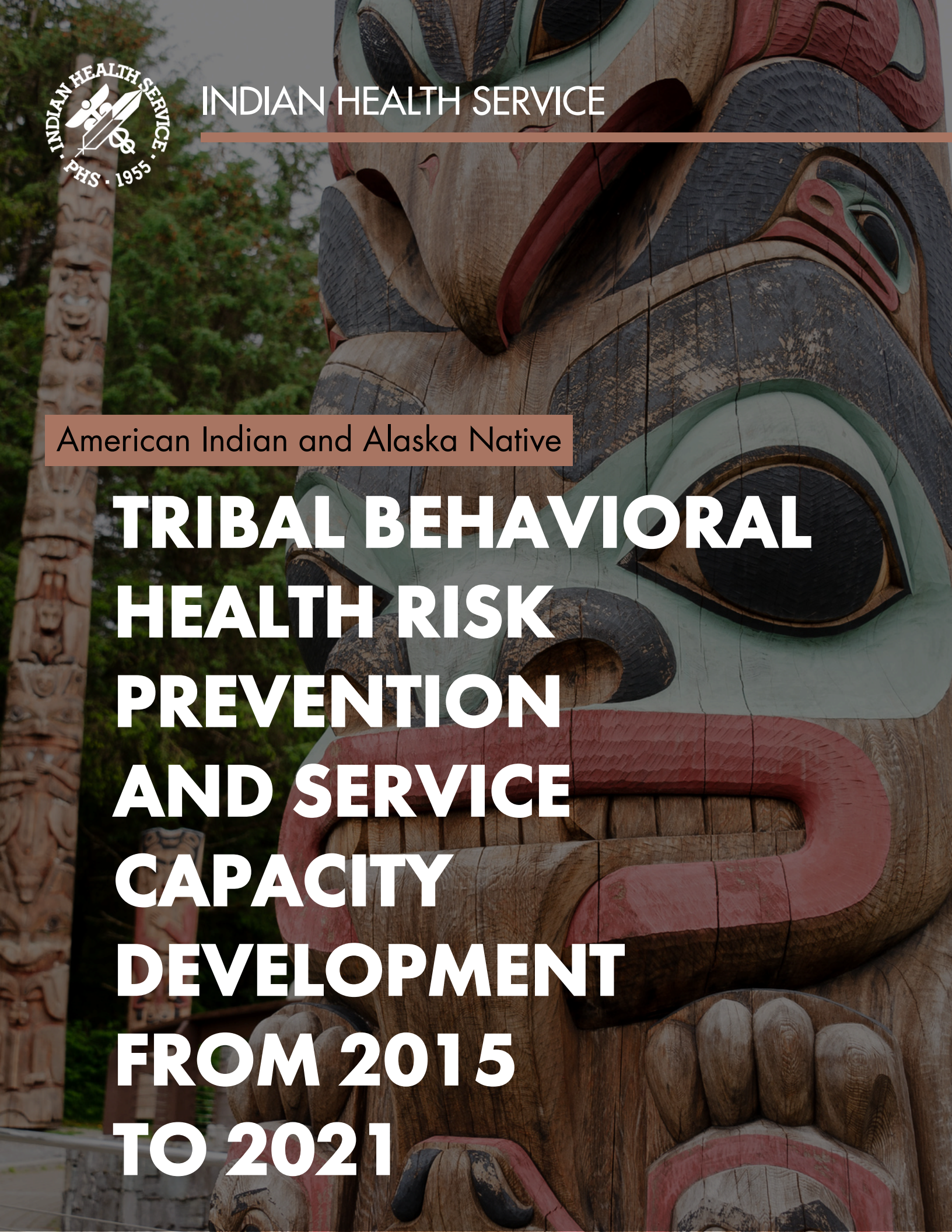

INDIAN HEALTH SERVICE

American Indian and Alaska Native

TRIBAL BEHAVIORAL HEALTH RISK PREVENTION AND SERVICE CAPACITY DEVELOPMENT FROM 2015 TO 2021

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
OFFICE OF CLINICAL AND PREVENTIVE SERVICES

Tribal Behavioral Health Risk Prevention and Service Capacity Development from 2015 to 2021

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Author note: Paschane performed final analyses and wrote the manuscript. English, Baloo, and Muchna performed the data cleaning and preview analyses. Solimon, James, and Espinoza aided in interpretation of analyses. Ontiveros provided the map. All authors discussed the results and commented on the manuscript.

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Executive Summary

From 2015 to 2021, the Indian Health Service (IHS) operated two priority grant-based programs within its human risk mitigation mission in Indian Country. The programs allowed for a diverse cohort of 175 Tribal partnerships and their respective mix of projects. The timing of the cohort preceded and overlapped the COVID-19 pandemic. The IHS formed the partnerships to mitigate psychological and behavioral risks and suffering, specific to substance use disorders, domestic violence, and suicides among American Indian and Alaska Native (AI/AN) persons, generally referred to as behavioral health initiatives. Operationally, the 257 projects focused on using grant funding to develop local risk mitigations and service capacities. The projects achieved their basic goals, including local service partnerships and provider training, while reaching AI/AN persons with risk screening, referrals, and services, including engagements with clients during the pandemic. The risk screenings identify over 6,000 cases of substance use disorders, nearly 8,500 cases of violence, and over 150,000 AI/AN persons who were at risk for suicide. The Tribal partners also faced notable barriers due to poor data infrastructure and limited cross-sector coordination. These barriers affected key operations, such as outreach to youth, keeping clients in treatment, and prosecuting crimes. Following this cohort of projects, the IHS made improvements to how it operates data collection with Tribes. Additional actions are needed to improve IHS methods, such as using advanced analytics to prioritize jurisdictions for projects, specific project agreements for timely results, strategic economies of scale for technology access, and inter-agency agreements to address cross-sector operations.

Tribal Partnership Cohort

The Indian Health Service (IHS) formed a national cohort of 175 Tribal partnerships, starting in September 2015. As increased funding became available to IHS, the cohort increased to a total of 257 projects among the 175 grant-based partners. Initially, the cohort was planned for five years, but due to the COVID pandemic it was expanded to six years. The work consisted of two Congressionally authorized programs, including *Substance Abuse and Suicide Prevention* (SASP; previously called Methamphetamine and Suicide Prevention Initiative) and *Domestic Violence Prevention* (DVP). To increase the likelihood of matching the programs to Tribal needs, the IHS subdivided SASP and DVP into six program areas of emphasis:

1. Community Coordination, including risk mitigation assessment and strategic planning,
2. Suicide Mitigation, including prevention, intervention, and postvention,
3. Substance Use Mitigation, including prevention, treatment, and aftercare,
4. Youth Risk Mitigation,
5. Violence Service Coordination, including domestic and sexual violence prevention, advocacy, and coordinated responses, and
6. Forensic Health Services.

The following table summarizes the counts of projects by the cohort program area (PA) participation each year (Y):

Program Areas	Y1	Y2	Y3	Y4	Y5	Y6
PA1: Community Coordination	3	3	3	3	3	3
PA2: Suicide Mitigation	46	45	45	45	45	45
PA3: Substance Use Mitigation	19	19	19	19	19	19
PA4: Youth Risk Mitigation	61	91	108	107	108	108
PA5: Violence Service Coordination	51	51	74	74	74	74
PA6: Forensic Health Services	6	6	8	8	8	8
Total Projects	***186***	***215***	***257***	***256***	***257***	***257***

The cohort experienced changes over time, including additional funding to PA4: Youth Risk Mitigation[1] and PA 5: Violence Service Coordination,[2] and a yearlong extension to the fifth year due to the COVID-19 pandemic, which essentially created a six-year cohort, pushing the end date to September 2021.

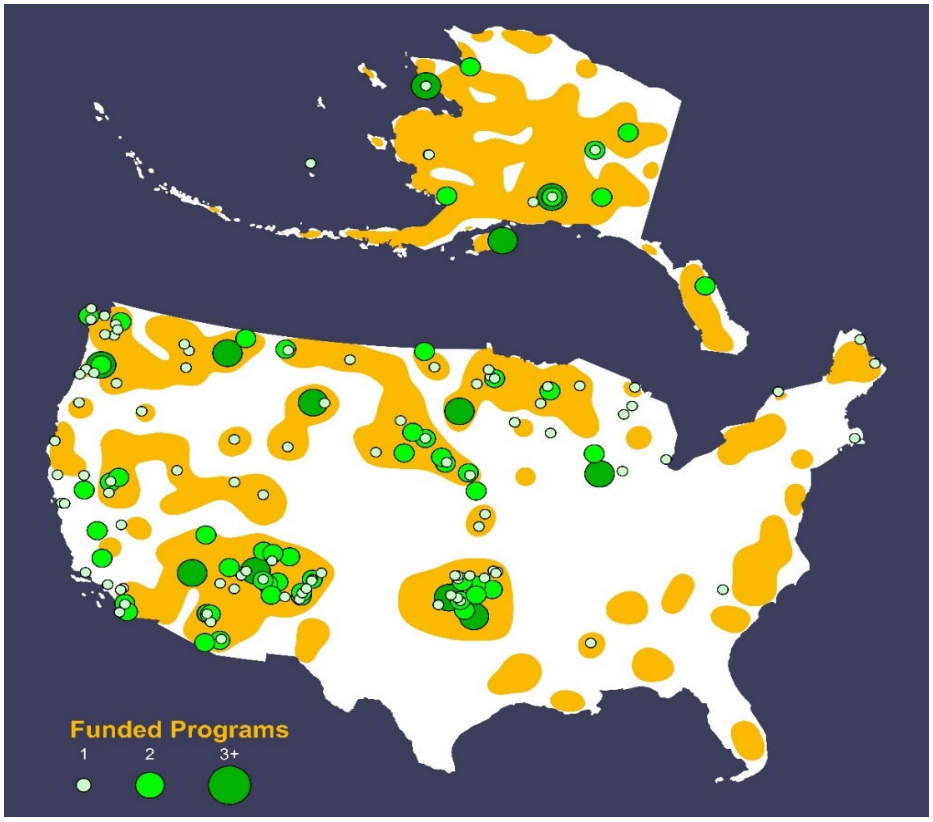
In total, the IHS distributed over $189.3 million in funds to support the six years of field operations among Tribal partners, with $86.3 million specific to the support of youth services. The table below outlines the total of the grant awards by programs and IHS service Area Offices.

[1] IHS Awards $16.5 Million in Grants to Support Behavioral Health Programs | 2017 Press Releases

[2] Methamphetamine and Suicide Prevention Initiative (MSPI). After a successful six year pilot project, the MSPI has been renamed the Substance Abuse and Suicide Prevention (SASP) program

Area Office	Count of Awards	SASP	DVP
Alaska	37	$ 22,217,733	$ 8,450,578
Albuquerque	17	$ 6,474,875	$ 2,866,000
Bemidji	16	$ 8,245,997	$ 2,386,500
Billings	14	$ 5,832,896	$ 1,607,750
California	12	$ 6,783,500	$ 1,898,500
Great Plains	23	$ 11,257,275	$ 6,986,980
Nashville	6	$ 2,936,465	$ -
Navajo	18	$ 14,406,934	$ 7,259,250
Oklahoma City	34	$ 22,233,649	$ 8,262,500
Phoenix	18	$ 9,713,332	$ 4,662,328
Portland	23	$ 8,430,175	$ 2,751,749
Tucson	4	$ 1,426,650	$ 472,625
Urban Indian Organizations	35	$ 15,117,935	$ 6,650,000
Total	***257***	**$ 135,077,416**	**$ 54,254,760**

The following map illustrates the distribution of the project partnerships (green circles) with their counts of grant awards (green circle size), overlayed on Tribal territories that are associated with federally recognized Tribal lands (yellow).[3] The illustration helps covey the complexity of jurisdictional leadership within the potential scope of human risk mitigation.



[3] Map provided by Albuquerque Area Southwest Tribal Epidemiology Center.

Data Collection Methods

In 2015, the IHS arranged a contracted data management team through the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC). The team has consistently provided high-quality data handling in support of Tribes, Tribal organizations, and the IHS, while acting as a trusted third-party agent for data protection, with respect to Tribal data sovereignty. In total, AASTEC has produced ten annual data reports that compliment this evaluation.

The initial IHS data collection methods were limited to a process of receiving scanned images of Tribal partners' annual data reports. The methods proved to be ineffective and inefficient. In response, AASTEC provided significant assistance in converting these images to digital data files. The COVID-19 pandemic required IHS to make some program changes and corresponding changes to data collection items. During these methodological challenges, Tribal partners continued to provide useful data and feedback for analyzing the cohort's impacts in Indian Country.

Following the pandemic, IHS worked with AASTEC to make significant improvements in data collection methods and tools. The IHS team now provides Tribal partners with a convenient and secure method of reporting their multiple projects' data through an online portal with project-specific private accounts.[4] AASTEC hosts and maintains the portal, which is compliant with the Health Insurance Portability and Accountability Act, and provides on-demand training videos for users, a ticket request system for user support, and a guided report template for offline uses. The Grants Quality Service Management Office of the U.S. Department of Health and Human Services reported on the significance of IHS data collection improvements in their June 2024 Tribal Customer Experience Pilot for Post-Award Reporting publication (pages 26-27).[5]

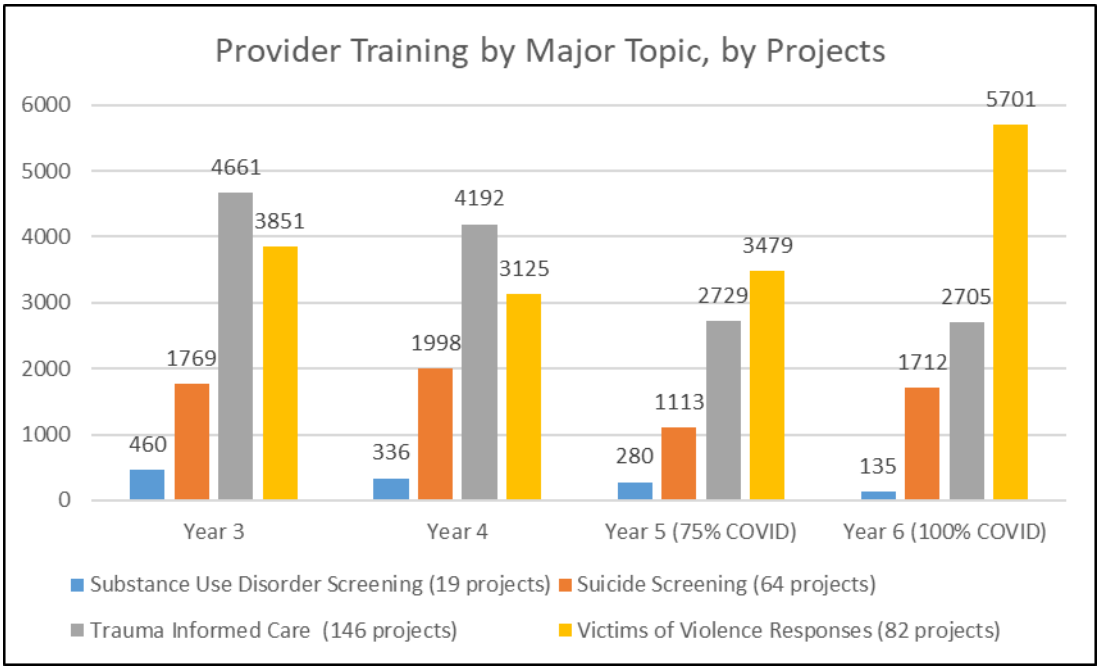
[4] Access the AASTEC portal at https://db.aastec.net/ndcsp/index.html

[5] Access the HHS report at https://www.hhs.gov/sites/default/files/grants-qsmo-tribal-cx-report.pdf

Service Development Trends

Over the six years of the total cohort, Tribal partners completed 6,932 official community partnerships through either new formations or revisions, as a method of building up the local continuums of services for risk prevention and service capacity development. Official community partnerships play a crucial role in the formation of jurisdiction-specific leadership in risk mitigation, and the optimized use of limited resources, especially when specific services are not within a reasonable travel distance to the community.

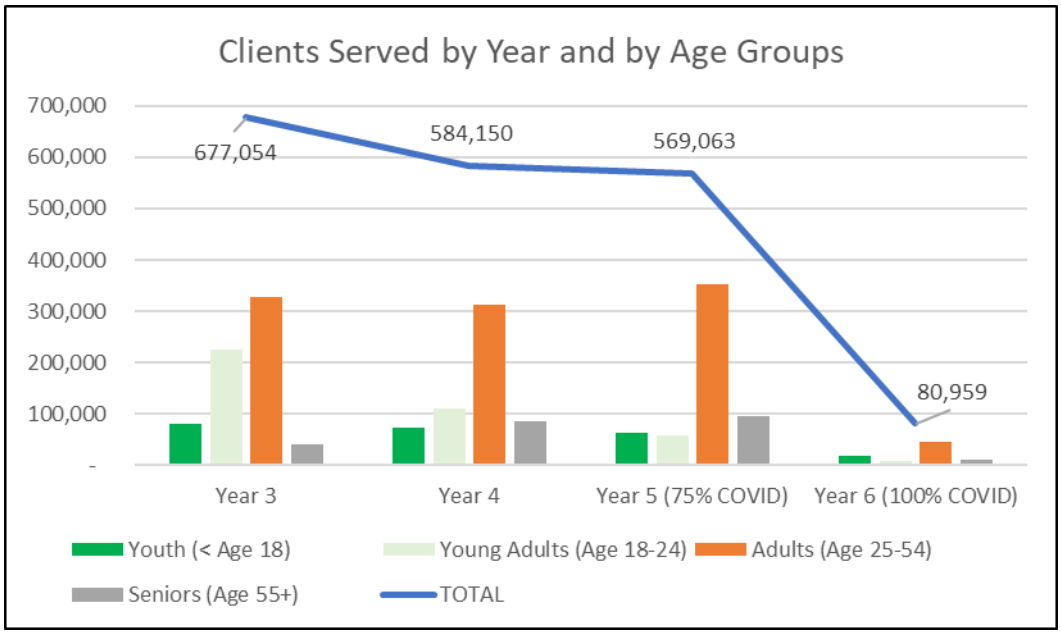
As illustrated below, Tribal partners leveraged community partnerships and their own emerging service capacity to deliver a notable volume of high priority training to healthcare providers. The data are limited to those projects reporting such data and in the final four years of the cohort. The total of not deduplicated counts[6] of training for healthcare providers was 41,245. The demand for victims of violence training increased 39% among healthcare providers during the COVID-19 pandemic.



[6] Counts can include people who participate more than once a year, people who participate in two separate projects located at the same site, and people who participated in the events and chose not to be participate in other activities.

Client Screening Trends

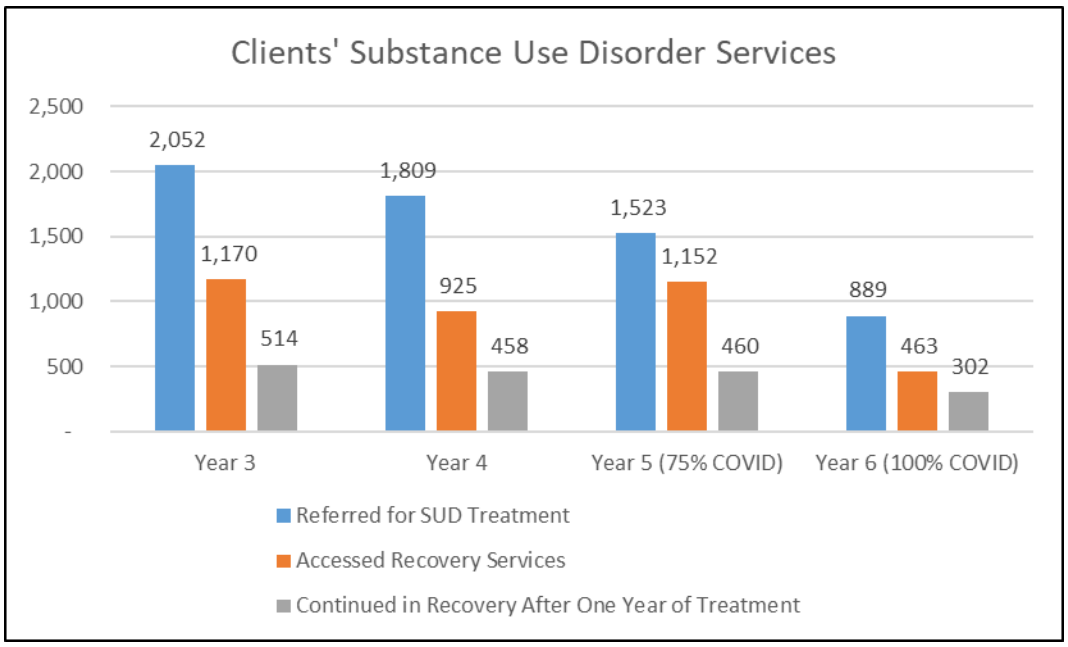
During years three through five, Tribal partners served an average of 610,089 not deduplicated counts of client services per year. The volume of clients served dropped by 603% from year 5 to year 6, due to the COVID-19 pandemic shutdowns. During the four years that IHS collected the client service data, the total of youth (under age 18) and young adults (age 18-24) was 33% of the total client service, which was nearly 2 million (1,911,226).



Projects also provided event-based services to clients as support of their traditional and spiritual interests. In total, 504,155 not deduplicated clients participated in service events, with 67% focused on traditional practices. During the final year of the four programs, which took place entirely during the COVID-19 pandemic, the increase for traditional services was 11% and the increase for faith-based services was 352%. The notable increase in the number of faith-based services in Year 6 is largely attributable to increased service delivery by a Tribal partner with three projects. Some Tribal partners accommodated the schedules of potential clients enabling 6,772 clients to be seen during periods outside regular service hours, 5,862 clients seen through school-based services, and 3,278 clients seen in their homes.

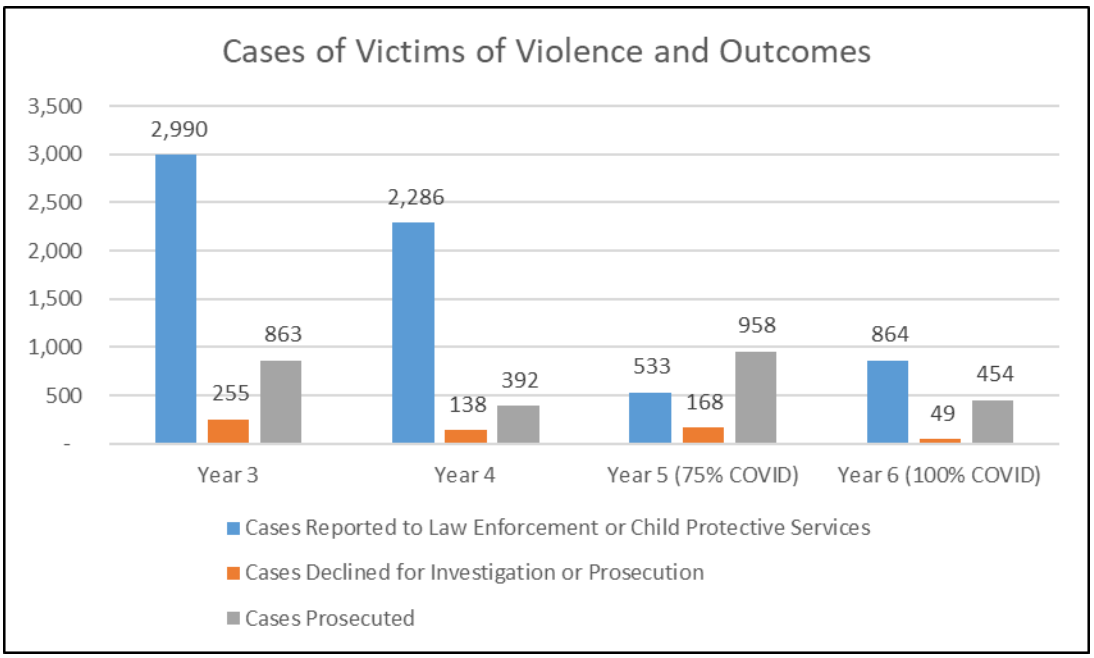
Substance Use Disorder Services

PA3: Substance Use Mitigation including substance use prevention, treatment, and aftercare, included 19 projects that concentrated on addressing substance use disorders (SUDs) in their respective communities. In total, these partners reported completing 69,262 screenings for SUDs and identified 6,273 persons who were referred for SUD treatment. Projects did not report patient-level case data that would describe the patterns of SUD services accessed and used by each client. However, projects reported a total of 3,710 clients who accessed recovery services after their treatment and a total of 1,734 clients who continued in recovery after one year of treatment. While SUD screening nearly tripled in the final year of the program, the client referrals for SUD treatment dropped by 42% and the access to recovery services after treatment dropped by 60%.



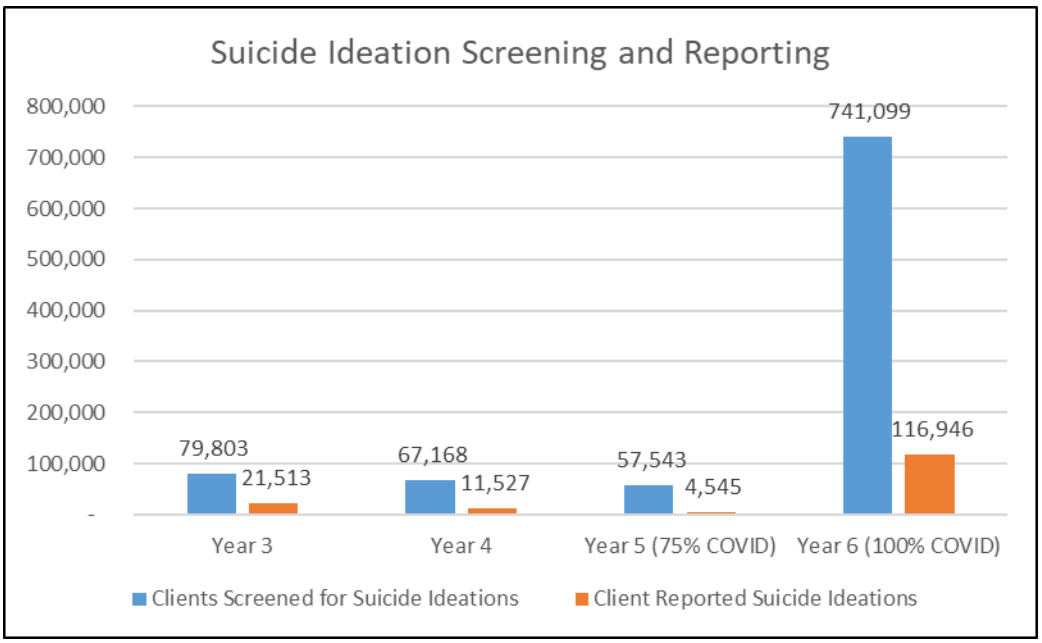
Services for Victims of Violence

Two program areas addressed victims of violence, including violence service coordination (PA5) and forensic health services (PA6), with 74 and eight projects, respectively. The former performed 381,295 screenings for violence and made 104,504 referrals, including referrals for potential victims of assault, human trafficking, sexual assault, and strangulation. Youth accounted for 22% of all screenings. In total, there were 6,989 reported victims of violence, including 37% that were sexual and 33% among children. A total of 1,160 victims received forensic exams through the project services. The number of reported victims increased 152% from year 5 to year 6. The results of the cases are illustrated below. In total, 6,673 cases were reported to law enforcement of child protective services, with 9% declined for investigation or prosecution, 40% prosecuted, and 51% with unknown outcomes.



Suicide Risk Mitigation Services

PA2: Suicide Mitigation including focus on suicide prevention, intervention, and postvention. From year 3 through year 6, the 45 projects completed 945,613 screenings for suicide ideation, averaging over 21,000 screenings per project. Through such screening, 154,531 AI/AN persons reported suicide ideation. As illustrated below, a notable rise in screening and reporting was in year 6, during the COVID-19 pandemic. In total, the projects reported 8,133 suicide attempts and 281 suicide deaths over the four-year period. It is likely that year 6 screening and reporting helped reduce suicides, as the percentage of suicides of those with ideation dropped from 1.23% to 0.04%.



Reported Service Capacity Barriers

Tribal partners consistently reported to the IHS through annual progress reports that they face barriers in developing behavioral health risk prevention and service capacities in their local communities and their broader continuums of services. The following summarizes those barriers.

Staffing
Within the start-up time, projects were unable to attract qualified applicants, such as those having the suitable education, certifications, and AI/AN heritage for the vacant positions. As a result, projects tended to be understaffed, leading to burnout and additional staff turnover. Many projects experienced service demands that far exceeded the local service capacity, which also affected patient follow-up and aftercare. The inadequate supply of external training opportunities for staff was another noted barrier.

Collaboration
Cross-sector collaboration was a consistent barrier for projects. A common barrier was collaboration with the local schools, law enforcement, and even IHS clinics and hospitals. Some projects reported barriers to collaboration among federal and state agencies. Projects also experienced problems with internal collaboration methods, such as poor recordkeeping and delays in procuring the equipment needed and training. Projects noted a lack of community trust and poor communication about the client's needs hindered collaboration.

Basic Services
Projects faced major deficits in basic human services. They cite problems with providing their clients with access to shelters and safe houses, or transitional housing when pursuing treatment. Furthermore, some noted that the lack of protocols with law enforcement, legal services, and case reporting affected their ability to protect clients' safety. Projects struggled with securing appropriate client spaces for services. Some projects noted that the inability to offer food to clients is a service barrier.

Access
Travel distance was a common barrier for projects, given the rurality and large geographic service areas. With insufficient transportation to meet local needs, clients were often unable to reach services. A lack of access to innovative service technologies was also a notable barrier.

Pandemic
The COVID-19 pandemic created significant barriers, including restricted access to Tribal services, delayed or cancelled events, service partner closures, travel bans, furloughed staff, closed schools, and staff and resources re-directed to COVID-19 responses.

Service Outcomes and Costs

Overall, the 2015 to 2021 cohort of 257 Tribal partnerships, as risk prevention and service capacity development projects, demonstrated notable successes despite structural barriers and the COVID-19 pandemic.

The projects built local service capacities through nearly 7,000 new or enhanced partnerships and delivered a volume of training-to-recipient counts that were over 40,000 for providers and over 100,000 for community volunteers. On average, they served over 600,000 clients a year until the pandemic, which then shifted to a notable increase in demand for traditional and faith-based services. They completed nearly 70,000 screenings for substance use disorders, identifying over 6,000 cases. Tribal partners also completed over 380,000 screenings for violence, identified nearly 8,500 cases, including 471 cases of human trafficking. They also completed nearly 950,000 screenings for suicide and identified over 150,000 AI/AN persons at-risk, with a massive increase in such risk during the pandemic.

The projects' development methods include a variety of activities, such as designing service protocols and policies, improving data gathering and handling, producing educational and outreach media, and educating and motivating volunteers and staff. Common difficulties in these projects include involving youth in prevention and treatment, tracking and encouraging the course of substance use disorder treatments, and prosecuting crimes for victims of violence. The project challenges are consistent with the general difficulty of operating across domains and sectors, such as using common decision-ready data among disparate health systems, justice systems, and educational systems.

The cost-effectiveness of the program design is difficult to measure, given the limited data that IHS collects from Tribal partners and the fact that costs are not attributed to the three phases of working with clients, such as general engagement, screening, and specialized services. The total cost of funding this total cohort was $189.3 million, drawing from congressionally appropriated budgets that included $135.0 million to mitigate substance use and suicide risk, with a portion of $86.3 million to mitigate youth substance use and suicide risk ("generation indigenous"), and another $54.3 million to mitigate risks associated with domestic violence.

Starting with the domestic violence program, the cost for serving all clients, including engagements and screening, was $197 per person. If the cost is only attributed to the 8,475 victims served, the cost per victim was $6,402. Victim cost is expected to be high because of the complexity of such cases, including the provision of forensic exams, personal safety, and legal services. The cost complexity may be notable higher among AI/AN persons, as reported by the Government Accountability Office after interviewing those who serve these clients, "AI/AN survivors may also not report sexual assault out of concern they will jeopardize their access to Tribal resources and support by reporting a perpetrator who can leverage their influence within the Tribal Nation to deny these resources to survivors, according to officials from another Tribal advocacy organization."[7]

[7] U.S. Government Accountability Office. Sexual Assault: States Provide for Survivors to Access Free Forensic Exams but Total Costs are Unknown. 2024, GAO-24-106036.

The program cost for substance use disorders and suicide risk is complicated by the definition of youth. Youth may be described as younger than 18 years old, or less than 25 years old. Among services for AI/AN persons, it is not uncommon to see young adults, from ages 18 to 24, included in the youth population. If the youth in this cohort are counted as less than 25 years old, that service cost is $80 per encounter. However, if we only count youth as less than 18 years old that service cost is $277 per encounter. It is important to note that these are not cases, rather they are youth encounters, so the same young person can be seen more than once a year, and over several years. In a similar manner, the adult costs must consider the starting ages of youth. If we count adults as those over the age of 24, the service cost is $84 per encounter. However, if we count adults as being over the age of 18, the service cost is $63 per encounter. Due to the lack of precise data, we are unable to estimate the costs per person identified at-risk for substance use disorders or suicides.

The benchmarks for the expected cost of services vary in the market, and there are no benchmarks for the cost of services in Tribal communities or among facilities that serve AI/AN persons. The benchmark cost problem is further illustrated in the highly varied cap of expenditures by states for sexual assault examinations.[8] The most generous state is North Dakota, with a cap of $660,000 for all related services, followed by Florida at $224,000. These services include medical exams and treatments, and services for psychological treatment, transportation or relocation, and loss of income as a type of disability insurance. Eight states have high cap expenditures for medical exams and treatments between $40,000 and $50,000 (Arkansas, Kansas, Minnesota, New Jersey, North Carolina, Ohio, Pennsylvania, and Texas). Of the other 24 states that report their expenditure caps, the average limit is $21,083. Sixteen states either do not report their expenditure caps, or they itemize each item to control the total costs. Comparing the average Tribal partner cost of $6,402 to the average state cost, of $21,083, the AI/AN service cost per victim is 229% less.

Without detailed data about the cost of specific services by Tribal partners, the IHS is unable to determine the cost-effectiveness of the cohort. This is generally acceptable by Tribes, as their political sovereignty warrants discretion in the management of grants and contracts issued by the federal government.

[8] U.S. Government Accountability Office. Sexual Assault: States Provide for Survivors to Access Free Forensic Exams but Total Costs are Unknown. 2024, GAO-24-106036.

Recommendations for Near-Term Actions

The mission of the IHS is to improve the physical, mental, social, and spiritual health of AI/AN persons in Indian Country and among Tribes. Analyses of IHS strategies, including this 2015 to 2021 cohort of Tribal partnerships, is an opportunity to evaluate how the IHS can improve its methods of fulfilling its mission when its customers are potentially outside the scope of direct IHS health system operations. The following are five near-term actions that warrant a review by the IHS and the U.S. Department of Health and Human Services:

1. The IHS should build an analytic capacity that is sufficient for proactive national, regional, and local strategic actions. The IHS is authorized to perform a range of evidence-informed risk mitigation actions under the authority of the Indian Health Care Improvement Act (IHCIA; 25 U.S.C. § 1601-1683). To date, IHS does not operate the level and scope of applied research that is needed to meet IHCIA requirements. The purpose of the IHCIA-required analyses is to identify the protective and risk factors that lead to multifactorial causes of psychological ill-health, as well as the interrelationships and interdependencies of ill-health on behaviors that cause accumulative unwanted suffering in AI/AN persons and their communities (§ 1605n). Furthermore, the IHS is required to use applied research to develop comprehensive plans with various partners to mitigate risks through local continuums of services (§ 1665a(c)(1)), with an emphasis on risk among AI/AN youth (§ 1605n(b)). As expected, IHS is required to evaluate and report the results of diverse program and strategy analyses (§ 1621h(j)) and sustain simplified access to such reports by Tribes and Tribal organizations through a readily accessible national clearinghouse and related tools (§ 1665a(b)(2)), which in contemporary terms is an online engagement platform and self-service applications. Moreover, the reports are necessary to coordinate cross-domain and cross-sector actions with pertinent federal agencies, with an emphasis on the Bureau of Indian Affairs (§ 1665b(a)).

2. The IHS should identify priority geographical gaps in regional continuum of services, where specific services are necessary for mitigating complex risk conditions. All Tribes would benefit from a national computable geographic atlas of trending human risks and risk mitigation capabilities by jurisdictions. Such an atlas would help clarify the continuums of services, persistent and overwhelming local health risk burdens, and gaps in service capacity and infrastructure to mitigate such risks. Federal agencies, including the IHS, can provide economies of scale for testing and vetting innovations that can advance the impact of local service providers, self-services, and service decision-making in complex cross-domain and cross-sector requirements.

3. The IHS should lead the federal use of jurisdictional-specific contracts to develop the infrastructure for specific service capacities in evidence-based priority areas. Congress set a precedent for burden-specific priority funding of services when it appropriated funds for the city of Gallup, New Mexico. The funding specified a facility for residential detoxification and a regional scope of risk mitigation, centered in McKinley County. The county is ranked at the top of the nation for its burden of alcohol-related deaths among AI/AN persons (2018-2023), including measures of period-long rates over the national

non-AI/AN rates, persistence year over year, a notable percentage of the total national AI/AN deaths, and a growth rate over 15%. The county is geographically in a region that includes nine other counties that meet these same measures. Following this notable precedent, the IHS can use geographical analyses of persistent human risk burdens to prioritize jurisdictions for service partnerships. Ideally, IHS would use flexible federal contracting authority to provide Tribes and Tribal organizations opportunities to fund specific service and infrastructural requirements per jurisdictional and service capacity goals and partnerships. The same contracts can be used to gain rapid access to services and tools that have been tested and reported on by the IHS analytic services. One example is the use of multi-spectrum light devices to detect and record evidence of injuries, such as subdermal damage to skin and other body tissues. Another example is the deployment of mobile medical units that can perform small-scale magnetic resonance imaging (MRI) or other hospital-level services in remote places.

4. The IHS should cooperate with federal agencies to apply analytic methods to emerging policies that affect AI/AN persons and Tribes. For example, evidence is required to determine the unwanted effects of using contingency management (CM),[9] a mechanistic intervention for risk mitigation in SUD treatment, which can negatively affect self-efficacy and community reinforcement approaches (CRA),[10] which are critical to the integration of traditional practices, spiritual interests, employability, and volunteer sponsorships.

Recent analytic actions by the IHS have prepared it for these near-term actions. These include responding to the National Tribal Behavioral Health Agenda,[11] as well as, analyses of (a) youth services for treating substance use disorders, (b) potential gaps in the comprehensiveness of local continuums of services for youth services, (c) the IHS methods of suicide risk mitigation, and (d) Tribal service capacity development for risk mitigation.[12] The IHS also works with other federal agencies to address cross-domain aspects of risk mitigation, including risks associated with justice matters, psychological coherence among soldiers[13] and isolated youth during the pandemic.[14]

[9] U.S. Health and Human Services. Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention. https://aspe.hhs.gov/reports/contingency-management-treatment-suds

[10] Developed by Nate Azrin in the 1970s, updated analyses of the methods are useful resources: Meyers RJ, Roozen, HG, Smith JE. The community reinforcement approach: An update of the evidence. Alcohol Research and Health, 33(4), 380-8, 2011.

[11] National Tribal Behavioral Health Agenda https://www.samhsa.gov/tribal-affairs/national-tribal-behavioral-health-agenda

[12] See IHS behavioral health analyses published at https://www.ihs.gov/dbh/

[13] Beymer M, Apostolou A, Smith C, Paschane DM, Gomez SAQ, James TD, Bell AMM, Santo TJ, Quartana, PJ. Mental Health Outcomes among American Indian and Alaska Native U.S. Army Soldiers: A Serial Cross-Sectional Analysis. Military Medicine, USAD049, 2023.

[14] Ali MM, West, KD, Dubenitz J, End of Horn P, Paschane D, Lieff S. Racial/Ethnic Differences in Suicidal Behavior among Medicaid Covered Children During the COVID-19 Pandemic. JAMA Pediatrics, E1-E2, 2023.

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