



**NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD**

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinalt Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

SENT VIA EMAIL: Pam.Hyde@SAMHSA.hhs.gov; blockgrants@samhsa.hhs.gov

September 21, 2012

Ms. Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Service Administration
1 Choke Cherry Rd.
Rockville, MD 20857

REF: Comments – Agency Information Collection Activities: Proposed Collection; Comment Request for: Uniform Application for the Mental Health Block Grant and Substance Abuse Block Grant FY 2014-2015, Application Guidance and Instructions (OMB No. 0930-0168)-Revision.

Dear Ms. Hyde:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization¹ that represents forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. On behalf of our member Tribes, we are writing to provide comments for the *Agency Information Collection Activities: Proposed Collection; Comment Request*, published in the *Federal Register*, Vol. 77, No. 135, Friday, July 13, 2012, notices.

We understand the purpose of this notice is to comment on: information from reports will have a practical utility; have accuracy of the agency's estimate of the burden of the proposed collection of information; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the collection techniques or other forms of information technology.

Before providing comment it is important for us to underscore our deep concern that there is no mention of Tribal governments in the entire document. We note a "casual" citation near the end of page 41434 and the reference to Native Americans on page 41435. The document overlooks the preferred reference and legislative term "American Indians and Alaska Native (AI/AN)" and we urge SAMHSA to use the preferred term in future publications. We are concerned that past comments we provided and issues discussed at the SAMHSA Tribal Advisory Committee meetings are not adequately addressed. These issues have also been raised in SAMHSA Tribal consultation sessions.

¹ As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

It is unclear if this was just an oversight or a lack of understanding of the government to government requirement. The proposed application requirements will have a direct impact of the ability of SAMHSA to further its mission and services for Tribal communities.

Please note the following comments from a submission dated June 6, 2011 per SAMHSA's request. Where these comment disregarded? We did not receive any feedback from the comments. These comments were directed toward the information provided in the Federal Register, Vol. 76, No. 69, Monday, April 11, 2011:

In regards to States following a four-step planning process consisting of: *(1) Assessing the strengths and needs of the service system; (2) identifying the unmet service needs and critical gaps within the current system; (3) prioritize the State planning activities, and; (4) develop goals, strategies and performance indicators*, there will be unintended consequences for Tribal population unless:

1. Tribes are consulted to address the strengths and needs of the population they serve. It would be impossible for a State to provide a comprehensive assessment of strengths and needs of the service system without the assistance of Tribes in their respective States.

Additionally, non-Medicaid encounter data from Tribal systems is often reported directly to the Federal government, (via Indian Health Service), and is not included in State databases. Furthermore, Tribal populations often do not access State services due to historical discrimination and mistreatment, resulting in an unrealized "silent need".

2. The unmet service needs are difficult to identify. States have various methods for gathering data, as do the 565 Federally Recognized Tribes. Currently, most policy for service provision is driven from encounter data. This results in a fatal flaw – no valid method to determine unmet service needs when there is no access or limited access to behavioral health services. As noted in numerous publications, including the *Report on State Responses to the FY 2011 Block Grant Addendum on Health Care Reform*, there is a current shortage of behavioral health professionals. This shortage is projected to amplify with the surge caused by the implementation of the Affordable Care Act, thus the intense need to determine actual levels of need.

This Proposed Project needs to clearly define how population needs will be assessed for people that do not have access to behavioral health services. There should be a specific section that elaborates on a method to not only determine this for Tribal populations but all rural populations as identified by the Health Professional Shortage Areas.

If this measure is not taken there will be a gross underestimate of service needs from populations that are never "counted" until they self-terminate or suffer catastrophic consequences.

3. States must be required to consult with Tribal representatives (specifically elected Tribal leaders or individuals formally appointed to represent their Tribal government) for any prioritization of State planning activities. Tribal populations will continue to be

underserved without this requirement.

4. Only Tribes know their population's attainable goals, strategies and performance indicators that are culturally applicable. This responsibility is accepted by Tribes for their constituents and not transferable. All Tribes, which have territories within State boundaries, should be consulted for any development of goals and performance indicators.

In regard to the paragraph *Description of State's Consultation with Tribes*, the following comments are provided:

We would suggest some additional language to fortify the government to government relationship that Tribes have with the Federal government. State relations history and Tribes as noted by Administrator Hyde in the *Alcoholism and Drug Abuse Weekly*, "... (Tribes) neither consulted with nor are their needs addressed when the state gets the dollars" ..., needs to be definitively improved and required.

While we have been advised that SAMHSA "cannot require" State to consult with Tribes, there should be required reporting components in the State reports that tracks the dollars spent. A suggested list of those components should at a minimum include:

- Name of Tribe(s)
 - Date of Consultation
 - Duration of Consultation (e.g. hours, days)
 - List of Tribal Representatives
 - Topic of Consultation
- Required Topics of Discussion must include:*
- Scope of service provision (amount and need)
 - Strategies for service provision
 - Utilization of services
 - Time frame for State implementation of Proposed Project
 - Involvement of "Dashboard" development (key performance indicators)
 - Suicide prevention
 - Technical assistance needs
 - Involvement of individuals and families
 - Use of technology
 - Collaboration

(* please note this is not an all inclusive list, more components could be required)

The list above should be strongly considered as a reporting requirement. Without such a requirement, history and experience has clearly shown that Tribal populations will be neglected/excluded from access to federal dollars that are appropriately designated for the needs of American Indians and Alaska Natives (AI/AN).

Lastly, SAMSHA should require States to include official Tribal representatives (from all Tribes in the State) to be a voting member of State Behavioral Health Advisory Councils (council names may vary by State). This is critical, and important that each Tribe be invited to name a representative for State level councils. It is not enough nor

appropriate just to have AI/AN individuals, they must be Tribal elected officials or their designee to maintain the required government to government relationship.

The above comments clearly explain the importance of the government to government relationship. Tribes have a distinct political and legal relationship with the federal and state governments. Thus, we recommend on page 41434, that SAMHSA include language that respects this political and legal relationship, rather than the current racial basis. After the initial clause of: *Health Disparities - In the Block Grant application, states are asked to define the populations they intend to serve.* We recommend inserting: "States that contain Tribal governments are asked to consult with those respective governments for assistance on impact to their populations."

We further recommend that SAMHSA change the term "Native American" to American Indian and Alaska Native.

In regard to the requested comments, is unclear how states (given the reasons in the June 6, 2011, comments) would/could determine people who are uninsured or access issues, as well as the other data elements (*listed as up to 25*), page 41433, for behavioral health services without the assistance of Tribes. It should also be noted that Tribes should not bare the burden of gathering/analyzing data without financial support from SAMHSA.

These comments are respectfully submitted to address this critical document. It truly has the potential to directly save lives. Should you have any questions or concerns about these comments and suggestions, please do not hesitate to contact Mr. Jim Roberts (503) 416-3276 or Dr. Linda Bane Frizzell (503) 313-3254).

Respectfully,



Joe Finkbonner, RPh, MHA
Executive Director

cc: Tribal Representatives, Secretary's Tribal Advisory Group
SAMHSA's Tribal Advisory Group
Summer King, SAMHSA Reports Clearance Officer