Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ACCESS TO MENTAL HEALTH SERVICES AT INDIAN HEALTH SERVICE AND TRIBAL FACILITIES

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which American Indians and Alaska Natives (AI/AN) have access to mental health services at Indian Health Service (IHS) and tribal facilities.

BACKGROUND

A member of Congress expressed concern about AI/ANs' access to mental health services and requested that the Office of Inspector General conduct this evaluation. According to a Government Accountability Office report, the demand for mental health services outstrips capacity at some IHS and tribal facilities.

AI/ANs experience a disproportionately higher rate of mental and behavioral health challenges compared to other populations in the United States. AI/ANs rank first among ethnic groups as likely to suffer mental health disorders such as anxiety and depression that can lead to suicide. They rank second to white non-Hispanics in suicides. The suicide rate among AI/ANs age 13 to 20 is 2.3 times the national average. Additionally, AI/AN communities experience high rates of suicide risk factors, such as low household income and high unemployment.

IHS and the tribes provide mental health services, including inpatient and outpatient care and residential substance abuse treatment. Mental health services include, but are not limited to, all psychiatric services, behavioral health services, substance abuse treatment, and traditional healing practices. These services are performed by licensed and unlicensed health care providers and are generally delivered in hospitals, health centers, urban Indian programs, and health stations.

Our findings are based primarily on a survey of IHS and tribal facilities that provided health care services from January 2008 to June 2009. The survey response rate was 82 percent (630 of 772 facilities). We also conducted onsite interviews at a sample of 98 facilities and at all IHS Area Offices.

FINDINGS

Eighty-two percent of IHS and tribal facilities reported that they provide some type of mental health service; however, the range of available services is limited at some facilities. Of the 630 IHS and tribal facilities that responded to our survey, 514 reported that they provided some level or type of mental health service. The 116 facilities that do not provide mental health services refer clients to other providers either in the non-AI/AN community or on the reservation. Thirty-nine percent of the facilities reported that they provide crisis intervention 24 hours a day.

Staffing issues and shortages of highly skilled providers limit AI/ANs' access to mental health services at IHS and tribal facilities. Although 82 percent of the surveyed facilities reported that they provide mental health services, a variety of staffing issues affect access to services. Facilities that do not provide mental health services reported that staff shortages are part of the reason. Shortages of psychiatrists and other licensed providers at IHS and tribal facilities limit access to mental health services. Some facilities reported that social workers, counselors, and nurses provided pharmacotherapy (medication management) services to meet AI/ANs' needs. To help address shortages of licensed providers, 17 percent of IHS and tribal facilities (87 of 514) use telemedicine for mental health services.

Physical, personal/social, and economic challenges may affect access to mental health services at IHS and tribal facilities. Approximately half of facilities (274 of 514) reported that physical barriers, such as travel conditions, affect clients' access to services. Approximately one-third of facilities (175 of 514) reported that personal and social barriers, such as the lack of child care, affect clients' access to services. Nearly one-third of facilities (147 of 514) reported that economic issues, such as difficulty paying copayments, affect access to services.

RECOMMENDATIONS

The high rates of suicide, substance abuse, depression, unemployment, and poverty in AI/AN communities contribute to the need for access to mental health services. Although 82 percent of IHS and tribal facilities reported that they provide mental health services, access to some services is limited by shortages of highly skilled

providers and by other staffing issues. In addition, the majority of AI/ANs attempting to obtain these services live in rural areas and face physical, personal/social, and economic barriers that limit access.

When we conducted this study, IHS could not provide a complete and accurate list of all IHS and tribal health care facilities. Therefore, we have no assurance that we have a database that represents all such facilities.

To address these issues, we recommend that IHS:

Provide guidance and technical assistance to help tribes explore potential partnerships with non-AI/AN providers of community mental and behavioral health services.

Continue to expand its telemedicine capabilities and provide guidance and technical assistance to tribal health care providers to expand and implement telemedicine.

Develop a plan to create a single database of all IHS and tribal health care facilities.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

IHS concurred with all of our recommendations. We did not make any changes in the report based on IHS's comments. For the full text of those comments, see Appendix G.

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INTRODUCTION

OBJECTIVE

To determine the extent to which American Indians and Alaska Natives (AI/AN) have access to mental health services at Indian Health Service (IHS) and tribal facilities.

BACKGROUND

A member of Congress expressed concern about AI/ANs' access to mental health services and requested that the Office of Inspector General (OIG) conduct this evaluation. According to a Government Accountability Office (GAO) report, the demand for mental health services outstrips capacity at some IHS and tribal facilities.[1]

AI/ANs experience a disproportionately higher rate of mental and behavioral health challenges compared to other populations in the United States. AI/ANs rank first among ethnic groups as likely to experience mental health disorders such as anxiety and depression that can lead to suicide.[2] They rank second to white non-Hispanics in suicides. See Table A in Appendix A for further information on health disparities.

In comparison to other populations, AI/AN youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse, and depression.[3] The suicide rate among AI/ANs age 13 to 20 is 2.3 times the national average. Suicide is the second leading cause of death and accounts for 19 percent of all deaths among AI/AN youth.

Additionally, AI/AN communities experience high rates of suicide risk factors, such as low household income and high unemployment.[4] The

[1] GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, GAO-05-789, August 2005.

[2] L.M. Olson and S. Wahab, "American Indians and suicide: A neglected area of research." *Trauma, Violence, and Abuse*, 2006, 7(1), 19-33.

[3] Suicide Prevention Resource Center, *Suicide Among American Indians/Alaska Natives*, April 5, 2007. Accessed at http://www.sprc.org/library/ai.an.facts.pdf on April 19, 2010.

[4] Peggy Halpern, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, *An American Indian/Alaska Native Suicide Prevention Hotline: Literature and Discussion with Experts,* November 2009. Accessed at http://aspe.hhs.gov/hsp/09/AIAN-SuicidePreventionHotline/index.shtml#risk on March 29, 2011.

income of one in every four AI/ANs falls below the Federal poverty level, a rate approximately twice that of the total population.[5] In the first half of 2009, the AI/AN unemployment rate was 13.6 percent.

The Federal Government first authorized appropriations for AI/AN health care in 1921 under the Snyder Act, which provided for "relief of distress and conservation of health."[6] The Indian Health Care Improvement Act (IHCIA) was enacted in 1976 to improve the services and facilities of Federal AI/AN health care programs.[7] The IHCIA expired in 2000, but Congress continued to appropriate funds annually for AI/AN health care. In 2010, the President signed the Patient Protection and Affordable Care Act of 2010 (ACA),[8] which reauthorized appropriations for the IHCIA and stated "that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy…."[9]

IHS-Funded Health Services

IHS is an agency in the Department of Health and Human Services (HHS) responsible for providing Federal health services to AI/ANs. Headquartered in Rockville, Maryland, IHS operates from 12 Area Offices across the country; these offices oversee the delivery of health services and provide administrative and technical support. IHS's mission is to raise AI/ANs' "physical, mental, social, and spiritual health to the highest level."[10] Members of the 564 federally recognized tribes are eligible for IHS health care. In partnership with the tribes, IHS

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[5] U.S. Census, *Population Profile of the United States: Dynamic Version,* Part V: Household Economics, Poverty in 2005. Accessed at http://www.census.gov/population/www/pop-profile/files/dynamic/poverty.pdf on June 23, 2011.

[6] Snyder Act, 1921, P.L. 67-85 § 13, 42 Stat. 208, 25 U.S.C. § 13.

[7] IHCIA, P.L. 94-437, 25 U.S.C. 1602.

[8] ACA, P.L. 111-148.

[9] ACA, Title X Part III § 10221, S. 1790 Title I § 103.

[10] IHS, *Indian Health Service Fact Sheets: Indian Health Service*. Accessed at http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp on February 15, 2009.

provides services to 1.9 million[11] of the approximately 4.3 million AI/ANs living in the United States.[12]

Indian Self-Determination and Education Assistance Act. In accordance with the Indian Self-Determination and Education Assistance Act (ISDEAA) (1975), as amended, there are three options for IHS-funded health care services.[13]

1. Tribes, independently or through tribal organizations or tribal consortiums, may choose to have IHS continue to provide health services directly to their members.
2. Through Title I, tribes can receive a share of money that IHS would have used to administer and operate health services. Under this option, commonly known as "638 contracting," tribes negotiate with IHS for funds to provide health services directly to their members, and IHS retains a measure of oversight and supervision.
3. Under Title V, self-governance compacts allow tribes to receive their share of money from IHS to provide direct health services and to assume greater control over the administrative functions that support the delivery of the services and tailor services to the needs of their communities.[14] Self-governance compacts offer tribes a greater degree of autonomy than does 638 contracting.

Direct Care Services. AI/ANs receive direct care services from IHS-operated or tribally operated facilities, generally hospitals, health centers, or health stations that provide direct health care services. In some situations, IHS and tribal programs share a building or hospital in which they operate their respective programs. Tribes, tribal consortiums, and IHS also may enter into cooperative arrangements with independent providers for specific services to be performed at their

[11] The remainder of AI/ANs may receive health care through other sources such as employer-provided health benefits, veterans' health services, or Medicare and Medicaid.

[12] U.S. Census Bureau, *We the People: American Indian and Alaska Natives in the United States*, February 2006. Accessed at http://www.census.gov/population/www/socdemo/race/censr-28.pdf on May 9, 2011.

[13] ISDEAA, 1975, P.L. 93-638, as amended.

[14] IHS, *IHS Fact Sheets: Tribal Self-Governance,* January 2009. Accessed at http://info.ihs.gov/TrblSlfDtrm.asp on January 14, 2009.

facilities. These may include dialysis and dialysis services, mobile diagnostic services, and psychiatric services.

IHS and tribal facilities may also bill Medicare and Medicaid for services provided to eligible AI/ANs.[15] For AI/AN Medicaid beneficiaries receiving services from IHS or tribal facilities, the Centers for Medicare & Medicaid Services (CMS) reimburses State Medicaid programs at 100 percent of the Federal medical assistance percentage. AI/ANs receiving services under Medicare at non-IHS or nontribal facilities are responsible for appropriate copayments and deductibles.

Contract Health Services Program. When an IHS or tribal facility cannot provide the required services, IHS and tribes rely on the Contract Health Services (CHS) program, which contracts with private providers such as hospitals and physicians to deliver services. The CHS program is the payer of last resort and often defers or denies lower priority services. [16] According to IHS, the CHS program can typically fund only the highest priority, or Level I, health services. The highest of the four priority levels, Level I services—"Emergent/Acutely Urgent Care Services"—are "necessary to prevent immediate death or serious impairment," and include emergency psychiatric care.[17] Services to address non-life-threatening mental and behavioral health issues are not considered to be Level I.

IHS mental health care programs. IHS and the tribes provide mental health services, including inpatient and outpatient care and residential substance abuse treatment. IHS's 2010 budget appropriation for mental health and alcohol and substance abuse services was 9 percent of its total clinical services budget ($267 million of $2.95 billion).[18] IHS apportions approximately

[15] IHCIA, P.L. 94-437, §§ 401 and 402.

[16] 42 CFR § 136.61. AI/ANs receiving services through CHS programs or Medicaid may not be charged copayments.

[17] IHS, *Contract Health Services, Requirements—Priorities of Care.* Accessed at http://www.ihs.gov/NonMedicalPrograms/chs/index.cfm?module=chs_requirements_priorities_of_care on April 8, 2010.

[18] The fiscal year 2010 appropriation for mental health care ($267 million) is the sum of two line items in the IHS budget for clinical services: mental health ($73 million), and alcohol and substance abuse ($194 million). Accessed at http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS%20FY%202011%20Congressional%20Justification.pdf on May 10, 2010.

50 percent of the $267 million for mental and behavioral health services directly through the tribes, via 638 contracting and self-governance compacts.[19]

Mental Health Care

Mental health services. For the purposes of this report, the term "mental health services" includes, but is not limited to, all psychiatric services, behavioral health services, substance abuse treatment, and traditional healing practices.[20]

Psychiatric and behavioral health services use a variety of techniques to improve individuals' functioning. Psychiatric services include, but are not limited to, psychotherapy and pharmacotherapy (i.e., medication management). Behavioral health services and substance abuse treatment include techniques to improve individuals' physical, mental, social, and spiritual well-being.[21] These services often include health-promotion counseling, 12-step addiction recovery programs, behavioral modification, and therapeutic drug treatment.

In addition, IHS and tribes provide traditional healing practices relevant to a community's unique culture, using a holistic approach to physical, spiritual, and mental health. In the AI/AN community, such treatments can include talking circles and sweat lodges.[22]

Some providers perform mental health services via telemedicine, sometimes called "telepsychiatry." Telemedicine is the use of medical information exchanged from one site to another via electronic communications, such as video conferencing. See Glossary of Terms in Appendix B for more information.

Mental health services providers. A range of providers, with varying scopes of practice, perform mental health services. However, such services are generally performed by licensed health care providers,

[19] Bryan Wooden, Deputy Director of IHS's Division of Behavioral Health. Interviewed on November 19, 2008.

[20] For additional definitions of selected terms and concepts in this report, see the Glossary of Terms in Appendix B.

[21] IHS, *Behavioral Health Home Page*. Accessed at http://www.ihs.gov/MedicalPrograms/Behavioral/ on February 15, 2010.

[22] A talking circle is a traditional method of conducting a discussion in a respectful, egalitarian manner. A sweat lodge is a structure heated by a central fire or steam from water poured on hot stones and is used for ritual or therapeutic sweating.

including psychiatrists, clinical psychologists, clinical social workers, and marriage and family counselors. Licensure requirements vary by State. Primary care providers, such as physicians and nurse practitioners, also perform some mental health services, (e.g., pharmacotherapy and emergency care).

Not all States require that other providers—such as aides, addiction counselors, mental health counselors, and peer counselors—be licensed. Regulations for counselor certification vary from State to State,[23] as do the training requirements for aides.

The IHS Community Health Aide Program includes certification requirements for Behavioral Health Aides (BHA), who provide some mental health services, such as case management and community outreach.[24] BHAs commonly provide mental health services in remote areas, such as Alaskan villages.[25]

Related Reports

In 2005, GAO visited 13 IHS facilities to determine the extent to which AI/ANs had access to health care.[26] GAO found that most facilities offered primary care and dental and vision services, but that access was not always assured because of waiting times and lack of transportation. GAO also found that in some cases, gaps in specialty and behavioral health care resulted in diagnosis or treatment delays that made patients' conditions worse and created a need for more intensive treatment.

In 2009, OIG examined the extent to which IHS and tribes paid for CHS hospital claims above the required Medicare rate from January to March 2008. The study found that IHS and tribes paid above the Medicare rate for 22 percent of hospital claims, resulting in $1 million

[23] American Counseling Association, *Licensure and Certification.* Accessed at http://www.counseling.org/Counselors/LicensureAndCert.aspx on March 29, 2011.

[24] The Community Health Aide Program was established pursuant to IHCIA, P.L. 94-437, § 119, 25 U.S.C. § 1616l.

[25] IHCIA, P.L. 94-437, § 121, 25 U.S.C. § 1616l.

[26] GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, GAO-05-789, August 2005.

in overpayments. If payments for nonhospital claims were capped at the Medicare rate, IHS could have saved as much as $13 million.[27]

In 2010, Senator Byron Dorgan, Chairman of the Senate Committee on Indian Affairs, released a report citing problems with credentialing and licensing of providers, accountability of controlled substances, and management of CHS program funds, among other issues, in the region covered by the IHS Area Office in Aberdeen, South Dakota.[28]

Companion Report

This report is one of two on AI/ANs' access to health care. The companion report is *Access to Kidney Dialysis Services at Indian Health Service and Tribal Facilities* (OEI-09-08-00581).

METHODOLOGY

Scope

This evaluation determines the extent to which AI/ANs had access to mental health services at IHS and tribal facilities between January 2008 and November 2009. We conducted this evaluation concurrently with our evaluation of AI/ANs' access to kidney dialysis services.

We did not review the quality and medical necessity of mental health services or review whether IHS paid appropriately for the services in accordance with Federal laws and regulations.

[27] OIG, *IHS Contract Health Services Program: Overpayments and Potential Savings,* OEI-05-08-00410, September 2009.

[28] U.S. Senate Committee on Indian Affairs, *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area*, December 28, 2010.

Survey and Fieldwork

Stage 1: Survey of IHS and tribal facilities. To identify all IHS and tribal health facilities, we took the following steps:

- To create one master list of IHS and tribal facilities, we combined the multiple lists that IHS provided to us, removing all duplicates.
- Because the list was missing information (e.g., names of current representatives of the facilities), we conducted research online and used an HHS employee directory to confirm information about facilities and their representatives. We also confirmed this information with IHS and tribal staff.
- We then attempted to contact each facility's representative to confirm the name and type of facility and confirm whether it was IHS operated or tribally operated.

We identified 777 IHS and tribal facilities that were providing health care services from June 2009 to November 2009.[29] For the purpose of this report, we excluded five facilities that provided only dialysis services. Therefore, this report is based on 772 IHS and tribal facilities.

We sent one survey per facility to the contact person we had identified. Some contacts were responsible for multiple facilities. We asked them to complete one survey for each facility so that we could attribute each response to the appropriate facility. We made a minimum of three attempts by email and/or telephone to ensure that all contact people submitted their surveys. We received completed surveys from 630 of the 772 facilities, for a response rate of 82 percent. See Tables C-1 and C-2 in Appendix C for details regarding responses.

Stage 2: Fieldwork at 98 IHS and tribal facilities. We visited 98 IHS and tribal facilities in 51 AI/AN communities and reservations. These facilities offered a range of health services, including inpatient and outpatient services and primary and specialty care. We also visited 11 of 12 IHS Area Offices in person and interviewed IHS officials at

[29] We sent surveys to all IHS and tribal facilities beginning in June 2009 and continued to receive responses for 6 months, until November 2009.

the remaining Area Office by telephone. We used standardized interview guides and interviewed 436 IHS and tribal administrators, providers, and clients.

Analysis

We based our findings on the synthesis of survey data, interviews, and observational fieldwork. The data we collected during the onsite work supplemented the survey data. Using SAS software, we analyzed the data collected through our survey and fieldwork.

Limitations

The findings in this report are not projected to all IHS and tribal facilities but are limited to the 630 survey respondents. We conducted the interviews concurrently with our evaluation of AI/ANs' access to dialysis services. Therefore, not all of the 436 interviews specifically addressed access to mental health services.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Eighty-two percent of IHS and tribal facilities reported that they provide some type of mental health service; however, the range of available services is limited at some facilities

Of the 630 IHS and tribal facilities that responded to our survey, 514 reported that they provide some level or type of mental health service. Most of the 514 facilities provide psychotherapy and various support groups. The most commonly provided services include individual child and adult psychotherapy, family and couples support groups, and addiction treatment and support programs. The type and level of services provided are generally determined by the type of facility and the qualifications of the staff. These facilities reported screening approximately 536,000 clients for mental and/or behavioral health problems during the 18 months beginning January 1, 2008. See Table 1 for more information on the types of services and referrals provided by facilities.

Table 1: Services and Referrals at IHS and Tribal Facilities

Type of Service	Percentage of Facilities That Provide the Service (n=514)	Facilities That Do Not Provide the Service (n=116)	
		Percentage That Provide Referrals	Percentage That Do Not Provide Referrals
Psychotherapy (all)	**81%**	**51%**	**49%**
Individual – adult	*81%*	*44%*	*56%*
Individual – child	*81%*	*52%*	*48%*
Group – adult	*44%*	*28%*	*72%*
Group – child	*35%*	*28%*	*72%*
Support groups (all)	**80%**	**84%**	**16%**
Family and couples	*71%*	*24%*	*76%*
Addiction and 12-step programs	*51%*	*36%*	*64%*
Family violence	*24%*	*8%*	*92%*
Victim of childhood sexual abuse	*20%*	*7%*	*93%*
Suicide	*19%*	*10%*	*90%*
Child of an alcoholic	*18%*	*13%*	*87%*
Family and friends of an alcoholic	*18%*	*9%*	*91%*
Parent of an alcoholic	*16%*	*8%*	*92%*
Parent of chemically dependent child	*16%*	*11%*	*89%*
Child of chemically dependent parent	*16%*	*8%*	*92%*
Chronically mentally ill	*15%*	*8%*	*92%*
Pharmacotherapy	**46%**	**8%**	**92%**
Traditional healing	**33%**	**1%**	**99%**
Hypnotherapy	**4%**	**<1%**	**>99%**
Electroconvulsive therapy	**1%**	**2%**	**98%**
Any Service	**100%**	**88%**	**12%**

Source: OIG analysis of survey data, 2010.

Of the 116 facilities that do not provide mental health services, 88 percent (102 of 116) reported that they refer clients to other providers. Generally, the facilities that do not provide mental health services refer clients to local support groups and individual psychotherapy, depending on the type of services the client may need. Because these facilities do not provide mental health services, the staff may have limited knowledge of where to refer clients for certain types and levels of services.

The range of mental health services varies by the type of facility

Most facilities reported that they provide mental health services, but the availability of some services is limited at certain types of facilities. Although all types of facilities reported providing some type of psychotherapy service or support group, hospitals and health centers were more likely to provide pharmacotherapy. Less than half of alcohol and substance abuse treatment and behavioral health facilities and only 22 percent of Alaska village clinics (25 of 112) reported that they provide pharmacotherapy. Traditional healing is provided most frequently in urban and school health centers (63 percent). See Table 2 for more information on the range of mental health services at IHS and tribal facilities. See Appendix D for more information on the community population served and number of clients screened by these facilities.

Table 2: Range of Mental Health Services at IHS and Tribal Facilities

Type of Facility	Total Facilities That Report Providing Mental Health Services (n=514)	Percentage of Facilities That Offer the Service					
		Psycho-therapy*	Support Groups*	Pharmaco-therapy	Traditional Healing	Hypno-therapy	Electro-convulsive Therapy
Health center	192	93%	91%	60%	25%	5%	1%
Alaska village clinic	112	86%	72%	22%	30%	4%	4%
Alcohol and substance abuse treatment center	55	75%	82%	36%	48%	2%	--
Hospital	35	100%	91%	77%	34%	3%	--
Health station	32	81%	81%	53%	16%	19%	--
Behavioral health facility	31	87%	74%	45%	32%	--	--
Urban health center	28	79%	82%	50%	63%	--	--
School health center	20	95%	70%	5%	63%	--	--
Remote health location	7	86%	86%	--	50%	--	--
Other residential	2	50%	50%	50%	--	--	--

* At least one type of psychotherapy service or support group is offered at the facility.
Source: OIG analysis of survey data, 2010.

Thirty-nine percent of IHS and tribal facilities that provide mental health services reported that they provide crisis intervention services 24 hours per day, 7 days per week

Thirty-nine percent of facilities that provide mental health services (199 of 514) reported that they provide crisis intervention services 24 hours a day. Crisis intervention is emergency psychological care provided by trained counselors in a variety of settings that enables an individual to return to normal levels of functioning. Only 26 percent of facilities providing 24-hour crisis intervention services (52 of 199) reported that mental health care staff are onsite the minimum number of hours necessary to provide 24-hour care (i.e., 168 total hours per week). The remaining facilities that provide 24-hour crisis intervention services (147 of 199) use on-call staff to respond to after-hours crises. In general, because of the limited number of mental health staff, most crisis intervention services are provided through primary care and emergency room providers.

Fifty-one percent of facilities (262 of 514) reported that they provide crisis intervention services fewer than 24 hours a day. Ten percent of facilities (53 of 514) do not provide any crisis intervention services. See Table 3 for more information on crisis intervention services at IHS and tribal facilities.

Table 3: Crisis Intervention Services at IHS and Tribal Facilities

Scope of Intervention Services Provided at Facilities	Percentage of Facilities	Number of Facilities
Provide crisis intervention services 24 hours per day, 7 days per week	**39%**	**199**
Staff are onsite a minimum 168 hours per week	*10%*	*52*
Staff are onsite fewer than 168 hours per week	*29%*	*147*
Provide crisis intervention services fewer than 24 hours per day, 7 days per week	**51%**	**262**
Provide no crisis intervention services	**10%**	**53**
Total respondent facilities that provide mental health services	**100%**	**514**

Source: OIG analysis of survey data, 2010.

Lack of licensed providers limits referrals to psychiatric facilities

In many instances of acute psychiatric crises, clients may have to be treated by health care providers in an acute-care hospital or by licensed providers who can admit the client to an inpatient psychiatric facility.

The 52 facilities that have mental health care staff onsite to provide 24-hour crisis intervention services are likely staffed with social workers and counselors who cannot admit patients to an inpatient psychiatric facility. The lack of staff and clinical training in these facilities limits the mental health services that can be provided during psychiatric emergencies and after-hours crises. See Table E in Appendix E for more information on the staffing levels at IHS and tribal facilities that provide onsite 24-hour crisis intervention services.

The director of a youth residential facility that provides onsite 24-hour crisis intervention services reported:

> If we had adequate resources we could provide a better quality of care for mental health and family mental health needs of our patients. The majority of our patients come with PTSD [Post-Traumatic Stress Disorder] and chemical dependencies. Our 24-hour monitoring staff falls far short of being able to engage therapeutically due to the lack of skills and training. We can only afford to hire non-skilled individuals.

IHS and tribal facilities provide limited inpatient psychiatric care

Approximately 81 percent of facilities that provide mental health services (416 of 514) provide only outpatient mental health services. Approximately 15 percent provide both inpatient and outpatient mental health services, and 4 percent provide only inpatient mental health services. The types of facilities providing inpatient mental health services include, but are not limited to, substance abuse and behavioral health residential treatment facilities.

IHS and tribes operate 43 inpatient medical hospitals, 4 of which provide short-term inpatient psychiatric care. The four hospitals that provide such care do so under special circumstances. Two of the four hospitals are in remote areas of Alaska. One has four psychiatric observation beds in a locked ward, supervised by a psychiatric nurse. The other provides inpatient crisis intervention. Both hospitals refer their patients to the State's only psychiatric hospital, which is in Anchorage and is accessible from their communities only by air.

IHS operates one inpatient psychiatric hospital, an adolescent treatment facility that admits patients ages 13 to 17. The hospital has capacity for 20 patients; however, at the time of our visit, it could

accommodate no more than 12 patients because it was not fully staffed.[30]

Most AI/ANs who need inpatient psychiatric care must use non-IHS/ nontribal facilities. Almost all IHS operated and tribally operated hospitals (39 of 43) can medically stabilize clients in psychiatric crisis, but most do not admit clients for psychiatric care. Once clients are stabilized, these hospitals will generally refer them to non-IHS/ nontribal psychiatric facilities.

Although inpatient psychiatric care may be provided at public and private general medical hospitals and public and private psychiatric hospitals, finding available inpatient psychiatric care for clients is challenging. At 29 facilities that we visited, 40 providers (including 20 physicians) who are on the front lines of psychiatric emergencies reported that it is often difficult to find inpatient psychiatric care for their clients. Non-IHS/nontribal psychiatric beds are scarce in rural areas. For example, Montana, North Dakota, South Dakota, and Wyoming have a total of only eight psychiatric hospitals. IHS and tribal facilities assist clients in finding inpatient psychiatric care, but provider interviews indicate that their staff cannot meet the demand for care. Frequently, non-IHS/nontribal psychiatric hospitals are full and cannot admit clients in a timely fashion. Furthermore, psychiatric care provided at non-IHS/nontribal facilities may not be culturally sensitive.

Additionally, States' reimbursement policies may affect AI/AN Medicaid beneficiaries' access to inpatient psychiatric services. During our visits to two AI/AN inpatient youth residential treatment facilities, staff reported that they were unable to bill for out-of-State patients referred to their facilities because the patients' State of residence did not enroll out-of-State providers. CMS reimburses State Medicaid programs for the full cost of inpatient services provided to Medicaid-eligible AI/ANs at IHS and tribal facilities, regardless of their State of residence or the location of the facility. However, some States do not recognize out-of-State providers and will not pay for out-of-State services except for emergency care.

[30] IHCIA, P.L. 94-437, § 708, 25 U.S.C. § 1665g authorizes the Secretary of HHS, acting through IHS, to construct at least one youth regional treatment center for addiction and behavioral health services in each region covered by an IHS Area Office.

Staffing issues and shortages of highly skilled providers limit AI/ANs' access to mental health services at IHS and tribal facilities

Although 82 percent of the surveyed facilities reported that they provide mental health services, the type of care and services are limited by an inadequate number of skilled professional staff.

IHS and tribal facilities that provide mental health services reported that a variety of staffing issues affect access to services

Forty-seven percent of IHS and tribal facilities that provide mental health services (243 of 514) have licensed medical providers (i.e., physicians, midlevel practitioners, and/or nurses) onsite. These providers render medical assistance and treatment to clients in crisis, including medically stabilizing patients, locating an appropriate psychiatric hospital, and arranging for clients to be admitted and transported to the hospitals.

Thirty-nine percent of the facilities (200 of 514) reported that access to services was affected by a variety of staffing issues. During interviews, providers explained that the lack of resources (e.g., financial, staff, and infrastructure) affected their ability to hire contractors, establish outreach programs, and provide adequate staff support. Survey responses indicated that access was limited by the number of appointments they could schedule with available staff and the number of hours the facility could remain open. See Table 4 for barriers related to staffing difficulties that limit AI/ANs' access to mental health services.

Table 4: Barriers That Limit Access to Mental Health Services at IHS and Tribal Facilities

Type of Barrier to Care	Percentage of All Facilities	Number of Facilities (n=514)
Facility's lack of resources	37%	192
Appointment availability	34%	173
Limited facility hours	25%	131

Source: OIG analysis of survey data, 2010.

Staff shortages prevent some IHS and tribal facilities from providing mental health services. Fifty-six of the 116 facilities that provide no mental health services reported that staff shortages and geographical remoteness prevent them from providing the services. These facilities

reported that they cannot retain and recruit mental health care providers. Half of these facilities (29 of 56) are clinics in Alaska that serve communities of fewer than 500 residents. Typically, facilities that do not provide mental health services (54 of 116) refer clients to facilities that do, including other IHS or tribal facilities and/or private facilities.

Shortages of psychiatrists at IHS and tribal facilities limit access to mental health services

The shortage of full-time psychiatrists is a problem in most IHS and tribal facilities. Seven percent of IHS and tribal facilities that provide mental health care (36 of 514) employ full-time psychiatrists. Although 32 percent of the facilities (162 of 514) reported that they employ psychiatrists, at half of such facilities (87 of 162), psychiatrists work 8 or fewer hours per week. In contrast, psychologists, licensed social workers, and counselors are onsite at 437 of the facilities, and their average hours per facility are approximately 4 times those of psychiatrists. See Table F in Appendix F for information on the median hours per week for mental health care staff by provider type.

Thirty-one percent of IHS and tribal facilities that do not employ full-time psychiatrists (146 of 478) are in designated health professional shortage areas (HPSA). HPSAs are designated by the Health Resources and Services Administration (HRSA) as having shortages of health providers in primary care, dental health, and mental health. HRSA has designated 208 AI/AN communities as having the highest possible degree of shortages of mental heath care providers. [31]

Unlicensed providers provide pharmacotherapy to meet access needs

Facilities often do not have appropriately licensed staff available to provide pharmacotherapy. Pharmacotherapy is the treatment of disease, especially mental disorders, with drugs.[32] Treatment can include dispensing drugs and monitoring clients; however, only licensed providers can prescribe the drugs used in pharmacotherapy. Forty-six

[31] The Public Health Service Act § 332 (amended by P.L. 101-597) requires HRSA to designate HPSAs. The aforementioned 208 AI/AN communities have unusually high needs for mental health services. HRSA, *Shortage Designation: HPSAs, MUAs [medically underserved areas] & MUPs [medically underserved populations].* Accessed at http://bhpr.hrsa.gov/shortage/index.htm on January 29, 2010.

[32] MedlinePlus, "Pharmacotherapy," *Medical Dictionary*. Accessed at http://www.merriam-webster.com/medlineplus/pharmacotherapy on February 14, 2010.

percent of facilities that provide mental health care (236 of 514) provide this treatment. Of the facilities that provide pharmacotherapy, 38 of 236 reported that social workers, counselors, and nurses provided some type of pharmacotherapy service, which may have included drug-related treatment other than prescribing medication. In addition, in 8 States that do not license psychologists to prescribe medicine, 13 facilities reported that psychologists perform pharmacotherapy.[33]

During our visits to five facilities in remote areas, respondents reported that they employ no providers who are licensed to prescribe medication that may be an essential part of crisis intervention treatment. The facilities reported that licensed providers who are not onsite write the initial prescriptions for clients. Unlicensed providers who are onsite then dispense the medication and monitor the clients. Providers reported that there are no alternatives in the community for clients who require medication. One hospital reported that clients wait 7 weeks to get an appointment with a psychiatrist for a prescription and treatment.

To help address shortages of licensed providers, 17 percent of IHS and tribal facilities use telemedicine for mental health treatment

Given staff shortages, telemedicine can be a practical and cost-effective way to expand health services to offsite locations. The IHCIA authorizes the Secretary of HHS to expend funds for the development and expansion of telehealth and telemedicine programs, where appropriate. In addition, Medicare[34] and some Medicaid State programs and third-party payers pay for certain telemedicine services.

Although telemedicine is being used in IHS and tribal facilities in fields such as cardiology, nutrition counseling, and eye care, only 17 percent of facilities (87 of 514) reported that they use it for mental health services. More than half of the facilities that provide telemedicine (52 of 87) are in remote areas of Alaska. Seventy-five percent of these facilities (65 of the 87) provide pharmacotherapy via telemedicine.

Providers reported that pharmacotherapy is one of the services most in demand for telemedicine and one of the services best suited for it. We

[33] This figure does not include Louisiana or New Mexico. At the time of this evaluation, Louisiana and New Mexico were the only States that licensed clinical psychologists to prescribe medication.

[34] 42 CFR § 410.78.

visited 11 facilities that currently use telemedicine. Providers at these facilities said they hoped to expand their existing telemedicine services, and providers at other facilities expressed interest in using telemedicine in the future. However, some facilities may encounter challenges with telemedicine. At one facility, providers reported that older clients are uncomfortable with telemedicine, especially for mental health services. Therefore, the facility does not provide psychiatric consultations or pharmacotherapy via telemedicine.

Physical, personal/social, and economic challenges may affect access to mental health services at IHS and tribal facilities

Approximately 69 percent of the facilities that provide mental health services (353 of 514) reported that AI/ANs face physical, personal/social, or economic barriers in obtaining mental health services at IHS and tribal facilities. See Table 5 for the individual barriers related to access to mental health services.

Table 5: IHS and Tribal Facilities That Reported That Their Clients Experience Barriers to Mental Health Services

Type of Barrier to Care	Percentage of All Facilities	Number of Facilities (n=514)
Physical barriers		
Transportation	53%	274
Weather	37%	191
Distance	36%	187
Poor roads	19%	98
Personal and social barriers		
Lack of child care	34%	175
Work schedule	31%	159
Personal schedule	30%	154
Economic barriers		
Financial	28%	147
Copayments	11%	61

Source: OIG analysis of survey data, 2010.

Approximately half of facilities reported that physical barriers affect clients' access to services

Approximately 53 percent (274 of 514) of facilities reported that transportation was a barrier to accessing services. More than one-third of the facilities reported that physical barriers, such as poor roads, distance, or weather, prevented clients living on rural reservations from obtaining mental health services. During interviews, providers and clients related concerns about dangerous travel through remote areas to access facilities. Twenty facilities reported that their clients may use alternative means of transportation—including snowmobile, dogsled, tractor, horse, or boat—to get to facilities.

Approximately one-third of facilities reported that personal and social issues affect clients' access to services

Approximately 30 percent of facilities reported that work and personal schedules affected clients' access to mental health services. Survey responses from 34 percent of the facilities that provide mental health services indicate that their clients have limited access to these services because of lack of child care.

During onsite visits, providers and clients in 24 communities related other personal and social barriers that affect access. According to respondents, domestic violence and sexual abuse, addiction to drugs and alcohol, and the personal stigma associated with seeking help for mental illness limited clients' ability and willingness to obtain mental health services. Clients in small communities were particularly concerned about confidentiality, fearing that their mental health treatment would become common knowledge.

Nearly one-third of facilities reported that economic issues affect clients' access to services

Twenty-eight percent of IHS and tribal facilities reported that their clients' financial situations may limit their access to mental health services. For example, 11 percent of the facilities reported that copayments may present a barrier to care when the AI/AN clients are referred to non-IHS/nontribal facilities.[35] The financial condition of clients also was mentioned in interviews with clients and staff. In

[35] SSA § 1916(j). AI/ANs referred to facilities under CHS are not charged copayments.

many instances, economic issues combine with personal and social factors to affect access to services. In rural areas, clients may not have enough money for transportation or other personal costs associated with trying to obtain services. For example, in several of our interviews, clients and providers cited clients' inability to pay for child care and the cost associated with clients' taking leave from their jobs as socioeconomic problems that serve as barriers to services.

The high rates of suicide, substance abuse, depression, unemployment, and poverty in AI/AN communities contribute to the need for access to mental health services. Although 82 percent of IHS and tribal facilities reported that they provide mental health treatment, access to some services is limited by staffing issues and shortages of highly skilled providers. In addition, the majority of AI/ANs attempting to obtain these services live in rural areas and face physical, personal/social, and economic barriers that limit access to services.

When we conducted this study, IHS could not provide a complete and accurate list of all IHS and tribal health care facilities. Although IHS attempts to collect information annually about IHS-funded health services, tribal facilities funded under Title I and Title V of the ISDEAA are not required to report specific information about their facilities. Therefore, IHS was unable to provide a complete, accurate list of all IHS and tribal health care facilities and contact individuals for them.

To address these issues, we recommend that IHS:

Provide guidance and technical assistance to help tribes explore potential partnerships with non-AI/AN providers of community mental and behavioral health services

To improve access to and coordination of community mental health services for AI/ANs, IHS should develop written guidance that addresses service gaps and lack of coordination among States, IHS and tribal facilities, and non-AI/AN providers. The written guidance should include a strategy to improve relationships with non-AI/AN community providers and access for and treatment of AI/ANs in underserved tribal communities. This may enable IHS and tribal providers to expand coverage for critical mental health services.

IHS should provide technical assistance to tribes and non-AI/AN providers serving AI/ANs regarding the Federal reimbursement policy for eligible AI/ANs under the IHCIA. Lastly, given that the needs of AI/ANs vary significantly among tribes and locations, IHS should assist tribes in collaborating with States and non-AI/AN providers to address the challenges of obtaining culturally sensitive services.

Continue to expand its telemedicine capabilities and provide guidance and technical assistance to tribal health care providers to expand and implement telemedicine

Seventeen percent of IHS and tribal facilities use telemedicine to help address staff shortages and expand access to professional health services. IHS should continue to address technical barriers to support and encourage use of telemedicine at IHS and tribal facilities. In addition, IHS should develop written guidance to work with and educate IHS and tribal providers, States, and non-AI/AN providers regarding telemedicine services. IHS should continue to provide technical assistance, if needed, to tribes that use telemedicine to ensure that they have the capability to bill Medicare, Medicaid, and third-party payers for appropriate telemedicine services. By being able to charge third-party payers, the facilities can increase their revenue to support facility-specific telemedicine services.

Develop a plan to create a single database of all IHS and tribal health care facilities

Our attempts to compile a comprehensive list of all IHS and tribal health care facilities were limited because there is no single database—either in IHS or among tribes and tribal organizations—of all IHS and tribal health care facilities, with the facilities' addresses and the names of contact people. Although tribes are not required under 638 contracting or self-governance compacting to report information about their facilities to IHS, a single database that identified all health care facilities and the services they offer would help the tribes and IHS to expand services under the reauthorized IHCIA. IHS should develop a plan to work with tribes, States, and Federal agencies to create a national database of AI/AN health care facilities, and it should include all such facilities, regardless of funding sources. Such a database would assist the Secretary in meeting the Administration's mandate to "formulate a comprehensive approach to Indian health care reform" and provide planning information relative to the distribution of health services for AI/ANs throughout the country.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

IHS concurred with all three of our recommendations. In response to our first recommendation—that IHS provide guidance and technical assistance to help tribes explore potential partnerships with non-AI/AN providers of community mental and behavioral health services—IHS stated that it will collaborate with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop written guidance that addresses service gaps and lack of coordination among States, IHS, tribal facilities, and non-AI/AN providers. IHS also stated that it will provide technical assistance to tribes regarding Federal reimbursement policies for eligible AI/ANs and that it will assist tribes in collaborating with SAMHSA, States, and non-AI/AN providers to address the challenges of obtaining culturally sensitive services for AI/AN patients.

In response to our second recommendation—that IHS continue to expand its telemedicine capabilities and provide guidance and technical assistance to tribal health care providers to expand and implement telemedicine—IHS stated that it will continue to expand implementation of telemedicine for behavioral health services, educate IHS and tribal providers regarding the use and effectiveness of telemedicine for behavioral health services, and address potential technical barriers to the use of telemedicine for behavioral health services at IHS and tribal facilities. IHS stated that it will also provide technical assistance to tribes that use telemedicine for behavioral health services to increase their ability to bill third-party payers for those services.

In response to our third recommendation—that IHS develop a plan to create a single database of all IHS and tribal health care facilities—IHS stated that it will work with tribes, States, and Federal agencies to create a database of AI/AN health care facilities to include physical locations, contact information, and available services.

We did not make any changes in the report based on IHS's comments. For the full text of IHS's comments, see Appendix G.

Health Disparities

Table A: Prevalence of Health Conditions and Mortality Rates by Race and Ethnicity

	American Indian/ Alaska Native	White, Non-Hispanic	Hispanic	Black, Non-Hispanic	Asian and Pacific Islander	Two or More Races
Health Condition *	**Prevalence of Health Condition**					
Two or more chronic conditions	18%	10%	6%	11%	5%	9%
Diabetes	12%	5%	6%	8%	5%	3%
Frequently anxious or depressed	23%	16%	13%	14%	8%	21%
Obesity	39%	28%	31%	38%	12%	20%
Cause of Death **	**Mortality Rate Per 100,000**					
Heart disease	141.8	210.7	157.3	271.3	113.3	---
Cancer	123.2	187.0	122.8	222.7	110.5	---
Diabetes	41.5	21.5	33.6	46.9	16.6	---
Chronic liver disease	22.6	8.7	13.9	7.7	3.6	---
Unintentional injuries	54.7	41.0	31.3	38.7	17.9	---
Motor vehicle accidents	24.8	15.5	14.7	14.5	7.6	---
Suicide	11.7	12.9	5.6	5.2	5.2	---

*Source: *A Profile of American Indians and Alaska Natives and Their Health Coverage*, September 2009, Figure 4: Prevalence of Health Conditions by Race/Ethnicity, 2004-2007. [36] Based on a percentage of the defined population.
**Source: *A Profile of American Indians and Alaska Natives and Their Health Coverage*, September 2009, Figure 6: Mortality Rate by Race/Ethnicity, 2005.[37] Based on age-adjusted death rates per 100,000 population.

[36] Cara James, Karyn Schwartz, and Julia Berndt, *Race, Ethnicity & Health Care Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage*, September 2009. Accessed at http://www.kff.org/minorityhealth/upload/7977.pdf on February 12, 2010.
[37] Ibid.

APPENDIX ~ B

Glossary of Terms

Clinic. A facility, physically separated from a hospital or health center, in which primary care physician services are available on a regularly scheduled basis but for less than 40 hours a week for outpatient care. Clinics are similar to health stations.[38]

Clinical Social Worker. A health professional trained in client-centered advocacy who assists clients with information, referral, and direct help in dealing with local, State, or Federal government agencies.[39]

Crisis Intervention. A brief therapeutic approach that is ameliorative rather than curative of acute psychiatric emergencies.[40]

Electroconvulsive Therapy. A procedure in which electric currents are passed through the brain, deliberately triggering a brief seizure. Electroconvulsive therapy seems to cause changes in brain chemistry that can immediately reverse symptoms of certain mental illnesses.[41]

Health Center. A facility, physically separated from a hospital, with a full range of ambulatory services, including physician, nursing, pharmacy, laboratory, and x-ray services. Services are available at least 40 hours per week for ambulatory care.[42]

Health Station. See "Clinic," above.

Hypnotherapy. The use of exercises that bring about deep relaxation and an altered state of consciousness. Persons in a deeply focused state can affect their own psychological responses.[43]

Marriage and Family Therapist. A person who evaluates and helps resolve problems in the context of a marriage or family. Such a therapist typically has a master's or doctoral degree. [44]

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[38] Definition accessed at http://www.anthc.org/ref/hs/codebook/asufac.cfm on March 30, 2011.

[39] Definition accessed at http://www.mentalhealthchannel.net/csw.shtml on June 13, 2010.

[40] Definition accessed at http://psycnet.apa.org on February 14, 2010.

[41] Definition accessed at http://www.mayoclinic.com/health/electroconvulsive-therapy/MY00129 on January 4, 2010.

[42] Definition accessed at http://www.anthc.org/ref/hs/codebook/asufac.cfm on March 30, 2011.

[43] Definition accessed at http://www.umm.edu/altmed/articles/hypnotherapy-000353.htm on January 4, 2010.

Mental Health Counselor. A broad term for a person who provides counseling. Most such individuals have at least a master's degree in social work or a related field, have several years of supervised work experience, and are licensed or certified. A mental health counselor may also be called a licensed professional counselor, licensed mental health counselor, or professional counselor.[45]

Midlevel Practitioner. A nurse midwife, nurse practitioner, or physician assistant, licensed by the State in which the individual practices.[46]

Pharmacotherapy. The treatment of disease, and especially mental disorder, with drugs.[47]

Post-Traumatic Stress Disorder (PTSD). A disorder in which a person "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and in which a person's response involved intense fear, helplessness, or horror."[48]

Psychiatric Crisis. A psychological or social condition characterized by unusual instability caused by excessive stress and either endangering or felt to endanger the continuity of an individual or group.[49]

Psychiatric Hospital. An institution that:[50]

- is engaged primarily in providing, by or under the supervision of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons;

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[44] Definition accessed at http://therapists.psychologytoday.com/rms/content/therapy_professionals.html on March 30, 2011.

[45] Ibid.

[46] Centers for Medicare & Medicaid Services (CMS), *Medicare State Operations Manual Provider Certification*. Accessed at http://www.cms.gov/transmittals/Downloads/R32SOM.pdf on April 8, 2010.

[47] Definition accessed at http://www.merriam-ebster.com/medlineplus/pharmacotherapy on March 29, 2011.

[48] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR*, 2000.

[49] Definition accessed at http://www.merriam-webster.com/medlineplus/crisis on March 29, 2011.

[50] CMS, *Psychiatric Hospitals*. Definition accessed at http://www.cms.hhs.gov/CertificationandComplianc/14_PsychHospitals.asp on February 14, 2010.

- satisfies the requirements of sections 1861(e)(3) through (e)(9) of the Social Security Act (general hospital requirements);
- maintains clinical and other records on all patients as the Secretary finds necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under Part A; and
- meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals receiving services in the institution.

Psychologist (Clinical Psychologist). A specialist in one or more branches of psychology, especially a practitioner of clinical psychology, counseling, or guidance. Psychology is a doctoral-level profession.[51]

School Health Center. A health center that is based at a school site and serves primarily students.

Telemedicine. The use of medical information that is exchanged from one site to another via electronic communications to improve clients' health. Closely associated with telemedicine is the term "telehealth," which often encompasses a broader definition of remote health care that does not always involve clinical services. Videoconferencing; transmission of still images; e-health, including patient portals; remote monitoring of vital signs; continuing medical education; and nursing call centers are all considered part of telemedicine and telehealth. Telemedicine is not a separate medical specialty.[52]

[51] Definition accessed at http://www.merriam-webster.com/medlineplus/psychologist on March 29, 2011.

[52] Definition accessed at http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333 on February 4, 2010.

APPENDIX ~ C

Response Rates

Table C-1: Fieldwork and Survey Response Rate by IHS and Tribal Facility Type

Type of Facility	Total Facilities Visited	SURVEYS									
		Response Rate	Total in Population			Nonrespondents			Respondents		
			Total	Tribal	IHS	Total	Tribal	IHS	Total	Tribal	IHS
Alaska village clinic	**3**	**94%**	**160**	**160**	**0**	**10**	**10**	**0**	**150**	**150**	**0**
Alcohol and substance abuse treatment center	**18**	**66%**	**99**	**93**	**6**	**34**	**34**	**0**	**65**	**59**	**6**
Residential	*13*	*78%*	*50*	*44*	*6*	*11*	*11*	*0*	*39*	*33*	*6*
Nonresidential	*5*	*53%*	*49*	*49*	*0*	*23*	*23*	*0*	*26*	*26*	*0*
Behavioral health facility	**10**	**79%**	**42**	**41**	**1**	**9**	**9**	**0**	**33**	**32**	**1**
Residential	*1*	*100%*	*7*	*7*	*0*	*0*	*0*	*0*	*7*	*7*	*0*
Nonresidential	*9*	*71%*	*35*	*34*	*1*	*10*	*9*	*1*	*25*	*25*	*0*
Health center	**36**	**84%**	**274**	**220**	**54**	**44**	**40**	**4**	**230**	**180**	**50**
Health station	**2**	**65%**	**68**	**56**	**12**	**24**	**24**	**0**	**44**	**32**	**12**
Hospital	**23**	**93%**	**44**	**14**	**30**	**3**	**2**	**1**	**41**	**12**	**29**
Medical	*22*	*88%*	*43*	*14*	*29*	*5*	*4*	*1*	*38*	*10*	*28*
Psychiatric	*1*	*100%*	*1*	*0*	*1*	*0*	*0*	*0*	*1*	*0*	*1*
Other residential	***0***	***100%***	***5***	***5***	***0***	***0***	***0***	***0***	***5***	***5***	***0***
Remote health locations	***0***	***85%***	***13***	***13***	***0***	***2***	***2***	***0***	***11***	***11***	***0***
School health center	**0**	**79%**	**28**	**5**	**23**	**6**	**3**	**3**	**22**	**2**	**20**
Urban health center	**0**	**82%**	**34**	**34**	**0**	**6**	**6**	**0**	**28**	**28**	**0**
Wellness/fitness center	**0**	**20%**	**5**	**5**	**0**	**4**	**4**	**0**	**1**	**1**	**0**
Total	**98**	**82%**	**772**	**646**	**126**	**142**	**134**	**8**	**630**	**512**	**118**

Source: Office of Inspector General (OIG) analysis of survey data, 2010.

Table C-2: Fieldwork and Survey Response Rate by IHS Service Area

IHS Service Area	VISITS	SURVEYS								
	Total Facilities	Response Rate	Total in Population			Nonrespondents			Respondents		
			Total	Tribal	IHS	Total	Tribal	IHS	Total	Tribal	IHS
Aberdeen, SD	13	51%	45	28	17	21	20	1	24	8	16
Alaska	19	92%	252	252	0	19	19	0	233	233	0
Albuquerque, NM	6	83%	24	10	14	4	3	1	20	7	13
Bemidji, MN	12	67%	86	81	5	27	27	0	59	54	5
Billings, MT	7	95%	22	11	11	1	0	1	21	11	10
California	10	93%	71	71	0	4	4	0	67	67	0
Nashville, TN*	4	67%	35	33	2	11	11	0	24	22	2
Navajo	3	83%	42	4	38	6	2	4	36	2	34
Oklahoma	8	78%	63	51	12	14	14	0	49	37	12
Phoenix, AZ	13	71%	68	51	17	20	19	1	48	32	16
Portland, OR	7	76%	55	49	6	13	13	0	42	36	6
Tucson, AZ	8	73%	9	5	4	2	2	0	7	3	4
Total	**110**	**82%**	**772**	**646**	**126**	**142**	**134**	**8**	**630**	**512**	**118**

Source: OIG analysis of survey data, 2010.
*Interviewed Area Office by phone.

APPENDIX ~ D

Population Served and Screened by Type of Facility

Table D: Community Population Served and Number of Clients Screened for Mental Health Services by Type of Facility

Type of Facility	Total Facilities That Report Providing Mental Health Services	Mean Community Population Served by the Facility*	Approximate Number of Clients Screened for Mental Health Services*
Health center	**192**	**27,000**	**238,000**
Alaska village clinic	**112**	**300**	**6,000**
Alcohol and substance abuse treatment center	**55**	**60,000**	**37,000**
Residential	*36*	*87,000*	*7,000*
Nonresidential	*19*	*54,000*	*30,000*
Hospital	**35**	**32,000**	**183,000**
Health station	**32**	**5,000**	**10,000**
Behavioral health facility	**31**	**38,000**	**28,000**
Residential	*7*	*44,000*	*2,000*
Nonresidential	*24*	*36,000*	*26,000*
Urban health center	**28**	**51,000**	**34,000**
School health center	**20**	**600**	**1,000**
Remote health location	**7**	**3,000**	**<1,000**
Other residential	**2**	**6,000**	**<1,000**
Total	**514**	**22,000**	**536,000**

*Based on facility-reported information on the population of the community served by the facility. Number of clients screened is from approximately January 2008 to November 2009.
Source: Office of Inspector General analysis of survey data, 2010.

APPENDIX ~ E

Crisis Intervention Services

Table E: Staffing Levels at IHS and Tribal Facilities That Provide 24-hour Crisis Intervention Services With Onsite Mental Health Care Staff

Type of Facility	Total Facilities That Provide 24-Hour Onsite Crisis Intervention Services	By Provider Type and Total Median Hours									
		Psychiatrist		Any Medical Provider		Psychologist		Social Worker, Counselor, Aide, and/or Traditional Healer		Any Mental Health Care Staff	
		Facilities*	Median Hours**	Facilities*	Median Hours**	Facilities*	Median Hours**	Facilities*	Median Hours**	Facilities*	Median Hours**
Alcohol and substance abuse treatment center	12	6	16	9	76	6	40	12	200	12	235
Behavioral health facility	8	7	39	8	78	3	20	7	248	8	321
Health center	16	13	8	16	204	9	16	16	120	16	341
Hospital	14	13	40	13	114	12	40	14	165	14	305
Urban health center	2	1	32	2	84	1	32	2	291	2	387
Total	**52**	**40**	**32**	**48**	**84**	**31**	**32**	**51**	**200**	**52**	**321**
Percentage of All Facilities That Reported Providing Mental Health Services (n=514)	10%	8%	---	9%	---	6%	---	10%	---	10%	---

*Facilities are counted once if they have at least one or more of each provider type.
**Median hours include all hours for each provider type per facility type. Facilities may employ more than one of each provider type.
Source: Office of Inspector General analysis of survey data, 2010.

APPENDIX ~ F

Mental Health Care Staff Onsite at Facilities

Table F: Median Hours Per Week for Mental Health Care Staff by Provider Type

Type of Provider	Percentage of Facilities* (n=514)	Median Hours Per Week**
Mental health care providers	**85%**	**40**
Psychologist	*29%*	*34*
Social worker	*35%*	*40*
Counselor/therapist	*69%*	*40*
Mental health care aide	*13%*	*22*
Peer counselor	*7%*	*38*
Physician	**41%**	**25**
Psychiatrist	*32%*	*8*
All other physicians	*20%*	*40*
Midlevel practitioners	**21%**	**40**
Physician assistant	*9%*	*32*
Psychiatric nurse practitioner	*4%*	*40*
Nurse practitioner	*15%*	*40*
Traditional providers	**12%**	**16**
Medicine man/woman	*2%*	*4*
Spiritual advisor	*5%*	*25*
Traditional healer	*10%*	*8*
Registered nurse	**10%**	**40**
Other	**4%**	**39**
Any level provider	**100%**	**66**

*Facilities are counted once if they have at least one or more of each provider type.
**Median hours include all hours for each provider type per facility type. Facilities may employ more than one of each provider type.
Source: Office of Inspector General analysis of survey data, 2010.

APPENDIX ~ G

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

AUG 19 2011

TO: Inspector General

FROM: Director

SUBJECT: Comments by the Indian Health Service on the OIG Draft Report *Access to Mental Health Services at Indian Health Service and Tribal Facilities* (Report No. OEI -09-08-00580)

Please accept the following responses to your June 23 memorandum transmitting the Office of Inspector General (OIG) draft report entitled *Access to Mental Health Services at Indian Health Service and Tribal Facilities* (Report No. OEI-09-08-00580). I appreciate the opportunity to address the recommendations to improve access to services in the Indian Health Service (IHS) and Tribal health systems.

In the ongoing effort to meet the health and behavioral health challenges, there is a trend toward Tribal management and delivery of behavioral health services in American Indian and Alaska Native (AI/AN) communities. Tribes have increasingly contracted or compacted via the Indian Self Determination and Education Assistance Act, Public Law 93-638, to provide those services themselves. Currently, 54 percent of the mental health and 84 percent of the alcohol and substance abuse programs are operated by Tribes. This evolution in behavioral health care delivery and management is changing the face of behavioral health services in Indian Country.

Where IHS was previously the principal behavioral health care delivery system for AI/ANs, there is now a less centralized and more diverse network of care provided by Federal, Tribal, and Urban Indian health programs. The "Indian health system" denotes this larger network of programs and the evolving care delivery system across Indian Country. Meeting the needs of this system requires an evolution in IHS and Tribal collaboration, particularly as Tribal programs take more direct responsibility for services and IHS supports them in doing so.

The IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. In particular, developing programs that are collaborative, community driven, and nationally supported, offer the most promising potential for long term success and sustainment. The IHS regularly relies on Tribal leadership and expertise to collaborate on a range of behavioral health problems and programs.

The IHS National Tribal Advisory Committee (NTAC) on Behavioral Health, which is made up of elected Tribal leaders from each IHS Area, provides recommendations and advice on the range of behavioral health issues in Indian Country. From making recommendations on significant funding allocations and service programs, to developing long term strategic plans for Tribal and Federal behavioral health programs for the future, the NTAC is the principal Tribal

advisory group for all behavioral health services to IHS. They ensure collaboration among Tribal and Federal health programs, provide Tribal input into the development of programs and services, and also provide the inclusive and transparent development of processes and programs so important to all our communities and programs.

The IHS National Behavioral Health Work Group (BHWG) is the technical advisory group to IHS. Comprised of mental health professionals from across the country, the BHWG furthers the agency priorities to strengthen partnerships with Tribes, improve quality and access to care for patients, and provide direct collaboration and input for accountable, fair, and inclusive services across the Indian behavioral health system. They provide expert advice and recommendations for services, programs, and intervention models, as well as long term strategic planning and goal development. As the national technical advisory group to the agency, they also work very closely with the elected Tribal leaders on the NTAC to provide collaborative links between the professional community and national Tribal leadership.

IHS Response to the OIG Draft Recommendations

1. **Provide guidance and technical assistance to help Tribes explore potential partnerships with non-American Indian and Alaska Native (AI/AN) providers of community mental and behavioral health services.**

The IHS concurs with this recommendation. The Agency will collaborate with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop written guidance that addresses service gaps and lack of coordination among States, IHS, Tribal facilities, and non-AI/AN providers. The guidance will include a strategy to address ways to improve relationships with non-AI/AN providers and access for and treatment of AI/AN patients in underserved Tribal communities which will assist IHS and Tribal providers to expand coverage of behavioral health services. The Agency will provide technical assistance to Tribes regarding Federal reimbursement policies for eligible AI/AN patients. The Agency will also assist Tribes in collaborating with SAMHSA, States, and non-AI/AN providers to address the challenges of accessing culturally sensitive services for AI/AN patients.

2. **Continue to expand its telemedicine capabilities and provide guidance and technical assistance to Tribal health care providers to expand and implement telemedicine.**

The IHS concurs with this recommendation. The IHS Tele-Behavioral Health Center of Excellence establishes a national network of tele-behavioral health services to augment existing services and increase access to evaluation, specialty care, and behavioral health management services across the Indian health system. Currently, over 50 IHS and Tribal facilities in eight IHS Areas are augmenting on-site services with tele-behavioral health services to improve access to care.

The IHS will continue to expand implementation of tele-behavioral health services, educate IHS and Tribal providers regarding the use and effectiveness of tele-behavioral health services, and address potential technical barriers to such utilization at IHS and Tribal facilities. The IHS will also provide technical assistance to Tribes that use tele-behavioral health services to increase their ability to bill third party payers for those services.

3. Develop a plan to create a single database of all IHS and Tribal health care facilities.

The IHS concurs with this recommendation. The Agency will develop a plan to create a single database that identifies all IHS and Tribal health care facilities to better assist Tribes and IHS in identifying and expanding services. The IHS will work with Tribes, States, and Federal agencies to create the single database of AI/AN health care facilities to include physical locations, contact information, and available services.

Thank you for providing IHS the opportunity to comment on the OIG's draft report. The IHS is committed to improving our health delivery system and increasing access to those requiring our services. We will continue to work in partnership with our Tribal health system to assist them in their ongoing efforts.

/S/

Yvette Roubideaux, M.D., M.P.H.

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