

TO: Megan DesCamps; Alison Grigonis
FR: Dr. Jacque Gray
RE: Follow-up Discussion Regarding Mental Health Care in Indian Country

Date: May 20, 2014

Purpose: Follow-up discussion from April 8, 2014 meeting with Sen. Heitkamp, Megan Descamps and Alison Grigonis regarding mental health care in Indian country.

Background: Dr. Jacqueline Gray is a research associate professor and the associate director of indigenous programs at the Center for Rural Health and the Department of Pathology at the University of North Dakota (UND) School of Medicine and Health Sciences. Gray directs the Seven Generations Center of Excellence in Native Behavioral Health (SGCoE) and the National Indigenous Elder Justice Initiative (NIEJI). She works with the National Resource Center on Native American Aging (NRCNAA), National Institute of Mental Health (NIMH) Outreach Partnership, Rural Psychology and Integrated Care and the UND American Indian Health Research Conference. Gray also directs the Native Research Health Team and mentors over 25 Native students on research in Indian Country. On April 8, 2014, Dr. Gray testified on behalf of the Friends of Indian Health Coalition before the House Appropriations Committee Subcommittee on the Interior regarding Indian Health Service (IHS) funding.

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Legislative and Regulatory Suggestions from Dr. Jacque Gray Re: Improvements to Mental Health Services and Outcomes in Indian Country

- I. Post-doc positions with IHS for IHS Scholarship applicants
 - a. Rationale: Students with IHS scholarships have to have time and a job somewhere to get their post-doc hours and get licensed. This takes from 1-2 years depending upon state licensure requirements. During that time, they don't qualify for IHS positions to do their payback or even get into the system, because they aren't yet licensed. It would help if there were IHS post-doc positions that could be for IHS scholarship recipients so they could have a place to get that supervised post-doctoral experience needed for licensure.
 - b. Suggested Course of Action: Provide Post-doctoral positions within IHS behavioral health for IHS scholarship recipients that would be up to two years to get licensure.
- II. Tele-supervision for students & post-docs
 - a. Rationale: Many times with placements in rural and tribal areas there is not a licensed supervisor within a reasonable commuting distance for students and

post-graduate clinical work toward licensure. Licensing boards in many states do not allow for tele-supervision (require face to face supervision which is interpreted as in-person) for licensure. Many have to find jobs in urban areas where they can get supervision to be licensed and then do not move to the rural areas. Once the providers are established in urban areas they are less likely to move to rural and remote areas.

- b. Suggested Course of Action: Encourage licensing boards through CMS reimbursements or other mechanisms to allow for video tele-supervision to rural and remote areas to encourage the location of newly graduated providers to these areas.

III. Community of Practice conference calls/webinars to prevent isolation of providers

- a. Rationale: Providers practicing in rural and remote areas have no colleagues to interact with and because the work they do is confidential, they may be very isolated socially and professionally in the rural and remote communities. Providing a mechanism for discussing cases with other professionals and learning about solutions other practitioners have used for similar types of problems can give the rural provider a sense of community and reduce burnout.
- b. Suggested Course of Action: Establish state or regional Communities of Practice (CoP) through SAMHSA programs where practitioners in rural and remote areas can sign up to join and be part of monthly webinar/video/tele-conferences that allow for sharing of ideas and needs within this community.

IV. Pipeline to train more people to provide culturally appropriate trauma focused training for Indian Country

- a. Rationale: Currently, the Indian Country Child Trauma Center at the University of Oklahoma is one of the only training programs for culturally adaptable trauma focused treatment of children that is operating. There is a need for more Native trainers to cover all the needs in Indian Country. Providing funding to the current center for a training of trainers program through post-doctoral training that will establish more facilities to provide this needed service. There are too many non-native contractors trying to fit their programs to tribes and the site visits and technical assistance requirements become a burden to tribes. Development of trauma informed therapy training in tribal colleges, masters and doctoral programs.
- b. Suggested Course of Action:
 - i. Paraprofessional programs that are reimbursed through CMS like the behavioral health aides in AK
 - ii. Educating our professionals on trauma informed care with clinical placements in training to give them experience before working in the communities.
 - iii. Funding to train more Native clinicians on trauma informed care including funding for post-doctoral fellows to become trainers.

- V. List IHS Psychologists positions as "licensed psychologists" to include all licensed psychologists instead of listing as clinical psychologists.
 - a. Rationale: There are many openings for psychologists in Indian Health Service. When they send out a list to CEOs to ask what health professionals are needed, currently they list "Clinical Psychologist" and "Counseling Psychologist" separately. CEOs have probably never heard of "Counseling Psychologists" and, therefore; only mark "Clinical Psychologists" so that's all that IHS advertises for. Clinical Psychologists, Counseling Psychologists, and School Psychologists all take the same exam and meet the same requirements for the same license as "Psychologists". Including Counseling and School Psychologists would increase the numbers of licensed psychologists to fill positions and at the same time increase the numbers who are trained to work with children and understand developmentally the needs of children.
 - b. Suggested Course of Action: Make the change from Clinical, Counseling, or School Psychologist to "Licensed Psychologist" so that any psychologists who is licensed can apply for the position and that they would not be categorized as "Clinical Psychologists" only.

- VI. More funding for loan repayment for IHS & NHSC
 - a. Rationale: The majority of positions for IHS and tribal behavioral health are qualified for loan repayment. Many of the applications by providers serving in these desperately needed locations are not funded due to the lack of funding for the IHS and National Health Service Corps loan repayment programs.
 - b. Suggested Course of Action: Increase funding for loan repayment programs to address more applications from those in areas of great need.

- VII. Support through BIA for counselors & psychologists in tribal schools to address problems early
 - a. Rationale: There is a lack of behavioral health providers in Indian Country. There is even a greater lack of providers who are trained to address the needs of children in Indian Country. Many schools do not have counselors in tribal schools.
 - b. Suggested Course of Action: Provide funding for positions for psychologists and counselors in BIA and tribal schools. These counselors and psychologists could address many of the needs of youth prior to their reaching the need for IHS providers or hospitalization if done during the school day at the school facility.

- VIII. MOUs between IHS & psych training programs to facilitate student placements
 - a. Rationale: IHS has a great need for behavioral health services at their facilities. Training programs for masters and doctoral level behavioral health professionals need supervised clinical placements for students to receive the necessary training to become licensed behavioral health professionals. Most of those placements are two days per week. Most of the training programs have certain criteria that must be met for a training site. IHS facilities have certain criteria for

student/volunteer placements. It also helps if funding or some type of assistance can be provided for lodging and mileage for the trips which may be up to 200 miles one way.

- b. Suggested Course of Action: Facilitate the utilization of rural and remote placement opportunities through Center of Excellence, Graduate Psychology Education, and other mental health training programs for rural, remote, and tribal placements. Have Memoranda of Understanding/Agreement established at the IHS Area level and University Training Programs to facilitate screening and placement of students.

IX. Support to evaluate tribally based practices to develop evidence of what works in Indian Country

- a. Rationale: There are very few evidence-based practices for mental health treatment and prevention programs that have been proven to work in Indian Country. Most evidence based practices are not culturally appropriate. Many tribes and practitioners have developed or adapted programs for use within Indian Country, but they have not been empirically tested. These may be viewed as promising or practice based evidence in Indian Country, but are not recognized by programs requiring the use of evidence based practice.
- b. Suggested Course of Action: Providing funding to evaluate community based and developed programs in Indian Country so that grant funded programs that are developed such as through the Garrett Lee Smith Tribal Suicide Prevention Grants and National Center on Elder Abuse Elder Abuse Prevention Grants or other programs developed in tribal communities to establish some evidence as to their effectiveness for treatment or prevention. Small grants could be utilized to evaluate these programs.

X. Support for training of trainers in Mental Health First Aid (MHFA) for rural & tribal communities.

- a. Rationale: There are not enough providers for mental health in Indian Country or rural North Dakota. There are large numbers of paraprofessionals that work with youth programs, organizations, etc. that have no mental health training. A program such as MHFA that addresses a more general need than suicide gatekeeper trainings would be beneficial in 1) how to talk with people in crisis, 2) how to de-escalate situations, and 3) how to get people to appropriate resources. MHFA would be great training for school staff, police officers, firemen, clergy, foster parents, domestic violence volunteers, and youth workers. In rural areas during the farm crisis we even talked about the need for bankers to be trained in MHFA to help reduce the farmer suicide rate. Unfortunately there are very few trainers in the rural and remote areas. It would be good if there were a training team in each reservation, county, or region that could focus on completing the trainings in that area.
- b. Suggested Course of Action: Support for MHFA Training for Trainers for tribal, rural and remote area training teams. WICHE has provided a training for

trainers for its member states, but only two or three trainers per state are not enough. Many of those who are sent to be trained are too busy to focus on just doing the trainings or doing enough trainings every year. They are stretched too thin. We need more trainers in these areas. North Dakota only has three trainers for the entire state. Two of those trainers are at Universities (different ones) and the third is in the western part of the state by herself. None are on reservations although one is Native.

- XI. Mechanism for paraprofessionals' services and other health professionals to be paid through CMS.
- a. Rationale: Community Health Workers and other pre-bachelor's degree level providers are trained through tribal colleges on reservations, but there is no funding stream to pay for the services they provide to elders, the disabled, and youth. Programs exist to train these paraprofessionals and more than one tribal college is preparing Native Elder Caregivers, Behavioral Health Aides, and other pre-bachelors level health professionals, but when they finish the training, there are no jobs they can be paid for. In addition, North Dakota is working to develop a community paramedic program (i.e. an expanded role for paramedics outside of traditional EMS roles). The Community Paramedic would be another class of health professionals for which expanded service options with accompanying reimbursement streams should be sought.
 - b. Suggested Course of Action: Payment for Home Health Aides, Behavioral Health Aides, Community Health Workers to provide medication review, case management, and elder caregivers through CMS. Cankdeska Cikana Community College has implemented the Native Elder Caregiver Curriculum developed by the National Resource Center on Native American Aging for an Associate's Degree. Sitting Bull College is also implementing the program. Dr. Chris Burd (retired Nursing professor at UND and faculty at CCCC) and John EagleShield (Senior Community Health Representative at Standing Rock) have been trying to get funding for properly trained CHRs through CMS for over 10 years.
- XII. Increased funding to Health Resources and Services Administration (HRSA), Office of Rural Health Policy (ORHP) to target increased and improved access to mental and behavioral health services for tribal, rural, and other remote sites through the existing Rural Health Outreach, Rural Health Network Development, and Rural Health Network Planning grants.
- a. Rationale: While mental and/or behavioral health can be addressed through these programs, they must compete with a wide range of important rural and tribal health needs. The three ORHP grant programs are the only federal grant programs exclusive to "rural health." The need to address rural mental health in North Dakota and other states is increasing. For example, the Center for Rural Health has used three separate statewide processes that have indicated a high need for improved access.
 - b. Suggested Course of Action: The three ORHP rural health grant programs should be expanded to include a set aside for rural and tribal mental and behavioral health innovation grants. Funding should be increased to support innovation

grants to address programmatic/service efforts (Outreach grants), mental health networks (Network Development grants), and one year mental health planning grants (Rural Health Planning grants). The core funding for these three grants should remain; however, to assure that there is a focus on improving rural and tribal access to essential mental health services innovation grants (for up to three years) should be encouraged with a specific funding target.