AI/ANs and the Indian programs that provide access to health services through Indian specific sections in Child Health Insurance Program Reauthorization Act and in the American Recovery and Reinvestment Act of 2009. These principles should be included in the following:

1. *Garrett Lee Smith (GLS) Memorial Act Reauthorization:* Tribal set-asides to support a national resource center to work with SAMHSA to provide technical assistance, training, evaluation, and SAMHSA support to GLS tribal grantees. At this time, there is no such program and with the addition of new tribal grantees each funding cycle, a need for assessment and evaluation of tribal grantees programming is needed.
2. *SAMHSA Reauthorization:* Tribes support SAMHSA reauthorization with improved authorization for Tribal programs and equal treatment of tribal governments where state, county, and local governments are included in the legislation. The NPAIHB has prepared a tribal draft of the reauthorization legislation for SAMHSA to discuss with Tribal leaders. We are attaching our recommendations for Tribal provisions in Title V of the Public Health Service Act.

IV. Summary of Tribal Testimony Submission

Reservation communities are facing significant barriers to the receipt of effective prevention and treatment services for behavioral health issues. Access to and the availability of mental health and drug abuse specialists, such as psychiatrists, psychologists, drug counselors, and social workers appears to be seriously lacking. Poverty, geographic location, and cultural differences further limit the amount and quality of services available. Research confirms that limited insurance coverage, scarce availability of services, excessive travel distances, weather hazards, increased personal monetary costs, and stigma related to behavioral health needs additionally contribute to poor access. Additionally, for those who do receive treatment, many find that the care provided is not intensive enough, not long enough, and/or lacking in important follow-up health and social services; and likely to be provided by the general medical sector rather than through formal mental health specialist services.

Additional intervention and prevention strategies are needed to meet the needs of AI/AN people. These strategies should build on the strengths of local community programs, complement existing service infrastructure provided by the IHS, and build on traditional cultural practices. The integration of these strategies can only happen with a strong commitment and partnership with SAMHSA programs and funding to address the mental health disparities. Lastly, since only the President's FY 2010 budget blueprint is available, we urge HHS and SAMHSA to continue to dialogue with Tribal leaders on SAMHSA budget recommendations. Without knowing where budget increases and cuts have been made in the SAMHSA budget, it makes is challenging to provide our recommendations for SAMHSA funding priorities for Indian Country. We hope that HHS and SAMHSA will continue this dialogue as the budget submissions are prepared by the Department for the FY 2010 cycle.