MENTAL HEALTH SERVICES

Indian Health Service

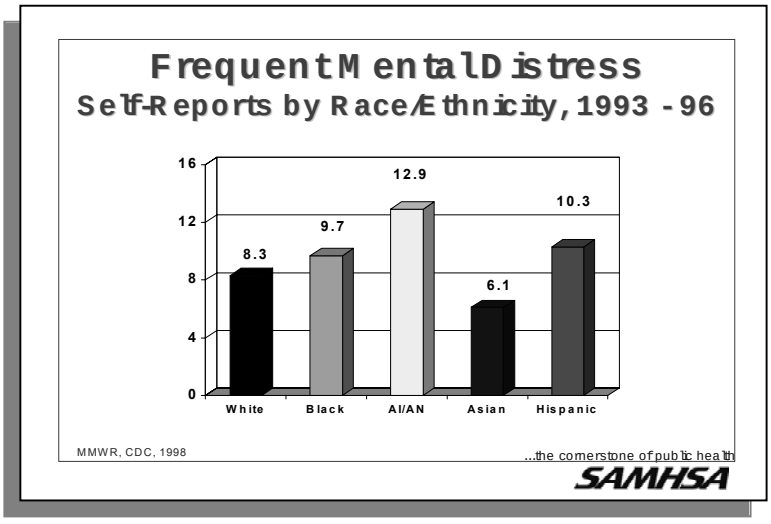
Clinical Services	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Mental Health					
Budget Authority	$43,245,000	$45,018,000	$47,142,000	+$3,897,000	+$2,124,000
FTE	283	297	303	+20	+6
Total Client Contacts	208,000	208,000	208,000	0	0

PURPOSE AND METHOD OF OPERATION

PROGRAM MISSION AND RESPONSIBILITIES

The IHS Mental Health and Social Services (MH & SS) program is a community oriented clinical and preventive service program. The programs and services provided are a part of a larger Behavioral Health Program that includes the Alcoholism and Substance Abuse Program. This collaborative effort addresses 4 of the top 10 health issues as identified conjointly by the IHS, Tribes, and Urban Programs (I/T/U) including behavioral health issues, domestic violence, child abuse and neglect, and alcohol and substance abuse disorders. American Indian and Alaska Native (AI/AN) communities possess considerable traditional and cultural resources; however, the level of psychosocial and emotional distress is alarmingly high.

The improvements in physical health status for AI/AN populations have not been paralleled in the mental health and social services area. Field staff report serious mental and social problems in many AI/AN communities on reservations and in urban settings.

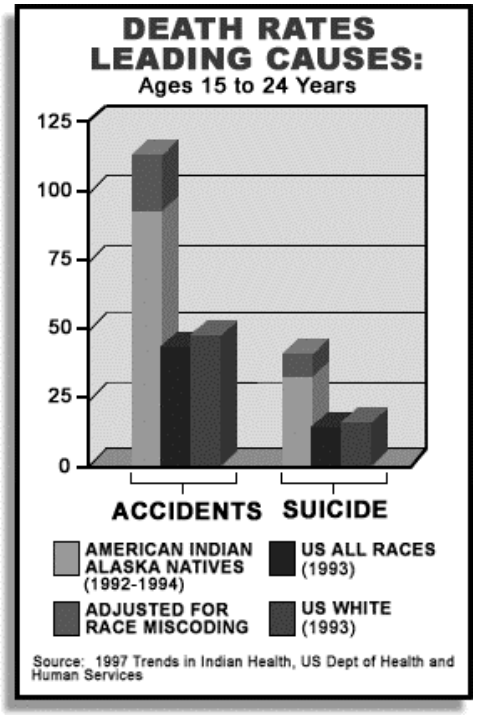


Studies indicate that mental health and social problems are associated with more than one-third of the demands made on health facilities for services. Depression, anxiety, and post-traumatic stress disorder are emotional problems that are reported frequently in IHS patient care data. Corroborating data from the Substance Abuse and Mental Health Services Administration (SAMHSA)

depicted in the graph below and shows that AI/ANs have the highest rates of mental distress of all ethnic and racial groups.

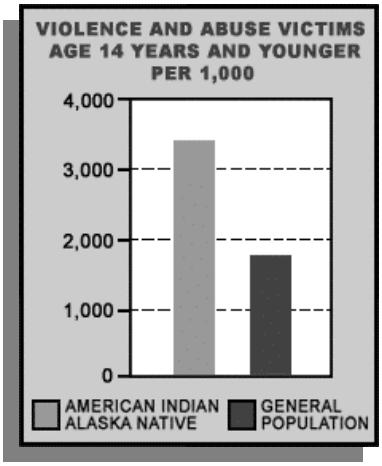
The overall suicide rate for the AI/AN population is approximately 72 percent higher than the national rate.

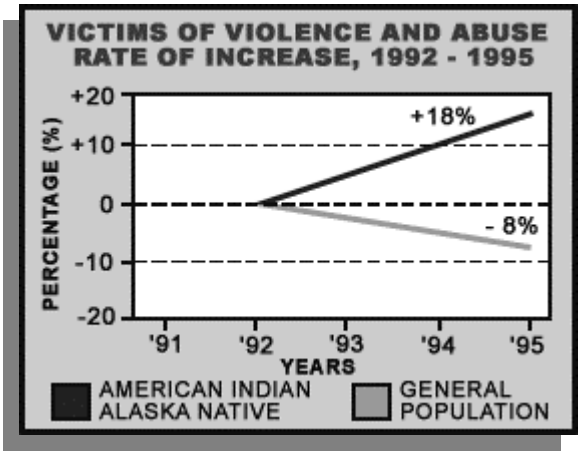
- The highest suicide rate is found in AI/ANs aged 15-34 as compared with the general population where the highest suicide rate is found for individuals aged 74 and older. The suicide rate for AI/AN males aged 15-34 is approximately 2.4 times the national rate or about 60 deaths per 100,000 populations. AI/ANs represent the fastest growing ethnic group in the U.S.; the median age is 27.8 years, approximately 8 years younger than that of the general population. AI/AN deaths due to accidents are approximately 3 times the rate for the general population. Many health professionals consider a substantial portion of deaths reported as accidents or injuries actually to be suicides. These data point to potential significant cultural, social, and economic impact for AI/AN people. These facts point to the severity of mental health problems in AI/AN communities.



- The rates of violence for every age group are higher among AI/ANs than that of the general population. Statistics point to a considerable problem of violence perpetrated both by and against AI/AN youth. The rate of violence for AI/AN youth aged 12-17 is 65 percent greater than the national rate for youth. Gang membership is increasing within urban as well as reservation/rural communities. Seventeen percent of AI/ANs arrested for violent crimes are under the age of 18.

The rate of homicide in AI/AN communities is 41 percent higher (approximately 15.1 per 100,000) than the national rate. The greatest numbers of homicides occur in AI/AN males ages 15-44 and reaches nearly 40 deaths per 100,000 (2.7 times greater than the aggregate AI/AN population homicide death rate).





- Domestic violence and childhood sexual abuse are reported at alarming rates in AI/AN country. The homicide mortality rate for American AI/AN female ages 25 to 34 years is about 1.5 times that for the general population of females in this age group.

- Over crowding in homes, lack of housing, and other socioeconomic issues are associated with these high rates of abuse and neglect. Higher rates of lethal aggression are found among economically impoverished communities; the number of AI/AN families who are at or below the poverty level is 25.9 percent, a number significantly higher than for the general population. Over 75 percent of family violence victims report that the perpetrator had been drinking at the time of the offense as compared to approximately 49 percent for the general population.

- Problems of alcohol abuse, depression and anxiety frequently underlie and complicate treatment for physical disorders and traumatic accidents, requiring considerable attention from caregivers. Alcoholism death rates are approximately 6.7 times the national rate; this is approximately 40 per 100,000 for the AI/AN population versus 5.9 for the general population. Liver disease, cancer diabetes mellitus, heart disease, cerebrovascular disease, as well as other diseases occur in significantly higher proportions in AI/AN communities as compared to the general population. The impact of chronic health problems on psychological well being, particularly depression and suicidal ideation, has significant implications for AI/AN individuals, families, and communities. Please refer to the Alcoholism and Substance Abuse Program narrative for additional information about substance abuse concerns.

The most common MH/SS program model is an acute, crises-oriented outpatient service staffed by one or more mental health professionals. On-call emergency mental health services are also provided outside of usual clinic or hospital hours. Medical and clinical social work are usually provided by one or more social workers to assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling. Completing priorities over existing resources and difficulties recruiting trained specialists lead to limited provision of specialized mental health services for populations such as children and the elderly. BIA, state or local community agencies may also provide supportive services to AI/AN persons with emotional problems. Virtually no partial hospitalization, transitional living, or child residential mental health programs exist in IHS or tribal operations, these services are obtained from local or state resources when available. Inpatient services are provided under contract with local general hospitals psychiatric units or private psychiatric hospitals. Emergency and long duration hospitalizations are generally provided by state mental hospitals. Such hospitals rarely consider cultural needs or offer culturally relevant services such as including traditional healers in the healing process.

Many critical components of mental health, child abuse and social service programs, such as day programs, suicide prevention, and child abuse victim treatment are not available to AI/AN communities. The IHS continues to emphasize community wide intervention and prevention strategies in collaboration with tribes with the goal of improving long term health for child and family based problems. Prevention and early intervention, although legitimate needs, are often deferred so that crisis intervention may be provided to a greater number of clients.

Traditional healers are utilized in most AI/AN communities. At the option of individual tribes, traditional medicine is coordinated with other health and mental health services. Traditional healing practices are important health resources in AI/AN communities.

Services available to AI/AN communities for serious mental health and social problems continue to be limited.

There is approximately 1 psychologist per 8,333 AI/ANs as compared to 1 per 2,213 for the general population.

Most service units and tribal programs are operated with little backup because of the rural and isolated nature of their practice. Professional turnover and burnout also affect the availability of services. In addition to the relatively low numbers of mental health professional available to provide services for AI/AN communities, researchers also suggest burnout is related to secondary traumatic stress - the effect that hearing about and dealing with other's trauma has on the mental health professional.

ACCOMPLISHMENTS

Accomplishments of the Mental Health/Social Services Program include the following:

Children's Mental Health

Significant programmatic activities include:

- Grants to support tribal child abuse and family violence prevention programs and day treatment for mentally ill persons. Other support for child abuse prevention includes providing training to IHS and tribal providers in cooperation with the University of Oklahoma and the University of New Mexico. Joint efforts with the BIA on conducting background checks for tribal, IHS and BIA programs, and joint collaborations with the DOJ and tribes on developing community-based prevention/intervention initiatives for adolescent sexual abuse perpetrators.

- Continuation of a $2.4 million AI/AN children's mental health initiative with SAMSHA.

- Joint efforts with the Head Start Bureau that provide health and mental health consultation and training to 152 AI/AN Head Start and Early Head Start programs including family violence prevention and intervention.

- Reestablished the National Child Protection workgroup, an interagency collaboration with the BIA, DOJ, and IHS. This group developed a child protection manual to educate and inform individuals working in AI/AN communities about child protection laws, indicators, and reporting procedures.

- Developed a Child Sexual Abuse Examination Training and Telemedicine Project in collaboration with OVC. This project provides colposcopes and auxiliary equipment as well as training, consultation, and technical support for medical practitioners.

- Continued the Indian Children's Program at full funding for another year. This provides a stronger focus on early identification and intervention with disabled children and their families.

- Training regarding the needs of high risk children and youth includes: the detection and intervention for emotionally disturbed youth and child abuse victims in BIA boarding schools; residential treatment centers (RTCs); tribal detention centers; and the Juvenile First Offender Diversion Program training in AI/AN communities with the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Major Partnerships

Major partnerships currently exist with Bureau of Indian Affairs (BIA), Substance Abuse and Mental Health Service Administration (SAMHSA), Center for Disease Control (CDC), Department of Justice (DOJ) and Administration for Children and Families (ACF).

- Developed a federal and non-federal interagency AI/AN Youth Violence workgroup for the purpose of information dissemination and education.

- Participation in multi-agency Area Child Protective Teams. These teams are designed to ensure communication, cooperation, and follow-through with neglect/abuse cases.

- Collaboration with the BIA, DOJ, CDC, as well as other national, state, and local agencies in providing training and consultation to I/T/U providers about domestic violence, child abuse, and elder abuse. Also, an IHS system wide identification and intervention for victims of domestic violence will continue in the I/T/U health facilities.

- Participated in a number of interagency activities, such as meetings and workgroups, with SAMHSA, the Office of Justice Juvenile Detention Program, and the National Center for Child Abuse and Neglect, and the BIA that has positively impacted services for AI/AN communities.

- Renewed several interagency agreements that have resulted in increased resources for AI/AN communities. These include agreements with: (a) the Office of Victims of Crime to provide funds to IHS for Child Protection Team Training; (b) SAMHSA to support an AI/AN Technical Assistance Center for the nine AI/AN grantees selected for the Circles of Care Children's Mental Health Initiative and to the three AI/AN Children's Mental Health Service grantees; (d) the Office of Child Abuse and Neglect to continue support of Project Making Medicine at the University of Oklahoma which provides training in child abuse treatment to IHS and Tribal mental health, social service, and substance abuse providers and training and technical assistance to their communities. This project also provides training and technical assistance to the American Indian Program Branch/Headstart grantees.

- Co-facilitated a BIA, DOJ, IHS interagency Indian Country Detention Summit to promote collaboration of law enforcement and behavioral health in providing expanded health services to adjudicated adults and juveniles.

- Continued implementation of suicide prevention strategies in collaboration with CDC including development of a tribally based national suicide prevention network/center.

- Provided mental health training and program consultation to eleven adolescent Regional Treatment Centers. See Alcoholism and Substance Abuse narrative for additional information.

- Funded eight 3-year Mental Health and Community Safety Initiative grants. This represents the IHS portion of a collaborative effort with DOJ, BIA, DOE, and SAMHSA providing over 5 million total in grants to AI/AN communities each year.

Training and Development

Training and development remain priorities not only to help existing staff keep current of advancements in treatment and prevention, but as a means to recruit behavioral health care providers into AI/AN communities.

- Continued the Social Work Fellowship Program with the University of New Mexico that provides child-specific training for AI/AN professionals.

- Continued the Southwest Consortium Pre-doctoral Psychology Internship program that provides training for one intern. This intern provides direct psychological services in the IHS Albuquerque Service Area; AI/AN preference is given to this position.

- Continued funding for the Annual Conference for Psychologists and Psychology students, a forum for students to present their research, develop mentorship relationships, and for I/T/Us to recruit mental health and social service providers.

- Developed and provided a national Behavioral Health Conference for I/T/U behavioral health providers, administrators, and other interested parties. Federal partners were invited to participate as well as grantees.

Data Collection

- Expansion of the MH/SS system in the I/T/U facilities for mental health data collection including suicide, child abuse, and domestic violence in addition to other clinical information. Data for baseline morbidity are essential to fully support the I/T/U planning and management of health programs.

PERFORMANCE PLAN

The following performance indicators are included in the IHS FY 2002 Annual Performance Plan. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN. At this funding level, IHS could achieve the following:

Indicator 16: During FY 2002 the IHS will assure that:

a. At least 82 percent of I/T/U medical facilities (providing direct patient care) will have written policies and procedures for routinely identifying and following:
    - Spouse/intimate partner abuse
    - Child abuse and neglect
    - Elder abuse or neglect

b. At least 56 percent of I/T/U medical facilities will provide training to the direct clinical staff on the application of these policies and procedures.

Indicator 18: During FY 2002, increase the number of I/T/U programs utilizing the Mental Health/Social Services (MH/SS) data reporting system by 5 percent over the FY 2001 rate.

Indicator 27: During FY 2002, increase by 10 percent over the FY 2001 level, the proportion of I/T/Us that have implemented systematic suicide surveillance and referral systems which include:

a. Monitoring the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions)
b. Assuring appropriate population-based prevention interventions are implemented and those identified at risk receive services

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$38,341,000	311	
1998	$39,379,000	308	
1999	$41,305,000	290	
2000	$43,245,000	283	
2001	$45,018,000	297	Enacted

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $47,142,000 and 303 FTE is an increase of $2,124,000 and 6 FTE over the FY 2001 enacted level of $45,018,000 and 297 FTE. The increases are as follows:

Built-in Increases: +$1,590,000

The request of $514,000 for inflation/tribal pay cost and $1,076,000 for federal personnel related costs would fund the built-in increases associated with on-going operations. Included is the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintains the FY 2001 level of service for American Indians and Alaska Natives. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$534,000 and 6 FTE

The request of $534,000 and 6 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities	**Dollars**	**FTE**
Parker, AZ Health Center	$534,000	6
Total	$534,000	6