

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INDIAN ALCOHOL AND SUBSTANCE ABUSE:
LEGISLATIVE INTENT AND REALITY**



OCTOBER 1992

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OCTOBER 1992 OEI-09-92-00010

EXECUTIVE SUMMARY

PURPOSE

This inspection assesses the Indian Health Service's coordination of alcohol and substance abuse programs.

BACKGROUND

Alcohol and substance abuse are the foremost health concerns for American Indians and Alaska Natives (hereafter referred to as "Indians"). Four of the top 10 causes of death among Indians are alcohol- and drug-related injuries, chronic liver disease and cirrhosis, suicide, and murder.

The Office of Inspector General (OIG) conducted this inspection at the request of the Senate Select Committee on Indian Affairs. The Committee requested that the OIG provide information to assist in the reauthorization of Indian alcohol and substance abuse legislation. Congress enacted the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, P.L. 99-570, to provide a coordinated and comprehensive attack on Indian alcohol and substance abuse with a particular emphasis on youth. As required by the law, the Secretaries of Interior and Health and Human Services entered into a Memorandum of Agreement. To determine the extent to which Congressional intent has been implemented, we interviewed officials from the Public Health Service's (PHS) Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) and reviewed laws, regulations, and policies that address the coordination of Indian alcohol and substance abuse programs.

FINDINGS

- *IHS and BIA have not achieved the level of coordination envisioned by Congress*
- *Limited coordination undermines a continuum of care and an holistic approach for treating Indian alcohol and substance abuse*

RECOMMENDATION

The Indian Health Service, in conjunction with the Bureau of Indian Affairs, should review, update, and streamline the Memorandum of Agreement with the goal of developing a practical plan of action

AGENCY COMMENTS

The PHS agreed with the OIG recommendation and in its comments on the draft report discusses actions it has taken or plans to take to address the specific issues.

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INTRODUCTION

PURPOSE

This inspection assesses the Indian Health Service's coordination of alcohol and substance abuse programs.

BACKGROUND

Alcohol and substance abuse are the foremost health concerns for American Indians and Alaska Natives (hereafter referred to as "Indians"). Four of the top 10 causes of death among Indians are alcohol and drug related injuries (18 percent of all deaths), chronic liver disease and cirrhosis (5 percent), suicide (3 percent), and murder (3 percent).¹

The Office of Inspector General (OIG) conducted this inspection at the request of the Senate Select Committee on Indian Affairs. The Committee requested that the OIG provide information to assist in the reauthorization of Indian alcohol and substance abuse legislation. The Committee also requested the Department of Interior's Office of Inspector General to review compliance with legislative requirements for alcohol and substance abuse programs.

In 1976, Congress enacted the Indian Health Care Improvement Act, P.L. 94-437, to respond to all aspects of Indian health including prevention and primary care. The Act's stated purpose is to "meet the national goal of providing the highest possible health status to Indians" As part of the Act, Congress has appropriated funds annually for the treatment and control of alcohol and substance abuse among Indians. The 1988 amendments to the Act call for the Department of Health and Human Services' Indian Health Service (IHS), the Department of Interior's Bureau of Indian Affairs (BIA), and the Indian tribes to coordinate their alcohol and substance abuse programs with their mental health programs.

The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, P.L. 99-570, Subtitle C, more specifically addresses Indian alcohol and substance abuse. With this Act, Congress sought to provide a comprehensive coordinated attack on Indian alcohol and substance abuse with a particular emphasis on youth. Congress directed the Secretaries of Interior and Health and Human Services to enter into a Memorandum of Agreement no later than 120 days after the law was enacted.

The IHS funds or directly provides comprehensive health services, including alcohol and substance abuse programs, for Indians. Within each of the 12 IHS area offices, full-time coordinators provide training and technical assistance to Indian alcohol and

¹"Anti-Drug Abuse Act of 1986," Section 4202 (4)-(5).

substance abuse programs. To meet the needs of the Indian communities, area offices can vary their staffing and operations. The area directors report directly to the IHS Deputy Director. At the headquarters level, IHS created the Alcoholism and Substance Abuse Program Branch, now located in Albuquerque, New Mexico. The branch, which has no line authority over the area offices, provides training, technical assistance, guidance, oversight, and funding to the area offices and the alcohol and substance abuse programs.

The BIA serves as the Federal Government's principal agent with federally-recognized Indian tribes. It provides or funds law enforcement, judicial services, social services, and education through 12 area offices, 84 local-level agencies, and 180 schools. Within BIA, the Office of Alcohol and Substance Abuse Prevention provides leadership and direction for all BIA alcohol and substance abuse prevention activities.

METHODOLOGY

To determine the extent to which Congressional intent has been implemented, we identified, collected, and reviewed laws, regulations, and policies that address the coordination of Indian alcohol and substance abuse programs. We obtained information through written requests to IHS headquarters. We focused first on the Memorandum of Agreement between IHS and BIA and requested (1) the Organizational Master Action Plan, (2) review guidelines, (3) the minimum standards compliance plan, (4) Tribal Action Plans and Local Action Plans, and (5) tribal comprehensive reports. We then focused on Memoranda of Agreement between IHS and other Federal agencies and departments and requested documentation that illustrates coordination activities.

We interviewed officials from IHS and BIA headquarters offices and discussed coordination and Memorandum of Agreement implementation. We visited IHS headquarters offices in Rockville, Maryland and Albuquerque, New Mexico. We visited BIA headquarters in Washington, D.C. and spoke with officials from the Office of Alcohol and Substance Abuse Prevention, Division of Law Enforcement, Branch of Judicial Services, Division of Social Services, and Office of Indian Education Programs. We conducted 21 headquarters interviews and spoke with 31 individuals.

We also interviewed officials from all IHS and BIA area offices. We conducted in-person interviews with officials in four IHS and four BIA offices and visited selected alcohol and substance abuse programs. We conducted telephone interviews with officials in all other area offices. In each case, we interviewed the area director and the alcohol and substance abuse coordinator. In some offices, we spoke with project officers, alcohol and substance abuse specialists, or others who administer or monitor the alcohol and substance abuse programs. We conducted 61 area office interviews and spoke with 67 individuals.

We also interviewed headquarters officials from the Department of Education. They described their Drug Free Schools program and their coordination activities with BIA.

FINDINGS

IHS AND BIA HAVE NOT ACHIEVED THE LEVEL OF COORDINATION ENVISIONED BY CONGRESS

The Memorandum of Agreement formalized the need for coordination

As required by the law, the Secretaries of Interior and Health and Human Services entered into a Memorandum of Agreement. The Agreement was published in the Federal Register on March 26, 1987 and specifically directs IHS and BIA to coordinate resources to "assist Indian tribes and Alaska Native villages to achieve their goals in the prevention, intervention, treatment, and follow-up of alcohol and substance abuse." It outlines the roles and responsibilities of IHS, BIA, and the tribes and details short- and long-term goals.

Many IHS and BIA officials praised the Memorandum of Agreement for initiating coordination where none previously existed. Typical was the comment of an IHS official, "Before the legislation, BIA washed their hands of substance abuse because it's a disease. IHS would not treat people with law and order problems because it was not their jurisdiction."

IHS and BIA have not implemented many of the Agreement's provisions

Despite their mutual desire for coordination, IHS and BIA officials have had limited success in accomplishing the Agreement's goals. Major provisions that remain incomplete include periodic reviews of both the Memorandum of Agreement and the Organizational Master Action Plan, Tribal Action Plans and Local Action Plans, and tribal comprehensive reports. For more detailed information on the major provisions of the Memorandum of Agreement, please see the Appendix.

The law requires the Departments of Interior and Health and Human Services to review the Memorandum of Agreement annually. This has not been done since 1988. Both IHS and BIA officials believe the Memorandum of Agreement should be updated to reflect their accomplishments and to refocus their efforts. At the beginning of her term, the current Director of BIA's Office of Alcohol and Substance Abuse Prevention declined an invitation from IHS to update the Memorandum of Agreement. She wanted time to gain a better understanding of her responsibilities. Later, both agencies deferred the update until IHS issued its report on the scope of the Indian alcohol and substance abuse problem. The IHS did release this report in February 1992.

Several barriers inhibit effective coordination between IHS and BIA

Barriers to coordination include:

- Differing missions

As indicated in the background section of this report, IHS and BIA have very different roles and missions. An IHS official summarized, "We have different missions. Cooperation is realistic, but should reflect these missions." Many IHS and BIA officials believe that (a) IHS should take the lead in implementing the legislation and have control over programs related to treatment and assessment and (b) BIA should provide support by using their law enforcement, judicial services, social services, and educational activities to provide referrals, prevention, and aftercare.

- Differing headquarters staff structures

For IHS, the Alcoholism and Substance Abuse Program Branch has primary responsibility for all headquarters activities related to alcohol and substance abuse. In contrast, BIA's Office of Alcohol and Substance Abuse Prevention attempts to coordinate efforts of the Division of Law Enforcement, Division of Social Services, Branch of Judicial Services, and Office of Indian Education Programs.

- Lack of area office and headquarters collocation

The alcohol and substance abuse branches for IHS and BIA are located in Albuquerque, New Mexico and Washington, D.C., respectively. A few IHS headquarters officials noted that collocation would make their work easier. Ten of the 24 area offices have difficulty coordinating because their counterparts are in different cities. In contrast, close proximity of area offices facilitates coordination. In some areas, BIA and IHS staff travel together to perform program reviews and conduct joint training.

- High staff turnover

Although Congress established BIA's Office of Alcohol and Substance Prevention with a permanent director position, five different temporary directors have been appointed since the office's inception in 1986. Officials from both IHS and BIA expressed frustration with the lack of a permanent director as mandated by the legislation.

At the area and local levels, burnout is common as staff handle many, sometimes conflicting, assignments. Both IHS and BIA officials described their jobs as responding to "fire drills" and operating in a "crisis mentality." Once trained, staff frequently leave to find higher-paying positions.

- Lack of full-time BIA area alcohol and substance abuse coordinators

Both IHS and BIA officials expressed frustration at the lack of full-time BIA area coordinators. For example, an IHS official stated, "We have not coordinated with BIA for 1 1/2 years. BIA does not have the staff to facilitate these activities. It would be better if BIA had funded coordinator positions."

At the local level, coordination occurs regardless of the efforts of area offices and headquarters

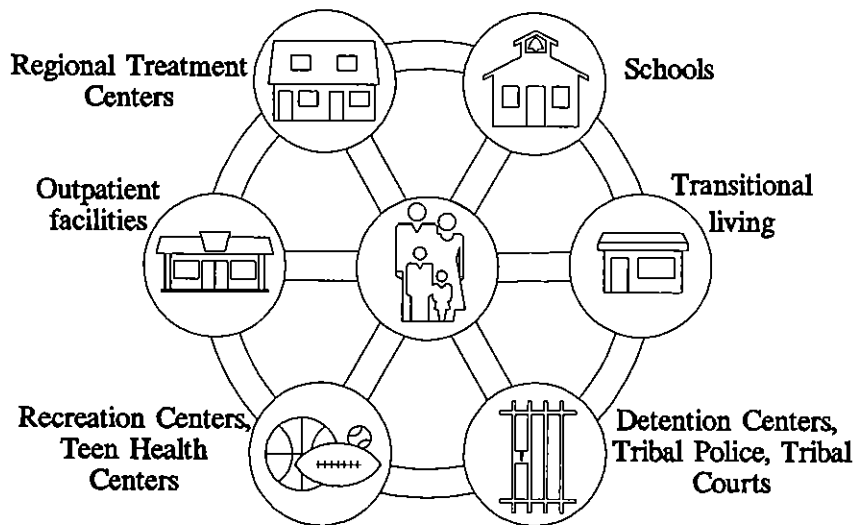
At the local level, coordination occurs because of community needs, not Memorandum of Agreement requirements. Many officials cited coordination efforts with State, local, and private agencies. Often, the cooperation is in the form of information sharing and referrals. "Social service workers frequently interact with the State on family and youth problems," a BIA official noted. In Alaska, BIA's role is severely reduced as State agencies handle law enforcement and schools for the tribes and villages. Nationally, coordination among IHS, States, and tribes has led to joint programs with local schools and churches and agreements with hospitals and clinics. These coordinated efforts allow the tribal programs to provide a greater range of services to their communities.

LIMITED COORDINATION UNDERMINES A CONTINUUM OF CARE AND AN HOLISTIC APPROACH FOR TREATING INDIAN ALCOHOL AND SUBSTANCE ABUSE

Alcohol and substance abuse laws currently provide a broad spectrum of prevention, treatment, and aftercare services and programs for adults, youth, and families. The IHS, through its mental health and substance abuse functions, is responsible for the direct treatment of alcohol and substance abuse. The BIA utilizes its education, social services, and law enforcement components to provide prevention, referrals, and aftercare.

Nevertheless, officials from IHS and BIA agree that existing coordination is not sufficient, and services are neither integrated nor complete. Despite the wide range of programs and services authorized by the legislation, these individual efforts do not provide a comprehensive solution to Indian alcohol and substance abuse.

COORDINATION IS ESSENTIAL FOR EFFECTIVE PREVENTION, TREATMENT, AND AFTERCARE



Presently, Indian alcohol and substance abuse services do not offer a comprehensive continuum of care

While treatment is essential for any successful alcohol or substance abuse program, many officials mentioned the need for a strengthened continuum of care. Almost all IHS and BIA area coordinators want stronger prevention and aftercare programs.

"Without proper prevention and aftercare, treatment often results in relapse."

The IHS and BIA currently fund some prevention activities in BIA schools such as Drug Abuse Resistance Education (D.A.R.E.) and Basic Alcohol and Addiction Beginning Education Studies (BABES). While these programs exist, officials expressed the need to improve as well as add programs. Currently, more Indian students attend public schools than BIA schools. Officials believe that some Indian education and prevention funds should be used for public school prevention programs designed specifically for Indian youth.

Aftercare and transitional living programs, which include emergency shelters, halfway houses, and detention centers, are insufficient. For example, only 10 of the 33 authorized emergency shelters are operational. Officials complained that site selection, construction time, and staffing considerations hinder program development. They also believe the ability to expand existing programs and add new programs would help extend the continuum of care.

Most IHS officials recommended a more holistic approach to the treatment of alcohol and substance abuse

Officials believe that treatment of alcohol and substance abuse purely as diseases is not always successful and that programs should address the multiple problems of individuals. Officials from 10 IHS area offices believe that IHS should integrate its mental health and social services with alcohol and substance abuse services. Some area offices already have integrated their services, but headquarters branches remain separate.

According to IHS, "During joint reviews, we found that over 70 percent of all alcoholism and substance abuse patients have mental health illnesses as well (i.e., dual diagnosis). IHS needs a Behavioral Health Office now. Integration is key."

Intervention teams and child protection teams are examples of effective coordination among IHS, BIA, tribes, and other government entities, but not all area offices use these approaches effectively. Generally, teams adopt a case management approach for placement and treatment plans. Both intervention and child protection teams consist of personnel from various disciplines, including chemical dependency, mental health, social services, medical services, law enforcement, and the courts. This assures treatment of an individual's total needs. For example, during child protection team

meetings, participants discuss alcohol and substance abuse as a factor in most child abuse and neglect cases. Many officials said that the child protection teams have done the most to foster coordination and focus attention on the problems of substance abuse.

Intervention teams focus on both adult and youth alcohol and substance abuse clients. One area official summarized the views of many who strongly support the team concept for assessing and treating clients. He stated:

Congress should know that the team approach has increased greatly our ability to handle clients. We have gone from around 300 to 1,600 clients per year since 1986. We are able to get a client into treatment in half a day. Others, who does not use the team approach, say it takes them 3 weeks. Plus it allows us to deal with multiple problems.

RECOMMENDATION

The Indian Health Service, in conjunction with the Bureau of Indian Affairs, should review, update, and streamline the Memorandum of Agreement with the goal of developing a practical plan of action. Consideration should be given to:

- (a) updating and revising the Organizational Master Action Plan and area office workplans,
- (b) completing and/or updating Tribal Action Plans and Local Action Plans,
- (c) collocating headquarters alcohol and substance abuse program offices,
- (d) resolving staff turnover problems,
- (e) issuing the emergency shelter guidelines, and
- (f) implementing an holistic approach for treating Indian alcohol and substance abuse.

AGENCY COMMENTS

The Public Health Service agreed with the OIG recommendation and in its comments on our draft report discusses some of the actions IHS has taken or plans to take to address the specific problems. The IHS is working actively with BIA on several issues. Representatives from IHS and BIA met on June 3, 1992 to revise the Memorandum of Agreement. After review and comment, both agencies expect to sign the Agreement in the near future. The IHS and BIA also met in June 1992 to discuss emergency shelters and in July to discuss detention centers. The emergency shelter guidelines have not been issued yet.

The IHS reported there are now Tribal Action Plans in place for 381 tribal groups out of a possible 546 plans. The agency expects to complete 69 more Tribal and Local Action Plans soon. The IHS is working diligently to recruit and retain more well-trained alcohol and substance abuse and mental health staff. According to IHS, collocating IHS and BIA staff would involve significant tribal consultation.

The complete text of the comments is contained in appendix B.

APPENDIX A

MEMORANDUM OF AGREEMENT: STATUS OF MAJOR PROVISIONS AS OF SPRING 1992

- The Memorandum of Agreement Review Process

The Memorandum of Agreement directed BIA and IHS to review the Agreement annually within a month of its signing. A formal review of the original Agreement was completed in August 1988. No subsequent reviews have occurred.

- Area Office Workplans

The Memorandum of Agreement requires that IHS and BIA area offices revise their workplans annually. Most area offices submitted one workplan with only one update. This corresponds with the single review of the Agreement that was completed in 1988. The IHS officials stated that the focus on workplans has diminished since 1989 because "many of the original items being tracked in the workplans have been completed" and "IHS/BIA/Tribal coordination is less than optimal in a number of areas."

- Tribal Action Plans/Local Action Plans

Overall, only 241 Tribal Action Plans and 6 Local Action Plans, out of a possible 546, have been completed. The Tribal Action Plans and Local Action Plans establish a basis for coordination at the tribal level. According to the legislation, IHS service unit directors and BIA agency and education superintendents were to enter into a Tribal Action Plan at the request of the tribe. The plan's purpose was "to coordinate resources and programs relevant to alcohol and substance abuse prevention and treatment." Indian tribes were to develop a Tribal Action Plan 90 days after the Memorandum of Agreement's publication in the Federal Register. If this did not occur, IHS and BIA officials were to develop a Local Action Plan for the tribe. Although five IHS area offices completed plans for all their tribal groups, two large area offices completed only 19 percent of their required plans.

- The Newsletter

According to P.L. 99-570, BIA was to publish and distribute a newsletter highlighting exemplary Indian alcohol and substance abuse programs. Partial funding was to come from IHS. This requirement has been partially and sporadically met. The OIG received copies of "Linkages," a bi-monthly newsletter dedicated to children's mental health issues. Beginning

February 1987, "Indians Against Drug Abuse" was published as an insert to "Linkages." The last edition of "Indians Against Drug Abuse" was distributed in June 1990.

For more than a year, no newsletter was published while BIA established a new contract. "Prevention Quarterly" replaced the former insert. It focuses on alcohol and substance abuse prevention and treatment. The first issue was published in September 1991.

- Community Training

As the lead agency for providing community training, IHS developed a trainer's manual that included daily schedules, modules, and guidance on group behavior and training techniques. All IHS area offices submitted documentation on completed training. The OIG did not assess the quality or effectiveness of the training materials.

- Judicial Services and Law Enforcement Training

As the lead agency in developing and implementing training for tribal judges and law enforcement personnel, BIA contracted with the National Indian Justice Center to develop a training program. The Center prepared a manual that includes training schedules, laws, court cases, and other background information.

- Identification of Programs

In response to this requirement, IHS produced a listing of alcohol and substance abuse programs for fiscal years 1988-1992. The listings include the program's name, director's name, contract information, program components, program costs, total staff, total number of counselors, and number of certified counselors.

- Emergency Medical Assessment

P.L. 99-570 mandates "the emergency medical assessment and treatment of every Indian youth arrested or detained by BIA or tribal law enforcement personnel for an offense relating to or involving alcohol or substance abuse." The IHS and BIA developed another Memorandum of Agreement to coordinate these services. Due to IHS staff limitations and continuity concerns with BIA staff, the degree to which this was successfully implemented has never been evaluated.

- Minimum Standards Compliance Plan

In consultation with Indian tribes, IHS and BIA were to establish minimum standards for alcohol and substance abuse programs. They did, in fact, establish a work group that included representatives from Indian-operated alcohol and substance abuse programs, IHS area coordinators, and members of the IHS Alcoholism and Substance Abuse Program Branch. Although IHS committed key resources to this effort, BIA did not play an active role in developing or reviewing the guidelines. All Indian alcohol and substance abuse program managers received draft standards.

- Scope of the Problem

Congress directed IHS, BIA, and the tribes to determine the scope of the problem of alcohol and substance abuse among Indian people and to report on the financial and human costs of people directly or indirectly affected by such abuse. The IHS and BIA accomplished this task. First, the Department of Interior's Office of Program Analysis issued a November 1987 report entitled "Scope of the Problem and Economic Costs Interim Report." Second, IHS contracted with the American Indian Health Care Association to conduct a follow-up study and released the study's final report in February 1992.

- Assessment of Resources

According to the Memorandum of Agreement, "IHS, in cooperation with BIA and tribes, will conduct an assessment of the existing and needed resources and provide an estimate of funding necessary for a program of prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse,..." Most IHS area offices developed a listing of resources that identify and group Federal, tribal, State, local, and private resources.

- Emergency Shelters

According to the Memorandum of Agreement, "BIA in cooperation with the IHS will promulgate standards by which the emergency shelters...shall be established and operating, by September 1987,..." The standards have not been issued. Draft guidelines are still under review.

- The Tribal Comprehensive Report

According to the Memorandum of Agreement, the tribal comprehensive report was to "provide tribes with...[a] report of BIA and IHS alcohol and substance abuse data." The Organizational Master Action Plan identified a work group of IHS and BIA representatives. The group was responsible for establishing guidelines for the collection, coordination, and distribution of this information. The work group developed draft materials, which were made available to the

area offices. These materials were never finalized, however. Only one IHS area office used the draft guidelines to develop its tribal comprehensive report.

- Child Abuse and Neglect

According to the Memorandum of Agreement, "BIA in cooperation with IHS will compile data relating to the number and types of child abuse and neglect cases and the type of assistance provided, reflecting those that involve, or appear to involve, alcohol and substance abuse, those which are recurring and those that involve other minor siblings." As required, BIA issued a report entitled "Fiscal Year 1988 Child Abuse and Neglect Data" that includes information on the total and suspected number of cases involving alcohol or substance abuse.

- Curriculum Assessment

The Memorandum of Agreement requires that "BIA in cooperation with IHS will provide technical assistance as necessary to develop and implement curricula in kindergarten and grades 1 through 12 relating to alcohol and substance abuse prevention and treatment." The IHS and BIA coordinated the assessment of BIA-funded school curricula. The IHS conducted a study entitled "School/Community-Based Alcoholism and Substance Abuse Prevention Survey," and BIA used the study's results to develop the Drug Free Schools program with the Department of Education.

- Crisis Intervention

The Memorandum of Agreement requires that "BIA in cooperation with the IHS will provide for individual student crisis intervention in schools funded by BIA and a reporting of all incidents relating to alcohol and substance abuse...." The BIA took the lead in developing a crisis intervention plan for its schools. The plan coordinates school, tribal, IHS, and BIA programs to place students who are in crisis into a treatment setting.

- Model Juvenile Code

The Memorandum of Agreement directed BIA, IHS, and the tribes to cooperate in developing a model juvenile code. The National Indian Justice Center developed a code under a BIA contract. Indian judges, tribes, and IHS officials reviewed the code before it was finalized.

APPENDIX B

AGENCY COMMENTS



Memorandum

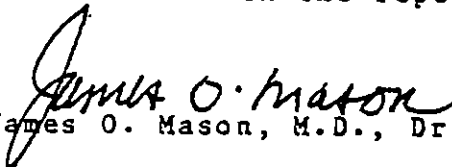
Date AUG 31 1992

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "Indian Alcohol and Substance Abuse: Legislative Intent and Reality,"
OEI-09-92-00010

To Acting Inspector General, OS

Attached are the Public Health Service comments on the subject draft report. We concur with the recommendation. In our comments we discuss some activities undertaken by the IHS to respond to the issues identified in the report.


James O. Mason, M.D., Dr.P.H.

Attachment

PHS COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT
REPORT "INDIAN ALCOHOL AND SUBSTANCE ABUSE: LEGISLATIVE
INTENT AND REALITY," OEI-09-92-00010

General Comments

The OIG report cites two major findings: (1) the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) have not achieved the level of coordination envisioned by Congress, and (2) limited coordination undermines the continuum of care for treating alcoholism and substance abuse. IHS agrees that the five barriers to coordination between IHS and BIA, that OIG has identified, have contributed significantly to these findings.

Actions could be taken by IHS and BIA to facilitate coordination by lessening or eliminating some of these barriers. Some of these actions could be accomplished rather easily and others, for historical or political reasons, would be very difficult to take. For example, IHS believes that hiring full-time BIA Alcoholism Coordinators would greatly improve coordination between these organizations. However, collocation of IHS and BIA Area Offices is a barrier not easily addressed and would involve significant tribal consultation.

Public Law (P.L.) 99-570 and its amendments directed funds primarily for youth services, a previously identified gap in programs initially established under the Indian Health Improvement Act, P.L. 94-437. However, it must be noted that significant gaps remain in the continuum of care as each tribe contracted for a slightly different focus in the scope of work. Access to IHS-funded prevention services; adult treatment services, both inpatient and outpatient; adolescent and adult group homes; halfway houses; and services targeting sub-populations such as women, pregnant women, and elders remain variable from one community to the next. Although regional treatment centers (RTC) are currently funded for adolescents, the majority of IHS- and BIA-funded programs continue to be contracted with individual tribes for services for their respective membership in accordance with P.L. 93-638. Coordination of resources among IHS, BIA and other agencies remains critical in planning for and site selection of additional services.

The issue of merging the Mental Health Program and the Alcoholism and Substance Abuse Program Branch (ASAPB) into a single organizational entity comes up from time to time when the coordination of increasingly complex medical disciplines is discussed. Currently, since these disciplines are housed in branches that are part of IHS' Division of Clinical and Preventive Services, there is considerable coordination of efforts. At this time, IHS does not believe that the

merging of these two disciplines at headquarters would result in better coordination, since such coordination already occurs at the division level.

The IHS believes that benefits remain at this time for maintaining separate disciplines while monitoring implementation of the new IHS alcoholism standards. These standards require a multi-disciplinary approach for treatment of alcoholism, including mental health and social work services. Concurrent with this effort, IHS will focus on improving the recruitment and retention of alcoholism and substance abuse, and mental health staff. These efforts will address cross-training of both disciplines.

The Appendix Section of the report lists the status of 12 major provisions of the Memorandum of Agreement (MOA) between IHS and BIA. Although only 241 Tribal Action Plans (TAPs) of a possible 546 were identified as completed, it should be noted that nine of these plans were submitted by Alaska Native Health Corporations representing a total of 149 tribal entities. Therefore, currently completed TAPs are in place for 381 tribal entities. In addition, 69 TAPs and Local Action Plans (LAPs) are in the development stage soon to be confirmed.

The memorandum transmitting the report includes the Issues and Responses prepared by OIG for the Senate Select Committee on Indian Affairs on September 24, 1991. It includes a statement that the P.L. 99-570 appropriations totalled \$12 million for construction and renovation of adolescent treatment centers for Fiscal Years (FY) 1989 - 1992. The actual amount appropriated for construction of RTCs for FY 1987 - 1992 was \$9.612 million.

One final point should be considered when viewing the availability and quality of alcoholism and substance abuse treatment provided by IHS. The OIG review of the IHS reality of implementation of the intent of Congress focused on the MOA. However, IHS continues to address several major items of the legislation which are not included in the MOA, including RTCs, community rehabilitation and aftercare. IHS, although mandated to collaborate with BIA on detention centers and emergency shelters, does not have primary responsibility for implementing these programs. IHS has and continues to work with BIA in workgroups and focused meetings on these topics.

OIG RECOMMENDATION

The IHS, in conjunction with BIA, should review, update, and streamline the MOA with the goal of developing a practical plan of action. Consideration should be given to:

- a) Updating and revising the Organizational Master Action Plan (OMAP) and Area Office Workplans;
- b) Completing and/or updating TAPs and LAPs;
- c) Collocating Headquarters ASAPB offices;
- d) Resolving staff turnover problems;
- e) Issuing the emergency shelter guidelines; and,
- f) Implementing an holistic approach for treating Indian alcohol and substance abuse.

PHS COMMENTS

We concur with the OIG recommendation. Actions that IHS has taken or plans to take to address the specific issues highlighted by OIG follow:

- a) Representatives of IHS and BIA ASAPB offices met on June 3, 1992 to develop a draft revision of the MOA. After the BIA and IHS staff review and comment on the draft and subsequent revisions, the MOA will be submitted to both Agencies for signature. The target date for completion is October 1992. The proposed revisions include specific language relative to coordination of services for adolescents admitted to detention centers, emergency shelters and regional treatment centers.
- b) Joint Area Workplans, as outlined in the MOA and OMAP, are to reflect TAPs. The MOA currently being revised, will reinforce the IHS and BIA role in updating TAPs or the development of LAPs. National Headquarters Offices of both BIA and IHS will identify a workgroup with Area and local level representation to develop a format and guidelines for workplans and LAPs.
- c) The IHS is advertising for a new ASAPB Chief to be located in Rockville. Interim plans include identification of staff within the current Headquarters Offices as the focal point for coordination with BIA staff. Ongoing joint IHS and BIA meetings also continue regarding emergency shelters and detention centers. Most recent meetings include an emergency shelter meeting in Albuquerque on June 23-25 and a detention center meeting in Washington, D.C. on July 7.

- d) Staff turnover remains a challenge within both Agencies. The IHS will maintain coordination with the BIA as a primary focus, assigning responsibilities to staff to assure continuity, even during future personnel changes. The IHS continues to recruit well trained staff to address alcoholism and substance abuse problems; however, competing employers who offer more lucrative salaries and lighter workloads hinder efforts to retain qualified staff.
- e) The emergency shelters remain a responsibility of the BIA. The IHS continues to participate in Headquarters level meetings regarding shelter standards. This focus will be broadened to include Area level BIA and IHS coordination to develop services (taking into consideration other resources) to address the continuum of care.
- f) The use of the term "holistic" in the present context is not clear. The desire is for broader coordination and integration of different disciplines, to bring to those with alcoholism, the most comprehensive array of services. IHS agrees that closer coordination between mental health and substance abuse treatment services would greatly benefit the program. The greatest barrier is the shortage of mental health workers throughout IHS. However, IHS believes also that the concept should not be limited only to mental health, but should involve other disciplines including education, rehabilitation, physical and recreation therapy, medicine, social services, and others. The MOA between IHS and BIA, and the ASAPB standards adapted in May 1991, reflect a goal of multi-disciplinary treatment.

The IHS coordinates services through its Division of Clinical and Preventive Services, within which these disciplines are encompassed. Adolescent RTC reviews are currently conducted by a Headquarters team, which includes representatives from Mental Health. The recently hired Quality Assurance (QA) Officer for the ASAPB, met with the Mental Health QA Officer to begin work on Area and program review elements, regarding improved coordination among the Branches, to enhance patient services. Several Area Offices, for example, Alaska, California and Oklahoma, continue to function as a behavioral health model including alcoholism and mental health as a single unit.

As noted in this report, coordination often occurs at the local level. This applies not only to BIA and IHS interaction, but also services of IHS, many of which are often contracted by tribes. Several tribal health departments now operate as a behavioral health model, combining alcohol and mental health services and cross training of staff.

The TAFs and LAPs may (depending on independent tribes) similarly reflect a more efficient and "holistic" approach to service delivery, often combining program services and funds. IHS continues to support separate Branches, but closer working relationships to provide multi-disciplinary team assessment and treatment approaches.