ABSTRACT

State - Tribal Fiscal Relations:
Administration of Federal & State Funds to Washington State Tribes
through the Department of Social & Health Services

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Our project examined tribal and state fiscal relationships through an analysis of funding patterns in two divisions of Washington State's Department of Social and Health Service: Mental Health and Alcohol and Substance Abuse. Our findings revealed that Native Americans getting services in Washington do not receive state funding at an equitable level compared to non-Native populations. We also found state government involvement in tribal funding for mental health and alcohol/substance abuse restricted access for Native Americans needing services. We conclude that for some tribes more effective means of funding for tribal programs are necessary to properly serve Native Americans in Washington. Furthermore, we believe state certification processes should be expanded to accommodate individual tribal needs. We also conclude that there is great benefit for tribes and state government to work toward improving government-to-government relationships.

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by
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ABBREVIATIONS

DASA – .....Division of Alcohol and Substance Abuse

DHHS – .....Department of Health and Human Services

DSHS – .....Department of Social and Health Services

GOIA – .....Governors Office of Indian Affairs

HCFA – .....Health Care Financing Administration

HRSA – .....Health and Rehabilitation Services Administration

IHS – .....Indian Health Service

IPAC – .....Indian Policy Advisory Council

IPSS – .....Indian Policy Support Services

MHD – .....Mental Health Division

MOA – .....Memorandum of Agreement between IHS and HCFA

PHP – .....Primary Health Provider

RSN – .....Regional Support Network

SAMHSA .....Substance Abuse and Mental Health Services Administration

PREFACE

The main goal of this project was to facilitate understanding of the funding and administration of tribal alcohol abuse, substance abuse and mental health services by the federal and state government. Sponsored by the Northwest Indian Applied Research Institute (NIARI), our project focused on the fiscal relationship between the Washington State Department of Social and Health Services (DSHS) and the Native American communities in Washington State. This was an effort to assist NIARI's goals of supporting tribal governance by improving relationships between tribal and state governments and advocating for more equitable fiscal relationships as a means to protecting Indian reservation societies.

Our intent was to provide an analysis of the funding streams for tribal program through the Mental Health Division (MHD) and the Division of Alcohol and Substance Abuse (DASA). The research explored some new ground in areas of intergovernmental relationships between the states and the tribes by following the flow of funding from federal sources to the state. We acknowledge both the limitations of primary research as well as the benefits thereof.

We were challenged by this project because of the limited timeframe and availability of information resources. But because these issues are so important and so complicated, they deserve much additional future research.

We received a great deal of assistance from a number of dedicated and helpful people. We owe a debt of gratitude to the people who assisted us with our project in spite of their busy schedules. We also would like to thank our families, friends and loved ones and they have been listed in the acknowledgements.

Our project focused on adult Native Americans who received services through tribal programs in Washington State; we did not specifically focus on children, adolescents or urban Indian programs.

This document, we hope, will provide a basis for decision making in the funding and management of Native American social and health services through DSHS. Our purpose in collecting information from the interviews we conducted and the documents we examined was to increase understanding of intergovernmental fiscal relationships. It is our belief that increased

understanding of these complex fiscal issues will lead to improved government-to-government relationships.

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EXECUTIVE SUMMARY

In this study, we investigated state and tribal fiscal relations by looking at how programs serving Native Americans were funded and administered by two divisions within Washington's Department of Social and Health Services (DSHS). We addressed this issue in the context of the current political environment in which tribal and Washington State governments are actively working towards improving intergovernmental relationships.

Our purpose was to provide useable information about the sources of funding for tribal alcohol/substance abuse and mental health treatment programs as well as how Native American services are affected by state administration of these funds. These issues include federal versus state participation in the funding of tribal mental health and alcohol/substance abuse programs; state funding equity for Native Americans; federal devolution of administrative responsibility to states for tribal programs; and tribal self-determination. Our findings supply information about state/tribal fiscal relationships, particularly with respect to state funding for Native American health services.

This document is intended for different audiences. Our primary audience consists of the 29 federally recognized tribes in Washington State, as well as tribal health policy makers and advisory councils concerned with improving programs for Native Americans. Our secondary audience is made up of public administrators and policy makers who craft public policy and are working to improve intergovernmental relationships between Washington State government and the tribes. This group includes the Washington State Legislature; the Governor's Office of Indian Affairs (GOIA); several divisions of DSHS including the Division of Alcohol and Substance Abuse (DASA); the Mental Health Division (MHD); the 14 Regional Support Networks (RSNs) who administer mental health services; Indian Policy Support Services (IPSS); the Indian Policy Advisory Council (IPAC); and the Medical Assistance Administration (MAA). Parts of this group are the federal agencies Health Care Financing Administration (HCFA) and the Indian Health Service (IHS). The citizens of Washington State may also benefit from our findings.

The research methods employed in this project involved the use of interview data, which we collected through personal interviews with federal and state program administrators, tribal liaisons, as well as tribal program administrators. We conducted a document analysis by reviewing state and federal data. We also consulted books, journals and other publications. Drafts of this document were reviewed by three individuals; two are Evergreen State College faculty members and one is involved with tribal issues through her work in the Governor's Office.

Our project focused on two related hypotheses. Our first hypothesis was that tribes do not receive equitable state funding for mental health and alcohol/substance abuse services as compared to other citizens of the state. Our second hypothesis was that state involvement in the administration of federal funds impedes tribal access for services, as tribes must comply with state requirements to receive federal funds. These hypotheses relate to the present condition of state and tribal intergovernmental relations in Washington State. Here is a summary of our main findings:

For all non-Native American state residents in Washington, a matching federal grant of approximately 50 percent combines with a 50 percent state funds to pay for services. We found that the state receives 100 percent federal funding for Native Americans treatment services. This means that virtually no state funds are allocated to Native Americans for MHD and DASA services. Although this fact alone does not prove that tribes are not a drain on the state's economy, we hope that current perceptions will begin to take this important fact into account.

We found that Native Americans have the largest percentage of need for alcohol/substance abuse and mental health treatment services among the state's racial and ethnic groups. They also have greater incidences of experiencing both mental illness and alcohol/substance abuse problems concurrently. Though Native Americans receive a high percentage of treatment compared to other population groups, the level of support is not adequate in relation to their needs.

For Native Americans treatment services, the ratio of dollars spent and number of clients served compared with similar ratios for other citizens of the

state show inadequate funding through MHD. However, under DASA, the data shows that dollars spent on Native American treatment services are slightly higher and the percentage of clients served is twice as high as other ethnicities. This can be explained by the greater needs for treatment services by Indians.

There are no federal restrictions on the amount of federal funds available for Native American services, and treatment services for Native Americans are fully reimbursed by the federal government. Unfortunately, this open-ended funding is not fully utilized due to stringent state application and eligibility requirements for individuals applying for services. Native Americans feel that they should not have to deal with state requirements since their medical care is guaranteed by the federal government as an entitlement based on federal trust responsibilities.

Through the process of federal devolution of administrative responsibility, the state is more accountable for the disbursement of federal pass-through dollars. This has led to rules and regulations governing the implementation of funds allocated for Native Americans. State regulation and certification processes can violate the essence of tribal sovereignty and self-determination. Certification requirements tend to require uniformity in compliance, which conflicts with the uniqueness and individuality of each of the tribes located within the state boundaries.

There has been an increase in devolutionary policies that have reduced federal, and increased state, responsibilities. As a result, states have only begun to establish relationships with the tribes similar to the federal government.

Alternate funding methods for Native American alcohol/substance abuse and mental health programs lessen the burden of tribes to meet strict state regulations for receiving funds. One example is direct federal funding for tribal programs that bypass the state. Another example is allowing tribes more discretion in administering programs through state grants of federal funds. Here is a list of our recommendations:

1. Improve state/tribal relationships by facilitating more alternative payment methods to allow federal funds to go directly to tribes.

2. Approve alternative certification processes for tribal-based mental health and alcohol/substance abuse programs in lieu of state regulatory, administrative, and certification requirements.
3. Promote distinct policies and procedures for state interaction between each of the tribal governments as recognition of their individual sovereignty.
4. Develop a comprehensive, on-going statewide training program on DSHS Administrative Policy 7.01 and the Centennial Accord, which detail the way that DSHS works with tribes on a government-to-government basis.
5. Promote increased understanding of fiscal issues faced by the state and the tribes in order to create better comprehension of each side's situation. Provide on-going training to the tribes regarding fiscal issues and how they impact service delivery development opportunities.
6. Empower tribal governments through the development of a House and Senate Indian Affairs Committee in the State Legislature.
7. Direct federal and state funding for services and programs that are specific to the needs of different racial and ethnic groups.
8. Foster collaboration, coordination, and sharing of information between the individual tribes and the state.

CHAPTER I: INTRODUCTION AND METHODOLOGY STATEMENT

Purpose

The prevalence of mental illness and alcohol /substance abuse among Native Americans is a very serious threat to the health of Indians and their communities in Washington State. A number of alterations in the funding and organizational structures at the federal, state and local levels have created challenges to programs that address these issues. How they are provided treatment for these serious health issues is greatly influenced by such themes in United States history as sovereignty, self-determination and devolution. Historically, Native Americans have been disproportionately high users of alcohol and substance abuse, as well as mental health services. Attention to their needs, consequently, is a matter of even higher priority than for non-Indians. Equitable and fair funding sources to meet those needs is a matter of considerable importance to Native Americans.

We were interested in this subject for several reasons. The primary reason was our interest in exploring the perception that Native American tribes are a drain on the state economy. Additionally, the impetus for our study was based on our concern about the greater need for treatment services reflected in the high incidence of mental illness and alcohol/substance abuse among Native Americans. We also wanted to explore this subject because of the gradually unfolding consequences of devolutionary policies. Finally, the notion of equitable state funding for programs benefiting state residents who are Native American was important to us in view of the monetary contribution the tribes provide to the state.

Differing perceptions of the issues further compound the difficulties and make research in the area more important. Among tribal leaders, we heard expressed that issues of equity and funding sources are not as significant as the serious social and health maladies found in tribal communities they see around them. For tribal leaders there is very little time or resources available to deal with broader policy questions as they are faced with the overwhelming needs of Indian people. For government workers and policy makers, figures, numbers and laws represent of the needs and concerns expressed by the tribes. Finding common

ground through these and other diverse perspectives is a serious challenge to effective intergovernmental fiscal relationships (S. Gobin, personal communication, April 17, 2000).

State government is increasingly granted greater discretion over federal funds for Native American programs through the devolution process. A lack of understanding in the area of building intergovernmental relationships and the comprehension of funding sources for Indian health services seems to exist among many states. Also important for states is an awareness of tribal treaties and agreements leading to the unique position of tribes in the United States as domestic dependent sovereign nations.

This project is designed to answer some of the serious questions and problems that arise with these complicated relationships. For the Native American community, it is important to have tools to understand state government in order to have effective communication and negotiation. It is important to analyze problems with the flow of funding that must be maneuvered to manage Indian social and health service programs.

In our project, we provide background for further research through investigating information on federal and state funding sources for alcohol and substance abuse programs as well as mental health services to Native Americans in Washington State. We identify how these funding sources produce complications between the state and the tribes providing Indian services. We discuss the impact the phenomenon of devolution has on the need for greater interaction between tribal, state and local governments. Another aspect of this project compares service delivery to American Indian populations as well as to other ethnic minority groups.

Hypotheses

Our project examines the fiscal and administrative relationships between the state and tribal governments through two divisions within the Department of Social and Health Services (DSHS): the Division of Alcohol and Substance Abuse (DASA) and the Mental Health Division (MHD). We explore the delivery of services to Native Americans in Washington State. We discuss our two main hypotheses

below.

Hypothesis 1: Native Americans do not receive equitable state funding for mental health and alcohol/substance abuse services compared to other citizens of the state.

Hypothesis 2: state government involvement in tribal funding for mental health and alcohol/substance abuse impedes access to services for Native Americans.

For hypothesis 1, we define equitable state funding as: 1) the state funds allocated for mental health and for alcohol/substance abuse services for Native Americans, 2) the need for these services by Native Americans versus the need among the general state population, and 3) the number of clients served, and the money spent, on services for Native Americans and other state citizens.

For hypothesis 2, state government involvement is defined as the relationship between the states and the tribes with respect to service delivery. We applied three criteria: 1) accessibility for Native Americans to receive services, 2) certification processes for treatment programs, and 3) alternative tribal treatment service funding.

For the purposes of our project the following terms and definitions will be used. Fiscal relationships are defined as the relationship between the federal, state, local and tribal governments as they coordinate the complex funding sources that provide services to the tribes. This includes direct and state administered "pass-through" federal funds. State refers generally to DSHS and specifically to DASA and MHD. Tribal government, for this project, refers to the federally recognized tribes of Washington State. We use the term Native American and Indian interchangeably throughout the text of this document. The general definition is a person with some amount of Indian blood who is accepted as a member by a tribe or community. For the purposes of federal law, an Indian would have to be a member of a federally recognized tribe (Pevar, 1992; American Indian Lawyer Training Program [AILTP], 1998). Federal matching funds are those funds granted to states for individuals receiving federally entitled

services, which match state contributions for state administered programs. The amount of federal match varies by program and demographic characteristics of the individuals receiving services.

Currently, the State of Washington, through DSHS, administers federal funds in a "pass through" arrangement to Native Americans through both state and tribal programs. The pass-through dollars represent monies allocated from several different sources such as Medicaid block grants and special projects. We review the funding structures within DASA and MHD. While both divisions manage federal pass-through dollars, each division has a distinct method for doing so.

Methodology

Our methodology took into consideration the manner in which intergovernmental relationships occur between the federal, state, and local levels. "[T]he extent to which national, state, and local jurisdictions are interconnected by dollar flows means that policy changes or actions at one level are likely to have important consequences at other levels" (Wright, 1978, p. 102). We relied on primarily unpublished data and interviews. This method created difficulties for collecting information, such as availability of information and scheduling time with key people. These types of difficulties are not uncommon when relying on primary sources. The following forms of data collection were used to examine the relevant fiscal issues for tribes and Washington state.

Interview Data

A major portion of our data collection consisted of face-to-face interviews. We interviewed ten people referred to us by administrators in federal and state agencies, government organizations, and tribal governments. To examine the state's role in implementing and managing state and federal dollars earmarked for tribes, we interviewed eight DSHS employees from DASA and MHD. For a tribal perspective, we conducted two interviews. We also spoke to federal employees from the Indian Health Service, Indian Health Board, and the Health Care Financing Administration. Since our study does not rely on surveys, we employed a less formal and less structured method for our interviews. Some of

the limitations of this method are that information may not be complete and may reflect some biases. We still felt, however, that these interviews were the best means to obtain the relevant data.

Document Analysis

The other form of data collection we employed was document analysis. We reviewed DSHS files and memos to gather our information. This entailed reviewing records that have been developed and maintained by state and tribal government agencies. We examined documents from both DASA and MHD under DSHS as well as the overall DSHS budget. Our goal was to follow the flow of money while differentiating between the federal pass-through dollars and funding derived from the state as well as other sources. Finally, we analyzed the manner in which DSHS manages and implements programs using federal dollars for tribal members.

Audience

We hope this project will find application among several audiences. The intended audiences for our study are public administrators and policy makers. Our goal is to provide a greater body of evidence to improve sound decision making. This research may benefit efforts to improve intergovernmental relationships between the State of Washington and the tribes located within its boundaries. Specifically, tribal relationships with DSHS (DASA and MHD), Indian Policy Support Services (IPSS), Medical Assistance Administration (MAA), and the Indian Policy Advisory Council (IPAC) can be improved with this information. The findings of this research may also prove helpful to the Governor's Office of Indian Affairs (GOIA), the 14 Regional Service Networks (RSNs), the Washington State Legislature, and the 29 federally recognized tribes and tribal programs providing mental health and alcohol/substance abuse services. We also hope to provide support for the New Millennium Agreement Action Plan (See Appendix F) that resulted from the tribal summit held in Leavenworth in the fall of 1999. We also hope to provide information for citizens of the state of Washington that might help to improve understanding and dispel myths about Native American program funding.

Organization of Materials

This document has nine chapters, a bibliography and appendices. In Chapter II, we present a literature review of several relevant subject areas. We discuss alcohol and substance abuse trends nationally and in Washington State, as well as cover current mental health issues affecting the general U.S. and Washington State population. Next, we present research on the relationship between mental health and alcohol/substance abuse. Then we briefly provide a Native American perspective on mental illness as well as alcohol and substance abuse in Indian Country. Finally, we discuss the importance of ethnicity in relationship to mental health and alcohol/substance abuse.

In Chapter III, we cover the historical background and context of the issues relating to our research question. We begin with a brief history of Native American policy. Then we examine tribal sovereignty in its historical context. Next, we discuss state and tribal intergovernmental relations in Washington State. We also cover issues around the current political environment and the perceptions that exist between state and tribal entities. We discuss the history and issues around devolution emphasizing its manifestation in federal, state, local and tribal governments. We conclude with a brief history of tribal alcohol and substance abuse as well as mental health concerns in Native American communities.

In Chapter IV, we discuss federal and state agencies and programs that have played a part in tribal health and social services. On the federal level, this includes the Department of Health and Human Services (DHHS) which contains the Substance Abuse and Mental Health Services Administration (SAMHSA), Indian Health Services (IHS), and the Health Care Financing Administration (HCFA). We describe an influential Memorandum of Agreement (MOA) between HCFA and IHS and discuss issues concerning Medicaid. At the state level, we describe DSHS, which includes the Indian Policy Support Services (IPSS) and the Indian Policy Advisory Council (IPAC) and their administrative policies. Finally, we discuss the Washington State Centennial Accord.

In Chapter V, we explore alcohol and substance abuse programs. We provide a general description of DASA and relevant Native American programs

within the division. Next, we discuss DASA's administrative procedures and service delivery functions. We also describe DASA's funding streams in relationship with the tribes. Finally, we present the need for DASA services among Native Americans.

In Chapter VI, we look at mental health programs. We describe MHD and its service delivery methods. We also describe other options given to Native Americans to receive mental health services through American Indian Mental Health Programs funded at the federal levels that bypass MHD.

In Chapter VII, we provide an analysis of MHD and DASA, which includes a comparison of their respective programs and how they are implemented. We highlight the differences and similarities of the certification processes of each division. We also conduct a fiscal comparison of DASA and MHD by discussing the differing funding structures. We also analyze service needs for Native Americans as well as clients served and dollars spent on Native Americans from both divisions.

In Chapter VIII, we present our findings for our two hypotheses pertaining to both DASA and MHD. We also bring together the evidence found throughout our project that supports our hypotheses.

In Chapter IX, we offer recommendations for future public policy and strategies for improvement of both equitable tribal service delivery and state/tribal relations. These recommendations are based on our research findings.

CHAPTER II: LITERATURE REVIEW

Introduction

The books, journals and research studies we reviewed provided a broad context for the understanding of substance abuse, mental health, and Native Americans' exposure to them. However, a traditional literature review was not possible for some aspects of our project. This was due to the limited availability of relevant studies dealing with funding mechanisms for mental health and alcohol/substance abuse. This chapter is divided into two areas based on the availability of literature: (a) general issues, and (b) Native American context.

For general issues, we begin with a review of research in the fields of alcohol/substance abuse and mental illness that applies to the general population. This was necessary in order to comprehend the severity of the problems these issues create for people struggling with these afflictions. The next part examines comorbidity, the connection between alcohol/substance abuse and mental illness. Finally, we discuss alcohol/substance abuse and mental illness related as they affect different ethnic groups. It is important to understand the interrelation of these conditions and their effects on the general population and ethnic minorities.

For Native American context, we conduct a review to determine the need for continued support and improvement of services to American Indians. We begin the section by investigating research on the issues around alcohol/substance abuse and mental illness for the Native American community. Next, we look at the effects of these conditions on Native Americans as found in alcohol/substance abuse as well as mental health research.

General Issues

Alcohol and Substance Abuse

The 1998 National Household Survey on Drug Abuse (NHSDA) found that alcohol was used by approximately 81 percent of the United States population that was 12 and older. This percentage has remained constant since 1990. Similarly, the rates of substance use have been relatively stable since 1991. Based on 1998 NHSDA data, 36 percent of the United States population was estimated to have

used an illicit drug in their lifetime; the most common illicit drug was cocaine (SAMHSA, 2000a).

In contrast with these national trends, annual reports on substance abuse trends in Washington State produced by DASA from 1992 to 1994 reveal that alcohol abuse treatment for adults has declined from 83 to 65 percent. However, drug addiction treatment for heroine and cocaine increased in the state from roughly 6 percent to 12 percent (State of Washington, 1995).

Another issue concerning alcohol and substance abuse services and their ramifications on our health care system is the increasing need for more services. A rise in expenditures may indicate more people are seeking assistance and/or the cost of treatment has increased. In 1994, it was estimated that approximately $20 billion was spent on inpatient hospital payments due to substance abuse and addiction services through federal and state programs. There are concerns about how programs will be able to pay for the increasingly high costs for these services in the future (National Center on Addiction and Substance Abuse, 1994).

Mental Health

Mental illness, specifically major depression, is the leading cause of disability among developed nations, according to a 1999 report from the US Surgeon General (1999). "For about one in five Americans, adulthood – a time for achieving productive vocations and for sustaining close relationships at home and in the community – is interrupted by mental illness" (p. 11).

The prevalence of mental illness and the need for treatment among all Washington State residents has recently been documented in a survey conducted by the Research and Data Analysis section of DSHS called the Prevalence Estimates of Mental Illness and Need for Services Study [PEMINS] (Holzer, Kabel, Kohlenburg, Nguyen & Nordlund, 1998). Table 1 is based on that study:

Table 1: Prevalence of Mental Illness in Washington Adult Population

Past-year Illness	All Adults[1]	Adults in Household	Adults in Household Living Below 200% FPL[2]
Major Depressive Episode	7.8	7.5	9.7
Generalized Anxiety Disorder	3.0	2.8	4.6
Panic Attacks	4.9	4.7	6.5
Manic Episodes	0.5	0.4	0.7
Psychosis	0.7	0.6	0.9
Any Above Illness	11.9	11.5	15.0

1. All Adults include those living in households, groupquarters (i.e. college dorms, military barracks, shelters, and other), and institutional settings (i.e. correctional institutions, nursing homes, psychiatric hospitals, and other). These population groups account for 96.9%, 1.6%, and 1.5% of Washington's 1998 adult population, respectively.
2. Adults in Households Living Below 200% Federal Poverty Level (FPL) represent 19.1% of Adults in Households and 18.6% of All Adults.
Source: Holzer, C.E., et al., 1998, p. 2

This table reflects the mental health care needs of all residents of the State of Washington, highlighting those who are under 200 percent of the Federal Poverty Level. There are 11.9 percent of adults that have been diagnosed with a mental illness, which includes major depressive episode, generalized anxiety disorder, panic attacks, manic episodes or psychosis in 1997 to 1998. Of that, there are 11.5 percent of adults in households that have been diagnosed with a mental illness. There are 15 percent of adults in households living below 200 percent of the federal poverty level that have been diagnosed with a mental illness. These data indicate that the poorer residents of the state have a slightly greater risk of mental illness.

Comorbidity of Mental Illness, Alcohol and Substance Abuse

There is a growing body of research connecting mental illness with alcohol/substance abuse. For the purposes of this section we will define comorbidity as the relationship between mental illness and alcohol and substance abuse as diseases. The Substance Abuse Mental Health Services Administration (SAMHSA) in a survey focusing on comorbidity conducted by the National

Institute of Mental Health Epidemiological Catchment Area Program found that in a sample of general population of individuals who were 18 or older "any past history of mental disorder was associated with more than twice the risk of having an alcohol disorder, and over four times the risk of having another drug disorder" (SAMHSA, 1998a, relying on Regier et al., 1990).

In another study conducted by the National Comorbidity Survey "found that mood, anxiety, antisocial personality disorder, and substance use disorders were highly comorbid in a general population sampled aged 15 to 54" (SAMHSA, 1998a, relying on Kessler et al., 1994).

It is important to note that mental illnesses occur before addictive illnesses in 83.5 percent of patients being treated for both mental and addictive disorders (SAMSHA, 1998a). "The lifetime co-occurrence of mental disorders with addictive disorders was estimated to be approximately 50 percent" (SAMHSA, 1998a, relying on Kessler et al., 1996).

Native American Context

Native American Mental Health, Alcohol and Substance Abuse Especially important among smaller subgroups, such as the Native American community, is the fact that the presence of multiple disorders tends to be both understudied and under treated. Therefore, further research and program development concerning ethnic communities is desperately needed (National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup, 1999).

The prevalence of mental illness, as well as alcohol/substance abuse in the Native American community are found to be higher than in the general population. Compared to other ethnic groups on a national level, American Indians are in a higher risk group for both mental illness and alcohol/substance abuse disorders (Steenhout & St. Charles, 1997). Several possible explanations for this are provided in chapter 4.

Effects of Alcohol on Native American Populations

Alcohol abuse is a very serious issue among Native American populations and the ramifications of this disease are far reaching. Table 2 provides information about

the causes of death among American Indians and Alaskan Natives as compared with the general population of the United States.

Alcohol is frequently cited as a direct contributing factor for at least 4 of the 10 causes of death: accidents, liver disease (cirrhosis), homicide, and suicide. In addition, excessive alcohol is known to be deleterious to human physiology. Thus, alcohol abuse could hasten death from heart disease, cerebrovascular disease, diabetes, cancers, and could possibly contribute to debilitating and fatal conditions affecting newborns, such as fetal alcohol syndrome (Indian Health Service, 1986, p.7).

Table 2 shows a breakdown of different causes of death for both the general population and Native Americans specifically. The combined percentages of Native American deaths associated with alcohol—which include chronic liver disease and cirrhosis, accidents, homicides, and suicides—is 28.3 percent. This figure is three times higher than the combined percentage of the general population, which is 8.4 percent. This is statistically significant because it reveals that Native Americans are suffering at a much higher percentage than the general population.

Table 2. - Leading causes of death among American Indians and Alaska Natives, 1981-1983, compared with the U.S. general population, 1983

	Indians & Alaska Natives, 1981-1983		All Races 1983	
Cause of Death[a]	Number	Percent	Number	Percent
Disease of the heart (1)	4,220	21.9	755,592	38.3
*Accidents (4)	3,324	17.3	94,082	4.8
Malignant neoplasms (2)	1,966	10.2	433,795	22
*Chronic liver disease & cirrhosis (8)	949	4.9	27,690	1.4
Cerebrovascular diseases (3)	915	4.8	157,710	8
Pneumonia and influenza (5)	638	3.3	48,886	2.5
*Homicide (9)	612	3.2	22,358	1.1
Diabetes mellitus (6)	594	3.1	34,583	1.7
*Suicide (10)	565	2.9	20,794	1
Certain conditions originating in the perinatal period (7)	383	2	28,242	1.4
Other	5,071	26.4	352,065	17.8
Total	19,237	100%	1,974,797	100%

[*]Indicates causes of death associated with alcohol use

[a]Numbers in parentheses = ranking for all races.

Source: Indian Health Service, 1986, p.5

In addition, alcohol abuse can affect individuals, families and communities through "chronic disability, loss of earning capacity, family disruption, incarceration, and considerable pain and illness" (IHS, 1986, p. 12).

The effects of alcohol and substance abuse on Indians are represented by recent DASA statistics citing the prevalence of need for this population. Over 4,950 Native Americans (18.1 percent of the population) were in need of services in 1998. Of those in need, 1,951 Native Americans received services; in 1999, the number rose slightly to 2,282. These numbers reveal that less than half of the Native American population who were in need for services actually received them (see Figure 3 and Table 6) (DASA, 2000a).

The major statistical trends based on recent DASA study on alcohol and substance use that compared Native American with non-Native American clients are summarized below.

Alcohol use is more common among Native Americans than in other clients. Across modalities [ethnicities], a higher proportion of Native American clients (67% - 78%) reported alcohol as their primary substance at the time of admission compared to other clients (46% - 60%).

Across modalities, Native American programs admitted a higher proportion of Native American clients (70% - 8 5%) reporting alcohol as their primary substance than non-Native American programs (7% - 73%).

Drugs other than alcohol and marijuana are not as common among Native Americans. Across modalities, a lower proportion of Native American clients (13% - 22%) reported drugs other than alcohol and marijuana as their primary substance at the time of admission compared to other clients (30% - 49%).

Native American clients (26% - 83%) completed treatment at nearly the same proportion as other clients (29% - 76%) (Rodriguez, 1998, p.1).

Native American Mental Health

Native American communities generally experience twice the national rate of domestic violence, teen pregnancies, child neglect and suicide. Most of these are indicators of mental health problems. The Swinomish Tribal Mental Health Project examined and categorized mental health problems in the Skagit tribes. This study found mental health problems in Indian communities could be characterized by the following:

- multiple and interacting family, financial, physical, legal and psychological problems
- acute symptoms often being masked by related problems (such as alcoholism, delinquency, violence or physical illness)
- diagnosis being complicated by different cultural values and symptom patterns
- the pervasiveness of depression in Indian communities

- a tendency to experience emotional and psychological problems as either physical illness or as caused by external stress only.

(Swinomish Tribal Community, 1991, p. 45)

Studies reveal that mental health problems have a tendency to interact with one another making them difficult to treat because of the complicated nature of their relationship. Mental health problems, particularly depression, are often complicated with alcoholism, so it is necessary to approach treatment practices in a holistic manner (Swinomish Tribal Community, 1991).

So far American Indian mental health needs are treated in the same way as non-Indians. The Diagnostic and Statistical Manual (DSM III-R) of the American Psychiatric Association, the most widely used system in the US for diagnosing mental illness, may not be applicable for use in tribal communities in all situations. It is difficult to assess whether Native American mental health needs are, or can be, met through strictly Western mental health diagnosis and treatment because "so little work has been done on the diagnosis and classification of mental illnesses among American Indians" (Neligh, 1990, p. 26). To complicate matters further, there has been a lack of recognition for culturally adequate theoretical and service models among mainstream agencies that are mandated to serve all communities within their jurisdiction (Swinomish Tribal Community, 1991). All these factors indicate a general lack of sensitivity to the particular mental health needs of Native Americans on the part of traditional Western treatment programs.

Conclusions

Alcohol/substance abuse and mental illness are both serious threats to the health of the general population as well as Native Americans. When the national and state figures illustrating the prevalence of alcohol/substance abuse and mental illness were reviewed, we found that Native Americans have a higher incidence of alcohol related deaths, approximately three times that of a non-Native American. Similarly, Native Americans are twice as likely to experience indicators of mental illness when compared to the general population. This demonstrates the

disproportionately greater need for Native American alcohol/substance abuse and mental health treatment programs and services.

The discussion of comorbidity relates mental illness with alcohol/substance abuse and that too reveals that Native Americans are subjected to it at a much higher rate than the general population.

All of the relevant evidence tends to emphasize the greater need for alcohol/substance abuse and mental health treatment among the state's Native American population. This implies the necessity for more funding of programs to address the higher rate of need. This supports our first hypothesis as it describes the higher rate of need for treatment services among Native Americans.

CHAPTER III: HISTORICAL BACKGROUND

Introduction

In this chapter, we examine the historical background of a wide variety of tribal issues. We do this in order to provide an appropriate backdrop on which to build our research. The complicated nature of our research hypotheses requires a broad review of historical subjects to provide a more complete picture of the project.

We begin by providing a brief history of the development of Indian policy in the United States. Next, we discuss tribal sovereignty in its historical context and relate it to present day. Then, we describe intergovernmental relations between Native American tribes and federal/state governments. We move to a discussion of devolution in relationship to federal and state governments as well as what it means for tribes. Finally, we briefly discuss history of tribal alcohol/substance abuse and mental health.

Brief Tribal History

A number of policy shifts have been experienced by Native Americans since the "discovery" of North America. Tribes maintained their independence until 1787, even during European immigration (Pevar, 1992). After the Revolutionary War, the United States government declared Indian Tribes to have the status of foreign nations and passed several laws protecting their rights. Unfortunately, these laws were not enforced (Pevar, 1992). American states grew increasingly interested in lands held by tribal members and sought ways to obtain them. States that took advantage of and abused the tribes put the rest of the confederation at risk of war with Native Americans. That led to the negotiation of new treaties but they too were subsequently disregarded as the demand for Indian lands grew (Lyons, Mohawk, Deloria, Hauptman, Berman, Grinde, Jr., Berkey, & Venables, 1992, as found in Berkey, 1992).

Later treaties established the status of Indians as citizens, which conferred rights to Native Americans by state and federal governments. As early as 1817, certain tribes began to receive governmental services (Taylor, 1984). In 1828, President Andrew Jackson initiated relocation of Indians, and in 1830 the Indian Removal Act was passed and Indian reservations were established. The General

Allotment Act (Dawes Act) was passed by Congress in 1887. The Act divided Indian land into individual parcels in an effort to promote assimilation of Indians into white farming culture.

The Meriam Report of 1928 brought changes in federal Indian policy because it revealed deplorable conditions of Native Americans living on reservations (AILTP, 1988). In 1934, Congress passed the Indian Reorganization Act (Wheeler-Howard Act) in an attempt to relieve years of oppression and to revitalize economic life of Indians (Pevar, 1992). This legislation helped to stabilize tribal land holdings and allowed for tribal self-governance and encouraged tribes to adopt their own constitutions. The Indian Claims Commission Act of 1946 allowed tribes to sue the federal government (AILTP, 1988).

The next era in federal Indian policy focused on the "termination" of Indians from government services. Termination is the "process by which congress abolishes a tribe's government and ends (terminates) the federal government's trust relationship with that tribe" (Pevar, 1992, p. 57). The Termination Acts called for the federal government to no longer recognize smaller tribes that weren't self-sufficient and relied on federal funding. Other parts of termination legislation forced assimilation into American society through boarding schools. Public Law 280 of 1953 extended state jurisdiction over tribal areas lying within state boundaries, undermining some of the relationships tribes had established with the federal government (AILTP, 1988).

The next federal policy era encouraged self-determination for Indian peoples. Indian self-determination policies started in the 1960's and continue to the present day. In 1968, President Johnson declared: "We must affirm the rights of the first Americans to remain Indians while exercising their rights as Americans. We must affirm their rights to freedom of choice and self-determination." (Pevar, 1992, p. 8). The Self-Determination and Education Assistance Act was passed in 1975, and is often referred to as "638" because it was passed as Public Law 93-638. Under that law, the tribes, through grants and

contracts from IHS, have an opportunity to manage programs that were originally administered through the Bureau of Indian Affairs.

The political status of American Indians in the contemporary context is ambiguous, allowing for changing interpretations by federal and state legislators.

American Indians, however, still stand outside the Constitution as tribes and only have partial protection as individuals. While Indian lands have become part of the United States, Indian communities have neither been allowed to remain isolated as independent political entities nor have they been granted full status within the American political system. Consequently, American Indians have been forced to live within a political/legal no man's land from which there seems to be no possibility of extrication (Lyons, et al., as found in Deloria, 1992, p. 282).

Federal Power Over Indians

The federal government's main source of power over Indians is military, which is supported by the United States Constitution (Pevar, 1992). Article 1, Section 8, Clause 3 (known as the Commerce Clause) states "Congress shall have the power…to regulate commerce with foreign nations, and among several states, and with Indian Tribes". This section of the Constitution recognizes the Indian tribes as a governmental power.

Article II, Section 2, Clause 2 states that the president "shall have power, by and with the advice and consent of the Senate, to make treaties, provided two-thirds of the Senators present concur…". This portion of the Constitution establishes the right to make treaties.

Article VI, Section 2 states "This Constitution and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every State shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding". This section gives Indian laws and treaties equal respect to federal laws, and superiority over state laws in case of a conflict.

The Fifth Amendment provides some limitations over Congress in relation to Indian tribes. The Due Process Clause prevents Congress from enforcing any

law that is arbitrary or discriminatory. The Just Compensation Clause forbids the federal government from taking property without just compensation. This is especially important because the courts have upheld that treaties are a form of property.

The Supreme Court has held that the federal government has the ability to enforce its laws over everyone in the United States because of European "discovery" and eventual "conquest" of the Natives who originally occupied the land. Also, "the Supreme Court has cited the doctrine of trust as a source of federal power over Indians" (Pevar, 1992, p. 48). The trust responsibility means that the federal government has a duty to protect and honor treaty agreements (Pevar, 1992).

Tribal Sovereignty

In most instances, Indian governmental powers are not delegated by Congress; they are inherent powers of a limited sovereign government referred to in the Tee-Hit-Ton Indians v. United States case of 1955 (AILTP, 1998). Essentially, this means tribes have control over both their members and their land. In 1831, the case of Cherokee Nation v. Georgia established the trust relationship between the United States and Indian tribes. This case conceived the phrase "domestic dependent nation" to describe tribes. In 1832, the case of Worcester v. Georgia found that state laws cannot be enforced on tribal lands.

Two important purposes of the limited sovereign government of the Indian nations are to protect tribal culture and provide support to tribal members. Therefore, it appears paramount that tribal governments be involved in the planning and administration of social service programs to tribal members.

In 1998, the Attorney General of the United States, Janet Reno, reaffirmed the recognition of tribes as "domestic dependent nations." This definition stems from Indian treaties that are considered part of the "Supreme Law of the Land." This also leads to the federal government's commitment to the tribes in the trust responsibility to protect Indian tribes and tribal sovereignty. This reaffirmation highlights the interests of the United States to deal with the tribes on a "government-to-government" basis. A reaffirmation of the United States' "unique

legal relationship with Native Americans Tribal governments" by President Clinton in 1994 listed several provisions. These included the tenant that the US government "consults, to the greatest extent practicable and permitted by law, with Indian tribal governments before taking actions that affect federally recognized tribes" (Reno, 1996). This document also states that executive departments and agencies must work to "remove procedural impediments to working directly with tribal governments on activities that affect trust property or governmental rights of the tribes" (Reno, 1996).

Tribes are granted the right of self-determination through firmly established federal policies based on the treaties established between the federal government and the tribes. With this clear directive from the federal government, states must work with the sovereign tribes in the ways described by the President (Reno, 1996).

Intergovernmental Relationships

Intergovernmental relationships between the US government and the Native American tribes result from years of mistakes, misunderstandings, and conflict. Sometimes these issues were resolved peacefully and cooperatively, at other times with great misery and bloodshed. State governments have found their role with tribes more ambiguous. The following is a quote from David Lester, Executive Director of the Council of Energy Resource Tribes. It poignantly states some of the desires and difficulties of establishing better relationships between the states and the tribes:

In the old days before the white people came, people would talk until the issue was resolved. And if a decision wasn't ready to be made, that was okay. We're trying, in a modern sense, to continue the tradition of some southwestern tribes that says, "Let's sit under a tree and talk. Let's share our food together. Let's reach a level of comfort so that we can, in a safe way, lay out our differences and begin to narrow those differences where possible, and define more precisely where our differences lie so that we can do more thinking and more information gathering around those differences. So the next time we talk, we can move the process further along (Reed & Zelio, 1995, p. 1).

Indians had little reason to trust white people because of what they had experienced. Tribal relationships with the European immigrants were strained and great disharmony resulted as the colonists arriving from Europe differed in many ways from the original residents. The Protestant European work ethic diverged from tribal ethics. The Protestant ethic saw humankind as having dominion over the universe, while tribal ethics saw humanity and the universe related in a circle. Norms, roles and institutions all differed between the two cultures, and were used as justification for the more "civilized" colonizers in their pursuit of Indian territories (Joe, 1986).

Even with the aforementioned problems, the federal government has had many opportunities and occasions to build relationships with the tribes. Indian treaties are part of the federal government arrangement from very early in the history of the United States. The states however, do not have this long, established process or procedure for relating to the tribes. As the federal government has worked to define its relationship with the states by giving and taking power, it has also done so with tribal governments. This has led to a severe lack of interaction between the states and the tribes (Reed & Zelio, 1995).

A more contemporary example of intergovernmental relationships results from the winter 2000 meeting of the National Governor's Association. The sentiments of states regarding funding and responsibility for Native Americans within their borders were clearly identified. State governors made the following recommendations regarding the issue of funding for the tribes.

States not be required to subsidize the U.S. government trust responsibility [to provide health care to Indian people];

The Indian Health Service and tribal governments be directly funded by the U.S. government at a level that does not require a state subsidy to provide health services; and

If states continue to be involved in the provision of health services to individuals covered by the federal trust responsibility, 100 percent federal funds be made available to states for such medically necessary care without regard to

the provider of the service or the location of the provider (National Governors' Association, 2000; R. Arnold, Personal communication, April 27, 2000).

Administrators of state programs express difficulty with their role as overseer of federal funds for tribes. The process of passing federal responsibility to states seems to put states in a sometimes ambiguous and difficult position as they deal with federal policy as well as with the tribes.

We increasingly find ourselves dealing with conflicting laws, directives, and regulations in the provision of and payment for Medicaid services to AI/AN clients [American Indian/Alaska Native]. The 1997 implementation of the Memorandum of Agreement between HIS and HCFA demonstrated just how different even these two federal agencies view things. Add 50 states, 550 + tribes, and numerous other entities and the situation gets real confusing (R. Arnold, Personal communication, April 27, 2000).

In an effort to continue the intent of the 1989 Centennial Accord (See Appendix A & Chapter 4), a tribal summit was held in the fall of 1999. This summit resulted in the New Millennium Agreement Action Plan that detailed a number of issues and expectations to improve state/tribal relations. This plan was coordinated through GOIA and included participants from several state agencies and tribes. (See Appendix F & Chapter 4)

"Intergovernmental relations involve relationships of power between and among sovereigns" (Mason, 1998, p. 1). The study of power relationships in federalism and intergovernmental relations has not generally focused on the relationships between the more than 300 federally recognized tribes in the United States and the federal, state and local governments (Mason, 1998).

Unfortunately, state and tribal relationships have tended to be conflictual rather than cooperative in nature. Several factors have contributed to this, but probably the most significant is the omission of any state in tribal relationships guidelines with the federal government in the US Constitution. Another potential source of the discord is that states may see tribal control and tribal profits as a loss of control and of profit for themselves. States begin seeking legal affirmation, by means of regulations and taxation, "in an effort to change the size and status of

Indian lands so that state power can overcome tribal governance" (Mason, 1998, p. 2).

In a 1999 study prepared for the Washington State Office of Attorney General, researchers found several challenges in regards to tribal/state relations. The following excerpt expresses sentiments from state and tribal leaders on health and social services issues.

Many Tribal leaders noted that funding for Indian welfare and health programs goes to the State and that their long term goal is for these funds to be passed through to Tribes. State officials noted that they are responsible for providing services to non-affiliated Indians as well as to Tribal members. Both the State and the Tribes acknowledge concerns about the data used to determine whether the appropriate funding levels are in fact going to Indian people. Several Tribal leaders especially questioned whether adequate mental health funding is being provided to Tribal members, noting that addiction and other mental health problems are very serious on the reservations (Prothro, 1999, p. 23).

Research conducted in 1996 and 1997 revealed several themes when describing the relationship between tribes, states, and local governments. One had to do with a great deal of variation between these intergovernmental relationships. Also, most governmental entities experienced or are presently experiencing difficulties in these interactions. Finally, some relationships were more effective than others, depending on the level of cooperation and understanding among the parties (Steenhout & St. Charles, 1997). This can occur both on the agency/department level as well as in the legislature. “State legislatures also are an increasingly important forum for the discussion and resolution of state-tribal relations, most particularly in states with significant populations of Indian citizens” (Reed & Zelio, 1995, p. 18).

In the area of Native American health care, a 1996 study revealed that current trends show that more programs are being transferred to tribes from the Indian Health Service. The study revealed the effects of devolution on Native Americans as well as strains in the intergovernmental relationship between the state and the tribes. The study also found that as more operational responsibility

was conferred to tribal programs, resource constraints caused a decrease in levels of service; and, consequently, the managed health care delivery systems grew. All these factors contributed to changes in the ways tribes and tribal programs interacted with governmental agencies; inevitably tribes had to establish relationships with governmental agencies not as familiar with tribal conditions (eg. states) (J. Noren, K. Kindig, A. Sprenger, 1996).

Prothro, (1999) also found that as devolution of programs and services from the federal government to the states increases, tribal leaders and state officials seek more collaborative relationships among all the interested parties. More communication and understanding is believed to facilitate greater cooperation and collaboration.

Devolution

Since the creation of the Constitution in 1787, there have been conflicts in the relationship between federal and state government (DiIulio & Kettl, 1995). Over the past 200 years, federalism has evolved from its intended decentralized approach to government to a more centralized approach (Liner, 1989). Recently that trend has been reversed; now state and local levels of government are provided new opportunities and power previously only exercised by the federal government (Liner, 1989). Devolution is essentially "the creation or strengthening of subnational levels of government…that are substantially independent of the national level with respect to a defined set of functions" (Mills, Vaughan, Smith, & Tabibzadeh, 1990, p. 19).

During the fifty years previous to the 1980s, the federal government took on a much-needed role as a more centralized government. Examples could be President Franklin Delano Roosevelt's New Deal and Social Security programs, which were established in a response to severe domestic problems that the state and local governments could not manage (Liner, 1989). During the 1950s, President Dwight D. Eisenhower conceived the national interstate highway system, federal housing programs, and "educational, medical, and pension programs for veterans" (Liner, 1989, p. 5). Several agencies and programs to address a number of issues having to do with civil rights, minorities, the disabled,

and the environment were created during the 1950s and 1960s. This ultimately led to the states implementing a lot of federal programs and regulations. During the 1970s there were numerous concerns and criticisms that emerged about the complexity of the federal government and the intergovernmental relationships that had evolved. Presidents Nixon, Ford and Carter all devolved some responsibilities of the federal government to the state. However, it wasn't until the 1980's, during the Reagan Administration, when the concept of devolution became a priority during Reagan's first term in office (Liner, 1989).

Generally, state and local governments favored devolution because it was a chance for them to gain some power. Unfortunately, there have been some drawbacks; state and local governments have experienced unfunded mandates and other fiscal dilemmas as a result of devolution (Liner, 1989).

Block grants are another instrument of devolution, and they have been steadily increasing. In 1927, federal aid represented less than 2 percent of state and local spending; in 1970 it grew to 19 percent; by 1980 it was 26 percent (see Table 3). Generally, state and local governments prefer block grants because they are receiving monies with little federal control over how they are distributed. Another example of federal devolution to the states is described below.

In 1915, the federal government gave less than $6 million in grants-in-aid to the states. By 1925, over $114 million was spent, by 1937 nearly $300 million. The great growth began in the 1960s: between 1960 and 1966 federal grants to the states doubled; from 1966 to 1970 they doubled again; between 1970 and 1975 they doubled yet again. By 1985 they amounted to over $100 billion a year and were spent through more than four hundred separate programs (DiIulio & Kettl, 1995, p. 31).

Table 3. - Federal Aid to State and Local Governments 1955 -1995

		Federal Aid as a Percentage of:	
Year	Total federal Aid (in billions)[a]	Federal Outlays	State and Local Outlays
1955	15.1	4.7%	10.1%
1960	29.1	7.6%	14.7%
1965	41.8	9.2%	15.3%
1970	73.6	12.3%	19.2%
1975	105.4	15.0%	23.0%
1980	127.6	15.5%	26.3%
1985	113	11.2%	21.0%
1990	119.7	10.8%	20.0%
1995	175.3 (estimated)	15.3% (estimated)	NA

In constant 1987 dollars.

Source: DiIulio & Kettl, 1995, p.34

The impact of devolution has been well received among the citizens of Washington state as well. In a recent survey, a strong majority of 71 percent of the respondents favored devolution and felt that it provided the public more opportunity in determining how government operated in their community. In the same survey, respondents felt that if control was devolving to a local level there would be greater public participation in policy making (W.K. Kellogg Foundation, 1999).

The discussion of devolution and block grants is relevant to the discussion of this project because of the way tribes increasingly rely on the state for federal pass-through funding. This is a change from the direct federal funding they received previously. Historically, Native American tribes have had direct relationships with the federal government. With the advent of devolution, tribes must now negotiate with state and local governments that have the power to administer programs to tribal members.

History of Tribal Alcohol and Substance Abuse

The history of Indians and alcohol dates back to the early Europeans settlers. Several diseases, such as syphilis, tuberculosis and smallpox were transmitted

from the new settlers to the Indians. The Native Americans were particularly susceptible to these Old World diseases because they had no prior exposure. Although it wasn't recognized by this term previously, alcohol was another disease the Europeans brought with them (IHS, 1986).

With the exception of two tribes who had discovered alcohol prior to European contact, Native Americans had no real exposure to alcohol. Even though the European immigrants were frightened by the effects alcohol had on the Indians, it was still traded for furs by hunters and trappers in spite of laws to prohibit its use (IHS, 1986).

According to Sanchez (1967), there are three historical phases relating to Indians and alcohol use. They are divided into the impact period, the prohibition period, and the recreation period. The impact period, which occurred between introduction of European immigrants until 1850, came about when Indians were introduced to alcohol, initially for social reasons and then later as a trade commodity. Although there were attempts to control Indian alcohol use during the 1830s with the passage of the Indian Trade and Intercourse Act, it was not until the prohibition period, from 1850 to 1953, that alcohol was made illegal for Indians.

During the prohibition period there were legal sanctions placed on "the purchase, possession, transportation, and use of alcohol…" even though it was still prevalent throughout Indian country (IHS, 1986, p. 4). Prohibition finally ended in 1953 because it was not enforceable.

The last phase, which is current and on-going, is termed the recreation period. Alcohol consumption is legal unless a reservation prohibits its use. Native American users of alcohol tend to practice rapid consumption instead of social drinking; this is a problem that many Indians and tribal communities face when dealing with alcohol (IHS, 1986).

History of Tribal Mental Health

Indian cultures have experienced widespread changes as a result of the subjugation of Indian territories. The removal of Native Americans from their traditional lands caused radical alterations in their ways of life. High incidences

of poverty are also part of the ongoing social and health problem among Native Americans. All of these developments have resulted in greater prevalence of mental illness among American Indian peoples (Steenhout & Charles, 1997).

Tribal governments acting as community centers are natural places for Indian people to receive care. Tribal mental health clinics have been the answer to many of the problem issues. However, tribal governments have not been able to meet all of their people's mental health care needs due to the lack of resources available to many tribes. Government support for tribal programs is available, yet not always easily attainable (Guilmet & Whited, 1989).

In Western history, the treatment of mental illness has ranged from cruelty and criminalization to self-esteem building programs and "medicalization" of mentally ill individuals. Mental health programs have not been favorably regarded by the American public or by policy makers and have subsequently experienced declines in funding. Indian mental health programs have traditionally been funded at lower levels than other American communities. They have not undergone, however, the same kinds of feast and famine support that other mental health programs have experienced (Neligh, 1990).

There is a considerable lack of community-based data concerning the rates of incidence and prevalence of mental health disorders among Native Americans. Thus little is known about major mental illness in the American Indian community (Spero & Dinges, 1988, as found in Neligh, 1988).

Conclusions

We have provided the backdrop that tribal history, tribal sovereignty, intergovernmental relationships, and devolution represent for considering the issues having to do with Indians and mental health and alcohol/substance abuse. By examining the history of Native American and US government interactions, we can begin to explain the policy context in which Native American intergovernmental relationships exist today. These relationships explain the responsibility the federal government has for Native Americans and explains the recognition of tribes as self-governing entities. This is important to remember as

we look at the transfer of federal administrative responsibility for tribes to the states through the devolutionary process.

We examined the history of intergovernmental relationships first between tribes and the federal government, and then between the tribes and the state to demonstrate the difficulty states and tribes have in implementing federal funding for tribal programs. We examined studies showing how Native American treatment services are affected by the application of federal and state funding mechanisms. These issues are significant because the arrangements can cause problems for tribes attempting to design programs to serve tribal members, which limits tribal sovereignty.

As mentioned above, studies revealed that intergovernmental relations between the states and the tribes made administration of funding more complicated and restrictive. The discussion of devolution reveals the shouldering of more responsibilities for providing services to Native Americans.

We also discuss the history of Native American alcohol and substance abuse as well as mental illness. These issues describe the ways in which the European-influenced American culture has severely affected Indians and in part caused greater incidences of mental illness and alcohol/substance abuse among them. This information is important as we look at the high rates of need for services by Native Americans and at the ways in which sources of funding for treatment programs are delivered to the neediest individuals in American society. This information provides some support for our first hypothesis as it relates to high rates of need for services by Native Americans.

CHAPTER IV: FEDERAL AND STATE AGENCIES AND POLICIES

Introduction

In this chapter, we discuss federal and state agencies and policies through which Native American services are administered. This background information is important for the project as we discuss the agencies and funding sources involved in serving the Native American population. We describe several federal agencies under DHHS that play an integral part in the interaction of social and health services to tribes. We discuss the Medicaid program and impact on to Native Americans receiving its services. Then we detail the relevant Washington State governmental agencies and policies affecting Native American services.

Federal Agencies and Policies

Department of Health and Human Services

DHHS is the federal agency that has the responsibility for protecting the health of all Americans. It has more than 300 health and human services programs, including Medicare, Medicaid, research, immunization, food and drug safety, Head Start, child abuse, domestic violence, services for the elderly, child support enforcement, financial assistance for low-income families, as well as comprehensive services delivery for American Indian and Alaska Natives. It works closely with state, local and tribal governments through eleven operating divisions to implement all of its service programs. Three DHHS divisions are relevant to the discussion of our project because they deal directly with Native American alcohol/substance abuse and mental health services. The three divisions are 1) Substance Abuse and Mental Health Services Administration, 2) Indian Health Services, and 3) the Health Care Financing Administration (DHHS, 2000).

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA), under DHHS, has a mission to "…to improve the quality and availability of prevention, treatment and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses (SAMHSA, 2000b). SAMHSA is divided into three centers: the Center for

Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. Additionally, it has offices of applied studies, managed care, AIDS, women's services, alcohol prevention and treatment, and minority concerns (SAMHSA, 2000c).

Indian Health Services

Under DHHS, Indian Health Services (IHS) provides federal health services to American Indians and Alaska Natives. IHS acts as the principal health care provider and advocate for Indian health care issues. Its mission states that in partnership with American Indian and Alaska Native people, the IHS works to raise Native American "physical, mental, social, and spiritual health to the highest level" (IHS, 2000b). Its goal "…is to ensure that comprehensive, culturally acceptable personnel and public health services are available and accessible…" (IHS, 2000b).

Health Care Financing Administration

Also under DHHS is the Health Care Financing Administration (HCFA). HCFA is responsible for running the national Medicare and Medicaid health care programs, which assist approximately 75 million Americans. HCFA spends over $360 billion annually to buy health care services and insure that contractors and state agencies properly manage these services. HCFA establishes payment policies to health care providers. HCFA also conducts research on health care management, treatment and financing (HCFA, 2000a).

Memorandum of Agreement between IHS and HCFA

The Memorandum of Agreement (MOA) between IHS and HCFA deals with sources of funding for Medicaid programs (see following section describing Medicaid). The MOA is important to discuss because the states and tribes must follow this agreement when utilizing Medicaid funds. The MOA was signed to improve payment policy for Medicaid services provided to American Indians. The MOA ensures that funding for tribal programs is the same for all other programs serving the general population.

The MOA was signed in 1996 and allows funding for tribal mental health and alcohol/substance abuse services to be reimbursed at the full Medicaid rate.

Under this arrangement, states are reimbursed for 100 percent of the costs of treatment for all Native Americans seeking services who qualify for Medicaid (Steenhout & St. Charles, 1997). (See Appendix C)

Medicaid

The basis for the Medicaid program is Title XIX of the Social Security Act. It became law in 1965 as a "jointly funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy person" (HCFA, 2000b). Medicaid is the largest medical and health related service program providing assistance mainly to the poorest people in the United States. States are given a great deal of authority over the Medicaid program. Each state determines its own eligibility standards, as well as the type, amount, duration, and scope of services. Each of the states also establishes the rate of payment for services, and administers its own program. Since the program is determined by each state independently, there are great variations in the way Medicaid is administered across the nation (HCFA, 2000b).

The federal government outlines certain minimum eligibility criteria that must be consistent among the states. One of the financial eligibility standards commonly used by states is the Federal Poverty Level (FPL). This level is determined annually by federal review of the criteria established by the US Census Bureau as a basis for determining eligibility for certain federal assistance programs. Examples of these provisions are low-income families with children; Supplemental Security Income (SSI) program for aged, blind and disabled recipients; infants born to Medicaid eligible pregnant women; beneficiaries of adoption assistance and foster care; certain Medicare recipients; and special protected groups (HCFA, 2000b).

In Washington State, Medicaid and the majority of Washington's health service programs are under the auspices of DSHS (Nichols, et al., 1997). Eligibility for Medicaid is established for children in families whose income is at or below 200 percent of the FPL. Pregnant women may receive Medicaid benefits if their personal income is at or below 185 percent of FPL. There are other requisites of eligibility for people enrolled in the Temporary Assistance to

Needy Families (TANF), formerly Aid to Families with Dependent Children (AFDC), and SSI Related Medical (Nichols, Ku, Norton & Wall, 1997).

As Medicaid is a joint venture between the federal government and the state, the State of Washington is obligated to provide approximately 50 percent of the funding for Medicaid programs. The other 50 percent is reimbursed by the federal government (HCFA, 1996).

Native Americans are entitled to the same state, local and federal programs as other citizens. The relevant state agency is then "responsible for meeting the cost of services provided for all individuals regardless of race or national origin, who apply and are found eligible" (HCFA, 1996). However, the Social Security Act, mandates that the Federal Medical Assistance Matching Percentage (FMAP) be 100 percent for Native Americans (HCFA, 1996).

State Agencies and Policies

Governor's Office of Indian Affairs

In 1969, the State of Washington established an advisory council to the governor. The office became known as the Governor's Office of Indian Affairs (GO|A), and has continued to serve in the capacity of a liaison between state and tribal governments in an advisory, resource, consultation, and educational capacity (GOIA, 2000).

GOIA's mission is to act as a liaison office between tribal, local, state, and federal governments, as well as to assist in improving communications and government-to-government relations. The office assists the governor with the development of legislation and public policies, and serves as an advisor to agencies and constituents. In addition, as called for in the Centennial Accord, GOIA conducts State-Tribal Relations Training for agency personnel who work with Indian people and tribes (GOIA, 2000).

Centennial Accord

As a result of federal devolution policies, Native American programs are shaped by new relations forged with tribes, states and local governments. The states are presented with increasing control of funds earmarked for tribal members. This change requires states and tribes to confront new challenges.

The governor and the federally recognized Indian tribes of Washington State entered into an Accord on August 4, 1989 in an effort to improve tribal-state relationships. Washington state is the only state that has entered into such an agreement with tribes. Under this Accord, each party respects the sovereignty of the other. Both parties have similar interests to achieve mutual goals and to negotiate disputes. The Accord demonstrates an attempt to promote efficiency and to improve beneficial services to both Indians and non-Indians through government-to-government relationships (State of Washington, 1989). In July 1997, Governor Gary Locke reaffirmed the intent of the 1989 Centennial Accord through a proclamation (State of Washington, 1997). The Accord lays the groundwork for understanding how state government is involved with policies affecting funding for tribal programs.

This Accord has been instrumental in creating better government-to-government relations between state agencies and tribes. Over a decade later, policies such as the 7.01 plan (discussed below) have developed in response to the guidelines outlined in the Accord. Both the states and the tribes acknowledge the importance of the Accord and increased communication has resulted. (See Appendix A for full text of the Centennial Accord)

Indian Policy Support Services

With a view to addressing the concerns of Native Americans, DSHS established the office of Indian Policy and Support Services (IPSS). IPSS follows both the 1989 Washington State Centennial Accord and the 1995 federal executive directive signed by President Clinton, which promotes government-to-government relationships. Overall, IPSS coordinates, monitors, facilitates and assesses all DSHS relationships with tribal governments and communities (IPSS, 2000).

To help with the implementation of government-to-government relationships, the department established the Indian Policy Advisory Committee (IPAC) which receives administrative support from IPSS. IPAC committee members are made up of numerous Native American leaders and DSHS division liaisons who represent their respective tribe, organization, or office and are appointed by the Secretary of DSHS. IPAC makes comments and

recommendations to DSHS concerning social and health services to Indian people (IPSS, 2000).

IPSS ensures that DSHS provides appropriate social and health services to Native Americans in compliance with both DSHS goals and Indian treaties, as well as executive orders, state/federal laws, court cases, and state/federal policies related to Native Americans. DSHS considers several factors when making Indian policy, including tribal sovereignty, American Indian self-determination and self-governance, tribal governments, and Native Americans unique social and legal status (IPSS, 2000).

DSHS Administrative Policy 7.01

On November 1, 1987, DSHS enacted Administrative Policy No. 7.01 to demonstrate its "commitment to planning and service delivery to American Indian governments and communities" (DSHS, 1996, p. 1). IPSS oversees coordination, monitoring, and assessment of all DSHS relationships with tribal members, governments and communities to promote intergovernmental relationships in accordance with the Centennial Accord. DSHS is to "provide the necessary and appropriate social and health services to people of American Indian governments" (DSHS, 1996, p. 1). DSHS continues to maintains IPAC to secure the quality of services being provided to the tribes through the 7.01 policies (DSHS, 1996).

This DSHS policy is important in dealing with all social and health issues relating to Native Americans. It acts as a foundation for DSHS divisions in working with Native American tribes on a government-to-government basis. Currently, government-to-government policy training, such as 7.01, is not systematically provided for DSHS employees to help employees recognize and implement Native American policy (See Appendix B for text of Administrative Policy 7.01)

Conclusions

This chapter briefly described federal and state agencies and policies through which Native American services are administered. The MOA allows Medicaid federal reimbursement of 100 percent for Native Americans receiving services. This is an important fact that supports our first hypothesis relating to equitable

state funding for Native Americans because all other state citizens receive 50 percent state Medicaid matching funds for services. Native Americans, on the other hand, receive no state funding for services.

Since the Medicaid program is implemented by each state individually, state government regulations and policies can create additional obstructions for funds earmarked for American Indians. State regulations for funding tribal programs may compromise established federal/tribal trust relationships.

The Indian policies, such as the Centennial Accord and the 7.01 plan, were developed with a view to improving the state/tribal relationships, yet problems still exist. Native Americans are restricted from services by stringent state regulations. This lends support to our second hypothesis.

CHAPTER V: THE DIVISION OF ALCOHOL AND SUBSTANCE ABUSE

Introduction

This chapter provides greater detail about alcohol and substance abuse treatment programs as administered through DASA. A greater understanding of this organization reflects the unique function it performs in relationship to treatment and prevention services to Native Americans for alcohol and substance abuse in Washington State. This chapter is intended to give a general description of DASA and how it relates to Native Americans receiving alcohol and substance abuse services as well as provide an understanding of the funding mechanisms that are related to Native Americans receiving DASA services.

DASA Description

Under DSHS and HRSA, DASA's mission complements the overall agency's belief that "by continuing to develop and enhance our statewide network of prevention and treatment services" DASA will be able "to provide persons with alcohol and other drug addiction with the tools necessary to establish and maintain alcohol/drug-free lifestyles" (DSHS, 2000c). DASA tries to accomplish this mission through a variety of programs and services.

DASA manages programs for alcohol and drug abuse prevention, treatment, and support services. Preference is given to pregnant women, new mothers and families with children, injection drug users, people with HIV/AIDS, recipients of child welfare, and child protective services and youth. Eligibility for treatment services is also available for low income or indigent people that have alcohol and substance abuse problems (HRSA, 2000).

Service Delivery Methods

DASA serves people at a community level. People are assessed for treatment needs and then receive inpatient or outpatient services, as well as other support services which include transitional housing, outreach, interpreter services, child care, vocational and training programs (HRSA, 2000).

DASA plans for services and contracts through five regional administrators, county coordinators and County Substance Abuse Administrative Boards; it also monitors all substance abuse treatment and prevention services.

DASA establishes contracts for community outpatient and prevention services at the county level, and inpatient services with non-profit treatment facilities (HRSA, 2000).

Native Americans and DASA

DASA also contracts with 27 Native American tribes1 for prevention and treatment services for their members. Native Americans access treatment through tribal and community treatment programs, which can sometimes be difficult at the community level since there can be a waiting list. Lack of resources is the primary reason for the wait list. Easier access may be obtained through treatment programs administered by individual tribes since they do not experience the problem of waiting lists as frequently as county programs (see figures 1 & 2); (K. Stark, personal communication, May 4, 2000).

DASA requires certification for all programs, including all tribal programs, in order to receive funding. There is an application fee of $500 for a new agency obtaining certification with DASA. In addition to certification to receive funding, tribes have to report on Treatment and Assessment Report Generation Tool (TARGET), which is managed by DASA to track client treatment (D. Curts, personal communication, May 12, 2000). One problem with the certification process is that it imposes state regulations on tribes. If tribes do not comply with state regulations they are not eligible for the federal funding needed to provide services. (See Appendix D)

DASA has been committed to improving intergovernmental relationships with Washington state tribes. One of DASA's goals is to partner with the tribes in order to assure beneficial and culturally appropriate services to Native Americans. DASA is requiring specific tribal programming training, which concentrates on the 7.01 plan and the government-to-government contracts to ensure respectful, sensitive and responsive services to Native American clients. The training is planned for fall of 2000 (DASA, 2000a).

1 There are currently 29 federally recognized tribes in Washington. DASA has not yet established relationships, in terms of contracts, with the newest two tribes.

The following flow chart, Figure 1, illustrates the money flow from both federal and state sources to DASA, and eventually, the community and tribal level where clients actually receive services. All of the money distributed to Native American treatment and prevention services is federal pass-through dollars. These federal dollars are channeled through the state and managed by DASA.

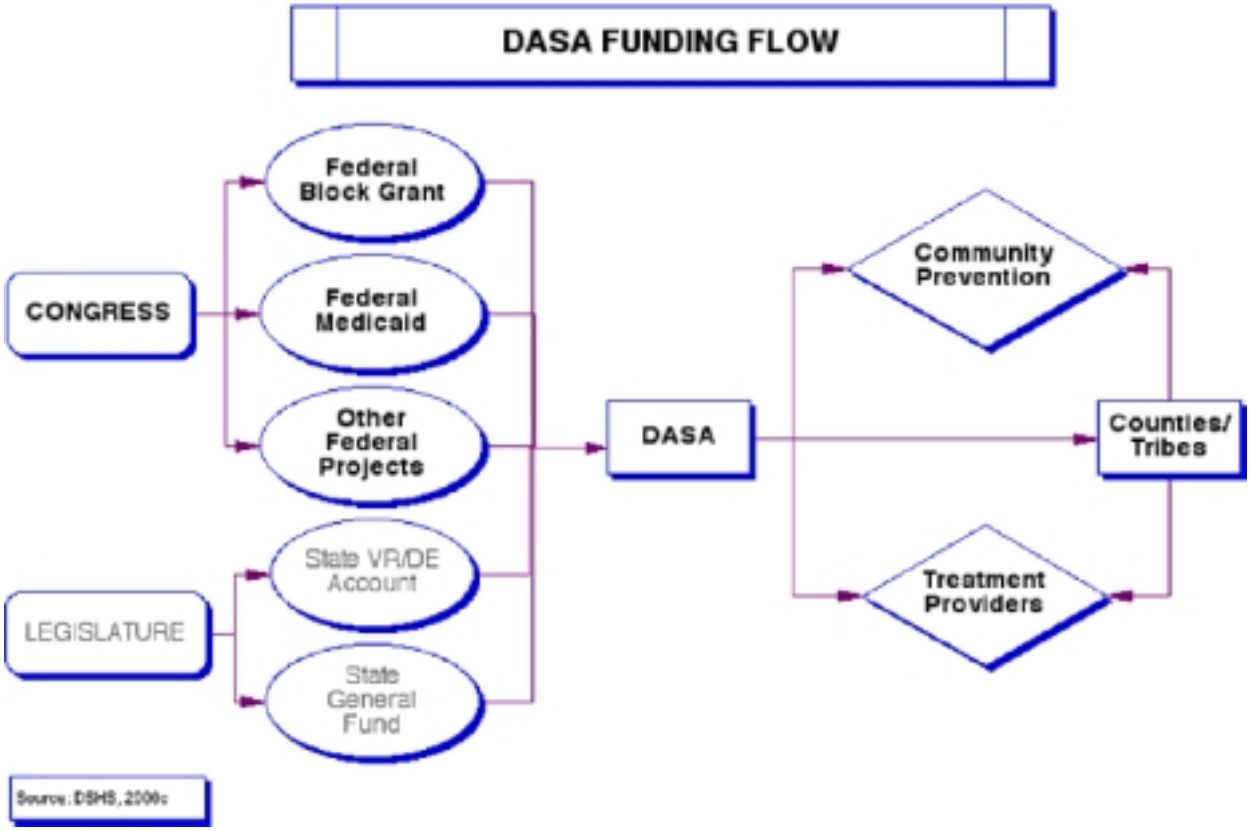
Specifically, money to tribes comes from three sources as illustrated in Table 4: the Federal Substance Abuse Prevention and Treatment (SAPT) block grant, SAPT special projects grant, and Title XIX dollars (Medicaid). These funds are passed through DASA and contracted out to community prevention and treatment providers, as well as to county and tribal programs (DSHS, 2000c; C. Hirsch, personal communication, March 14, 2000).

Table 4: FY 1999-2001 Federal Dollars for Native American Programs through DASA

Federal SAPT Block Grant	$1,400,000
Federal SAPT Projects	$206,000
Title XIX, Medicaid (estimated)	$500,000
State Funds	$0
Total Dollars	$2,106,000

Source: C. Hirsch, personal communication, March 14, 2000

Figure 1



The DASA figures for fiscal year 1999-2001 show the federal monies allocated to tribes. The SAPT block grant was $1.4 million, SAPT special projects was $206,000. Title XIX Medicaid dollars are yet to be determined for this biennium since they are a federal reimbursement to the states based on services that are actually used. Fiscal year 1997-1999 Title XIX dollars were approximately $500,000. If FY 1997-1999 Medicaid dollars are used to help estimate the current biennium's figure, Native Americans would be receiving just over $2 million in federal funding (See Table 4) (C. Hirsch, personal communication, March 14, 2000; May 2, 2000).

Figure 2 lists the statewide DASA programs dedicated to treatment and prevention of Native American alcohol and substance abuse. The column on the left displays state direct contract funding to tribes, while the right column

describes state contract funding to counties. All of the programming represents federal funds that are being managed by DSHS through DASA (DASA, 2000a).

Figure 2

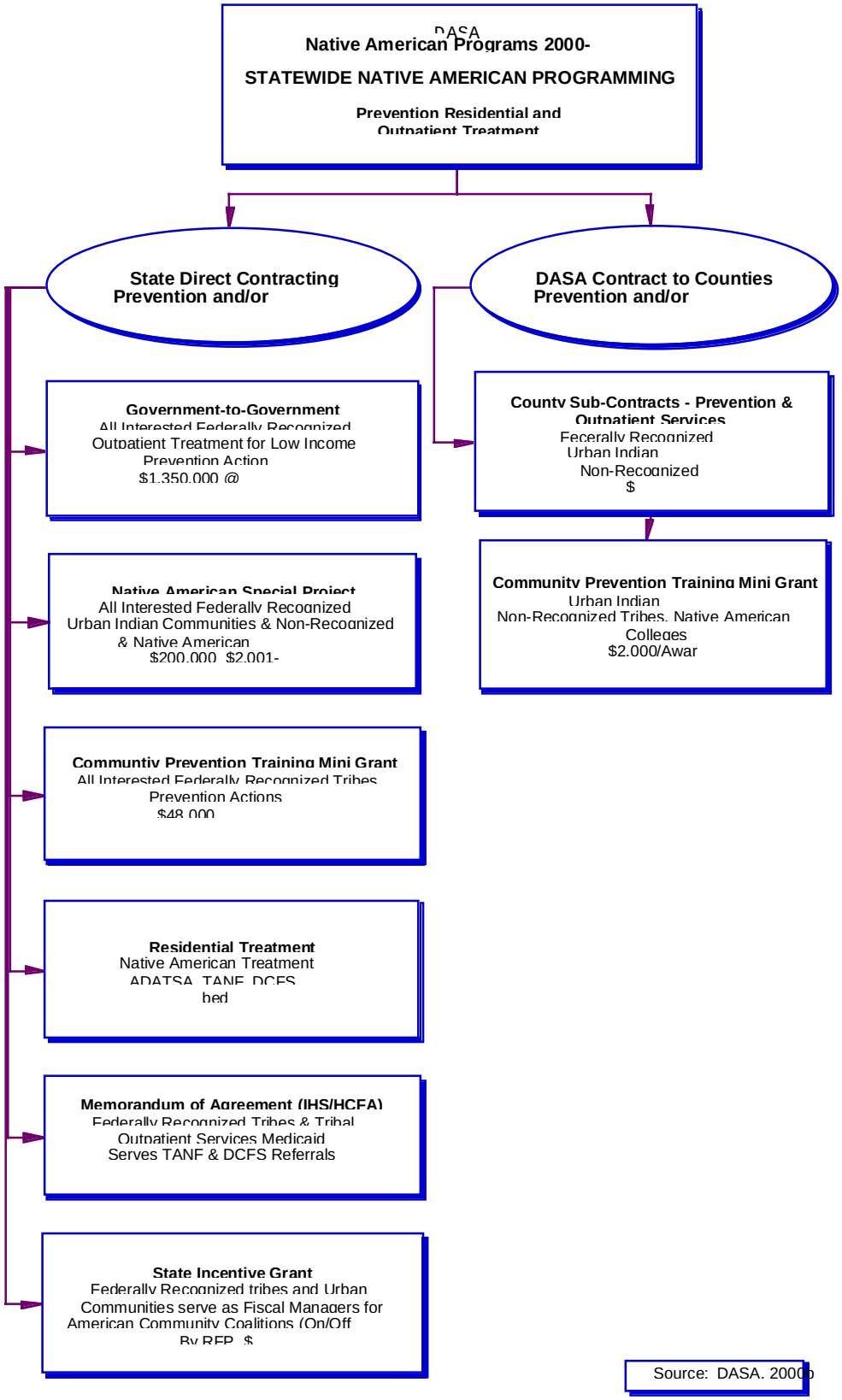

DASA
Native American Programs 2000-
STATEWIDE NATIVE AMERICAN PROGRAMMING
Prevention Residential and
Outpatient Treatment
State Direct Contracting
Prevention and/or
DASA Contract to Counties
Prevention and/or
Government-to-Government
All Interested Federally Recognized
Outpatient Treatment for Low Income
Prevention Action
$1,350,000 @
County Sub-Contracts - Prevention &
Outpatient Services
Fecerally Recognized
Urban Indian
Non-Recognized
$
Native American Special Project
All Interested Federally Recognized
Urban Indian Communities & Non-Recognized
& Native American
$200,000 $2,001-
Community Prevention Training Mini Grant
Urban Indian
Non-Recognized Tribes, Native American
Colleges
$2,000/Awar
Community Prevention Training Mini Grant
All Interested Federally Recognized Tribes
Prevention Actions
$48,000
Residential Treatment
Native American Treatment
ADATSA, TANF, DCFS
bed
Memorandum of Agreement (IHS/HCFA)
Federally Recognized Tribes & Tribal
Outpatient Services Medicaid
Serves TANF & DCFS Referrals
State Incentive Grant
Federally Recognized tribes and Urban
Communities serve as Fiscal Managers for
American Community Coalitions (On/Off
By REP $
Source: DASA. 2000b

Table 5: 1999 DASA Rates of Need & Clients Served for Adult Racial/Ethnic Populations in Washington State

Race/Ethnicity	Treatment Need		Number Served	% Served
White	90,970	12.4%	13,412	14.7%
Black	3,122	8.1%	1,799	57.6%
American Indian	4,950	18.1%	2,282	46.1%
Asian/Pacific Islander	1,509	2.3%	295	19.5%
Hispanic	7,273	7.2%	1,824	25.1%

Source: DASA, 2000c

Table 5 shows the state population broken out by each ethnicity. It shows the percent of each ethnicity's population needing alcohol/substance abuse treatment based on the 1993-1994 Washington State Needs Assessment Household Survey. At 18.1 percent, Native Americans have the largest percentage of need compared to other racial and ethnic groups (DASA, 2000c).

The table also reveals the number of people from each group that actually received treatment for 1999. Native Americans received 46.1 percent of DASA services for 1999. The percentage of the number treated to the number in need of treatment is shown visually in Figure 3 below (DASA, 2000c).

Figure 3 indicates that Native Americans are second only to African Americans in receiving treatment for the people who need it (DASA, 2000c).

Conclusions

This chapter provided an overview of DASA and the services they render to Native American clients. We described the federal pass-through dollars dedicated to the tribes that are administered by DASA. We illustrated how DASA's funding stream does not include any state monies for its tribal programs. Our first hypothesis—tribes do not receive equitable state funding as compared with other Washington state citizens—was supported by the description and illustrations of DASA's funding mechanisms.

We also demonstrated in this chapter that Native Americans have the largest percentage of need for alcohol/substance treatment services among the state's racial and ethnic groups (see Table 5). We also show that Native

Americans do not receive treatment in proportion to their need. The review of treatment needs versus clients served among racial/ethnic groups supports our first hypothesis.

A description of the certification requirements for new prevention/treatment programs was also provided. The necessity for the tribes to comply with state regulations in order to receive needed federal funding supports our second hypothesis, asserting state involvement in tribal mental health, and alcohol/substance abuse treatment impedes access for Native Americans to receive services.

Due to limited state resources, Native Americans may find access to treatment services difficult. Limited accessibility also gives support to our second hypothesis.

CHAPTER VI: THE MENTAL HEALTH DIVISION

Introduction

This chapter describes the Mental Health Division (MHD) of DSHS and explains its role in serving both the general and the Native American population of Washington State. As with the previous chapter, a basic understanding of this division is necessary to provide the groundwork for comprehending the manner in which Indians receive mental health services.

The first part of the chapter provides a description of the agency, examining how services are provided to the broader population of Washington State. Next, we offer a brief comparison of MHD with other states, showing the condition and availability of mental health programs in Washington. Following this is a description of how MHD serves the Native American population. The chapter closes with a discussion of current issues affecting services to Native Americans by MHD.

MHD Description

Under the Health and Rehabilitative Services Administration (HRSA) of DSHS, MHD administers a system of care for adults and children with serious mental illness or who are emotionally disturbed (Nichols, Ku, Norton, & Wall, 1997). Operating as a branch of the Medicaid program, MHD is responsible for providing a system of care in Washington State for people with the greatest need, yet who are least able to meet it. MHD's system of care then "focuses on those with the most profound mental illnesses or mental health crises who do not have the personal financial resources to access care" (Health and Rehabilitative Services Administration [HRSA], 2000). The division also administers programs for people ordered into care by the courts. Statewide, the system serves people with mental health needs of all ages and ethnic backgrounds (HRSA, 2000).

Service Delivery Methods

Born out of the Mental Health Reform Act passed by the legislature in 1989, MHD began to consolidate outpatient mental health services through contracts with 14 Regional Support Networks (RSNs) to provide community-based services. Community-based services, as mentioned earlier, are services that allow

and encourage victims of mental illness to remain in the communities where they live. This is accomplished through the use of outpatient services, medication management, individual and group therapy, day treatment services and case management. Presently, the RSNs arrange outpatient services, or provide them directly, but soon they will also arrange for community based inpatient services for Washington State residents afflicted by mental illness as well (Nichols, Ku, Norton, & Wall, 1997; HRSA, 2000).

The legislation of 1989 also mandated that 100 percent funding for mental health programs be directed to the RSNs. This has reduced the ability for MHD to monitor and assure equal access and proper program implementation of mental health programs to potentially underserved individuals (Y. Misiaszek, personal communication, March 13, 2000; HRSA, 2000). With RSNs receiving 100 percent of the funding allocated for mental health services, another layer is added to the funding flow.

In 1993, the division implemented a capitated payment system, which prepays medical providers on a per-patient, per-month basis, with the goal of providing high quality needed care within the resources available. Each of the RSNs were awarded contracts to serve as a managed mental health care plan for its region. Since enrollment with an RSN is mandatory for all Medicaid recipients, the RSN is responsible for providing all mental health services to the entire eligible population in RSN boundaries with few exceptions (Nichols, Ku, Norton, & Wall, 1997).

To effectively serve the residents of the state of Washington, the RSNs offer an array of services including assessment, service definition and planning, support, and monitoring for the mental health care needs of the population. The RSNs manage local resources for crisis assessment and intervention, treatment, housing, medication management (providing regular medical assistance to persons taking medication) and other needed services. Beginning in 1997, the RSNs began to provide authorization for inpatient services, serving as the gatekeepers to the state hospitals (HRSA, 2000).

In response to state directives, the RSNs craft a plan of care and services to meet the particular mental health needs of all the residents within their local service areas (RCW 71.24: WAC 275-57). To accomplish this, using the systems approach, the RSN pairs mental health resources with the resources of other community systems into an organized plan that addresses all aspects of an individual's life (HRSA, 2000).

Where mental health issues are coupled with other problems, partnerships are developed with other DSHS divisions and administrations including Developmental Disabilities; Alcohol and Substance Abuse; Vocational Rehabilitation; Children and Family; Aging and Adult; Juvenile Rehabilitation; and others. There are also occasions where a particular client situation will necessitate partnerships outside of DSHS, for example, with the Department of Corrections, Department of Health, local schools, local juvenile facilities, advocacy groups, and others. This is all in an effort to combine efforts and resources to help all Washington State residents succeed in their home communities (HRSA, 2000).

DSHS and MHD have also made considerable progress treating individuals with mental illness in community settings. For the years 1993-1995, MHD directed a larger portion of its resources, 69 percent, to funding community-based programs than any other state in the union (Nichols, Ku, Norton, & Wall, 1997).

For its entire client population, MHD has been more successful at obtaining greater federal funding for its patients. Compared to most of the other states, the early and mid 1990's saw greater than average increases in Medicaid matching funds obtained for mental health services in Washington State (Nichols, Ku, Norton, & Wall, 1997). "In 1995, more than 90,000 persons were served through the division, up from 50,000 in 1990" (Nichols, Ku, Norton, & Wall, 1997, p. 51)

MHD and Native Americans

In accordance with the MOA between HCFA and IHS, MHD developed a certification process for mental health programs desiring eligibility for state

funding. These approval and certification processes are quite lengthy and tribal programs must be highly sophisticated to meet the regulations. For example, tribal programs desiring certification must include mental health specialists in four distinct areas of expertise, have a management information system, and have an elaborate certification and credentialing protocol. This is prohibitive for most small tribes with limited resources and geographical access to mental health professionals. (See Appendix E for the certification process documentation)

Another method for securing funding is to have another outlet available for tribes desiring to run mental health programs. The federal government, through IHS as part of self-determination or 638 arrangements as described earlier, can provide funding directly to the tribes. This arrangement is more desirable for tribes than the process by which Medicaid funds are received through MHD. Throughout our interviews with tribal program representatives, we heard expressions similar to the following: "Tribes could secure direct federal Medicaid funding for American Indians by billing HCFA directly for provided services" (L. Mattson, personal communication, March 3, 2000).

To improve accessibility to Native Americans, the RSNs are charged with providing "culturally competent services", which means services provided in a "…holistic, or whole body, approach in services delivery and address many mental illnesses that are common to American Indian populations…" (Steenhout & St. Charles, 1997, p. 122). However, a study by Steenhout and St. Charles revealed that RSN's have not been able to live up to this requirement by either not employing or contracting with mental health treatment providers with culturally competent certification. The result of this is that accessibility to services for Native Americans is jeopardized (Steenhout & St. Charles, 1997).

The following flow chart illustrates the methods and sources of mental health funding and support to the RSNs and the methods by which Native Americans may access mental health programs. Figure 4 shows how funds for mental health services are allocated by Congress and passed through DHHS to IHS and HCFA. Looking at the upper part of the chart, funding for American Indian Mental Health programs is represented by the line flowing from Congress

to DHHS to IHS, which flows directly to tribal clinics. State funding flows are represented in the lower portion of the chart. Following the flow (represented by the line) of federal dollars from Congress to DHHS, the diagram shows that money is then passed to HCFA. HCFA then passes the funds to state programs through DSHS, which passes them on to HRSA, which then arrives at MHD. MHD then distributes funds to the 14 RSNs who in turn contract with either tribal clinics or Primary Health Providers (PHPs). One can get a sense from this illustration that funding flows are much more complicated when the state is involved.

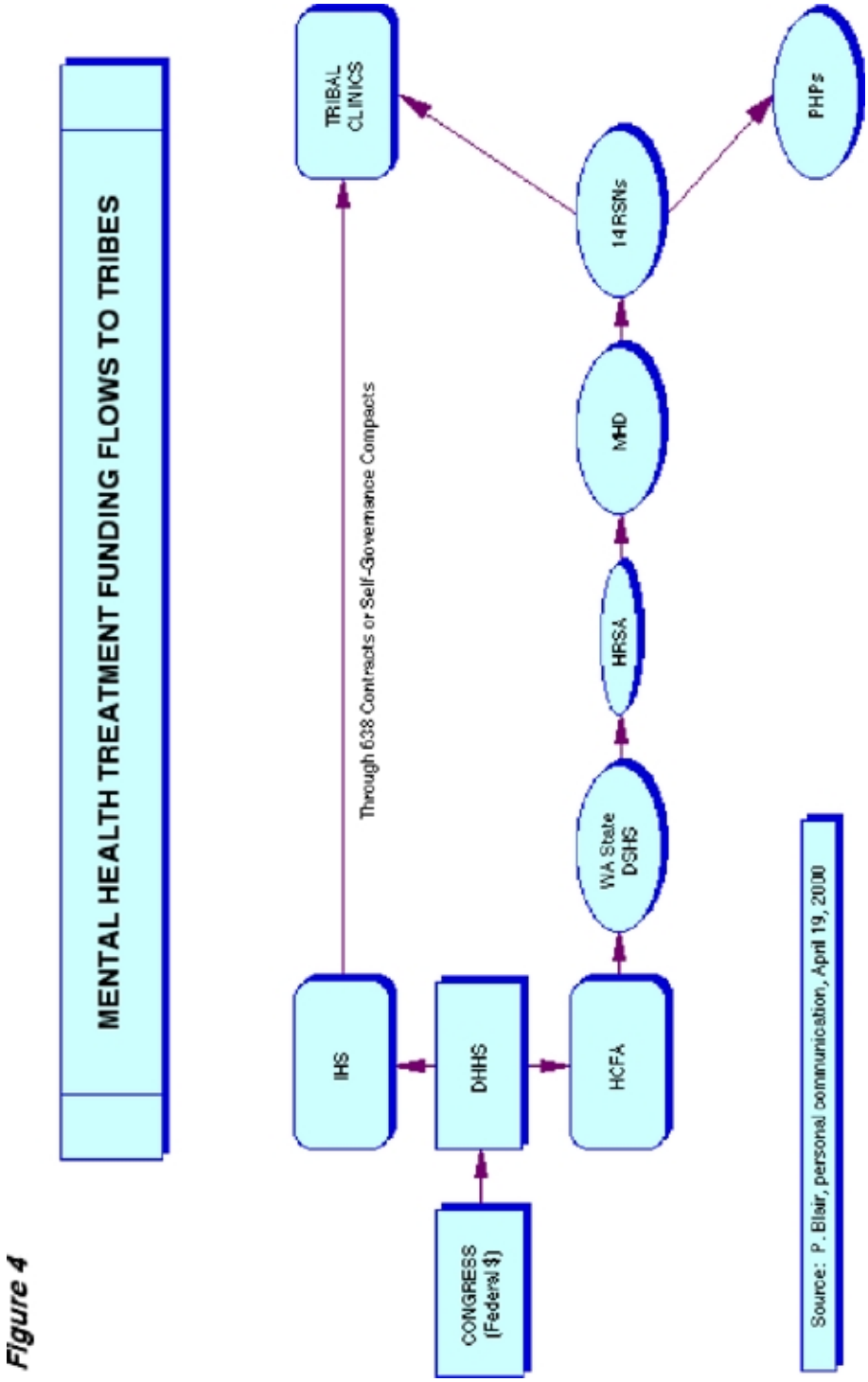


Figure 4

Table 6 demonstrates that 18.5 percent of the Native American households polled by the Washington Needs Assessment Household Survey included persons who experienced a mental health disorder. This was the highest rate of any ethnic group. The next highest group, at 12.1 percent, was the White Non-Hispanic

(NH) population. The lowest rate of mental health disorder experience was the Asian population. Of 1,341 Asian households surveyed, only 5.6 percent of people had a mental health disorder (Holzer, et al., 1998).

This small sample illustrates the greater mental health needs of the Native American population, as well as the importance of adequate funding and administration to help alleviate these problems among Native American communities in Washington State.

Table 6: Percentage of People Surveyed Who Had a Mental Health Disorder		
WAshington Needs Assessment Household Survey (WANAS)		
Ethnicity	Number in Survey	Rate (Percentage)
White - NH*	1655	12.1
Black - NH*	1173	9.6
Asian	1341	5.6
Native American	1174	18.5
Hispanic	1658	9.0

Source: Holzer, et al., 1998, Chapter 9

*NH - Non-Hispanic

There are some questions as to the effectiveness of the RSNs in providing services to the Native American community. The governing body of the RSN is made up of county commissioners who arrive at their positions usually by election and may not necessarily be knowledgeable about mental health services or the effectiveness of certain programs.

Conclusions

This chapter described the MHD and explained its role in serving both the general and the Native American population of Washington State. We discussed issues regarding the funding flow for mental health services and found that exclusively federal funds are utilized for services to Native Americans. This information supports our first hypothesis, i.e., Native Americans do not receive the same level of state funding for mental health services as other state residents.

We found that the services provided by MHD to Native Americans may not be adequate because needs are so much greater than other ethnic groups as

demonstrated in Table 6. This supports our first hypothesis that Native Americans do not receive equitable state services compared to other ethnic groups since greater levels of services are not delivered to Native Americans.

The system of service delivery through the RSNs imposes another layer of government for Native Americans desiring to receive Mental Health services. This may be discouraging to Indians because Medicaid funding is directed through these agencies to the general population and not directly to tribal members requiring mental health services. As mentioned earlier in the Steenhout & St. Charles (1997) study, the RSNs have not been very successful at reaching out to the Native American population. The RSNs' failure to provide services that are accessible to Native Americans through cultural competency upholds our second hypothesis that state government involvement in tribal funding may impede access to services.

Additional backing for our second hypothesis can be found in the certification requirements for tribal programs receiving MHD support. Through the state administration of Medicaid funds that support tribal programs, state certification requirements tend to be burdensome for tribes desiring to provide services to tribal members.

CHAPTER VII: COMPARISON OF MHD AND DASA

Introduction

This chapter focuses on administrative differences between MHD and DASA. We begin by describing the DSHS budget and breakdown the current MHD and DASA portions for this biennium. Next, we compare DASA and MHD with respect to clients served and dollars spent. Then we move to differences in how the respective MHD and DASA divisions manage funding earmarked for the tribes, including a fiscal comparison within each division. Next we describe the state certification process required for tribal programs in order to receive federal dollars and services. We conclude the chapter with a discussion of Native American access to services.

DSHS Budget

DSHS makes up approximately 24.9 percent of the total 1999-2001 State General Fund biennium budget. Aside from public schools, this is the largest portion funded by the state (DSHS, 2000b). DSHS has the most interaction with the state's Native American population of any state agency. However, there are no state dollars earmarked for the tribes; all of the money is federal pass-through funds.

The DSHS budget for the 1999 – 2001 biennial budget was $12,154.5 million, including federal and state monies. The DSHS budget includes the Health and Rehabilitation Services Administration (HRSA), which receives $2,321.5 million (19.1 percent) of the total DSHS funds. Within the HRSA budget, MHD receives $989.96 million (42.6 percent) of the HRSA funds and DASA receives $218.22 million (9.4 percent) (DSHS, 2000b).

These figures demonstrate that greater than half of HRSA's budget (comprised of both federal and state dollars) goes towards MHD and DASA. Table 7 shows the breakdown of the estimated 1999-2001 figures for DASA and MHD across all citizens and Native American populations. Current DASA figures for Native American services in the 1999-2001 biennium can be estimated at approximately $2 million in federal funding. DASA will spend an estimated $216 million on the non-Native American population of the state. Current MHD

figures for Native American services in the 1999-2001 biennium can be estimated at approximately $26.8 million in federal funding. MHD will spend an estimated $990 million of its budget on the citizens of Washington. (DSHS, 2000b; C. Hirsch, personal communication, March 14, 2000; S. Lucas, personal communication, May 22, 2000).

Table 7: 1999-2001 Estimated Dollars for DASA & MHD

	DASA	MHD
Native Americans	$2 million	$26.8 million
All Citizens	$216 million	$999 million

Source: DSHS, 2000b; C. Hirsch, personal communication, March 14, 2000; S. Lucas, personal communication, May 22, 2000

DASA and MHD Comparisons

MHD and DASA have similarities with respect to their funding sources and administration, but they also differ in some important ways. In this section, we compare the administrative structures of DASA and MHD to examine the different organizational frameworks through which Washington's Native American tribes interact. We examine the subtle funding flow differences and make statistical comparisons of the two divisions. This information is helpful in understanding the differences between the two divisions and how they implement Native American social and health services.

Table 8: 1994 Total Clients Served & Dollars Spent on MHD & DASA

State	All Ethnicities				Indian (Non-hispanic)			
	Clients	Pct.	$/Thousands	P t	Clients	Pct.	$/Thousands	Pct.
DASA Total	46,665	4.4%	50,711	1.3%	2,810	8.5%	3,467	3.1%
MHD Total	81,960	7.7%	357,786	9.2%	2,340	7.1%	6,660	6.0%
All Others	942,550	88.0%	3,475,769	89.5%	27,830	84.4%	101,640	90.9%
DSHS Agency Total	1,071,175	100.0%	3,884,266	100.0%	32,980	100.0%	111,767	100.0%

Source: DSHS, 1994, p. 18-19

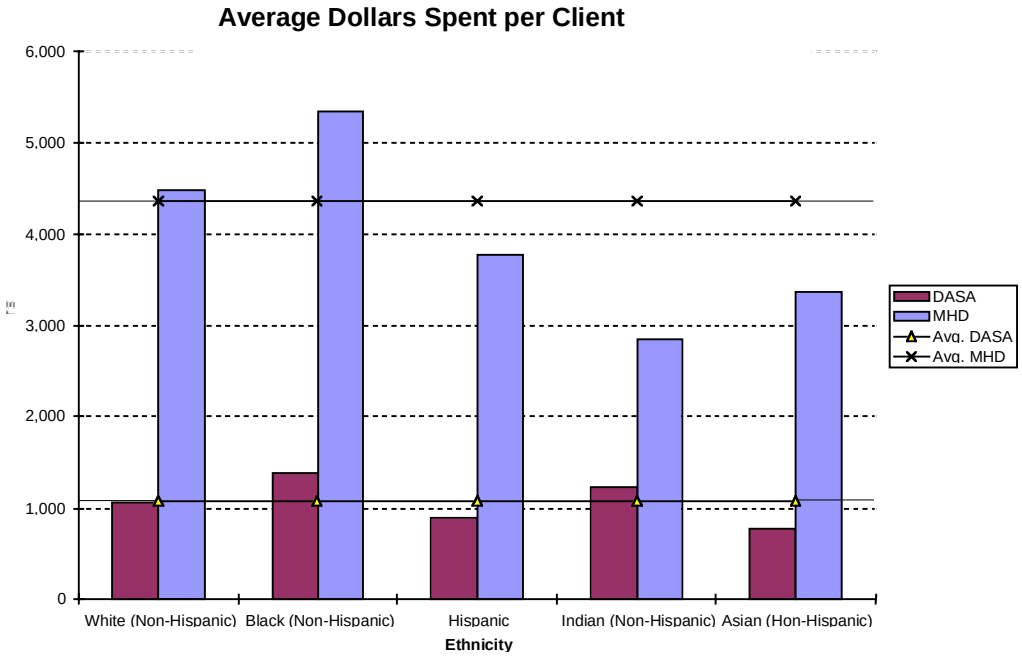
Table 8 shows the number of clients served and dollars spent by DASA, MHD and all other DSHS divisions for the year 1994. The first block shows the totals for all ethnicities, the second shows only the Native American statistics.

The table shows that Native Americans experience higher rates of drug and alcohol problems. The percentage of Native Americans clients seeking DASA services (8.5%) is almost twice as high as the combined total for all races (4.4%). As expected, there is also more money spent on Native American DASA treatments.

When examining the MHD numbers, the percentage of Native Americans seeking treatment is roughly equivalent to the overall total (7.1% vs. 7.7%). The dollars spent on treatment, however, are significantly lower for Native Americans.

This fact is illustrated graphically in Figure 5. This chart shows the average dollars spent per client for each of the five major ethnic groups by both DASA and MHD. The MHD average for Native Americans is the lowest for any ethnicity. This is especially surprising since it costs the state nothing to treat the Indian population. The state is responsible for approximately half of the treatment dollars for all other ethnicities.

Figure 5: 1994 Average Dollars Spent for MHD & DASA across Racial Groups



	All Ethnicities	White (Non-Hispanic)	Black (Non-Hispanic)	Hispanic	Indian (Non-Hispanic)	Asian (Non-Hispanic)
DASA	1,087	1,068	1,383	897	1,234	770
MHD	4,365	4,483	5,348	3,769	2,846	3,363

Source: DSHS, 1994, p. 18-19

Tribal Program Funding Differences

DASA has a relatively simple funding process. Federal funds in the form of block grants, special project grants and Medicaid are received by DASA, and in turn distributed to counties and tribes for prevention and treatment programs. The process for tribal programs to access available funds is simplified because money is received directly from DASA.

MHD's funding streams are more complex. MHD is mandated to distribute 100 percent of funds to the RSNs, which creates an extra level of bureaucracy for tribal programs. This extra layer presents a barrier for tribes because they must interact with another governmental entity.

An alternate payment method for tribal mental health programs exists between the tribes and the federal government (IHS). This funding method bypasses the state system and allows tribes to deal directly with the IHS and is the funding method that the tribes prefer.

One example of where DASA has made some strides in recognizing and acknowledging tribal control over tribal programs is with the allocation of $50,000 biennially for tribal programs. These funds are left to the discretion of tribal programs to use as they see fit, and tribal program administrators are pleased with this arrangement. This allows tribal programs the flexibility needed for the effective administration of programs without any restrictions on how the money may be spent. Tribes have used this money to enhance existing programs as well as develop new prevention programs (L. Thadei, personal communication, April 16, 2000).

Fiscal Comparison within each Division

DASA

In this section we breakdown DASA figures to show differences of federal and state dollars between the general population and Native Americans for 1997-1999 biennium. DASA bills treatment services on a fee-for-service basis. Restated, a bill is generated for each visit to a treatment program and reimbursed by the state using either state and/or federal matching Title XIX Medicaid dollars. Therefore, current figures are estimated and not actual.

Table 9: FY 1997-1999 Medicaid Dollars for DASA

	General Population	Native Americans
Federal	$15,104,804	Approx. $500,000
State	$13,722,830	$0

Source: C. Hirsch, personal communication, May 22, 2000 & May 2, 2000

Table 9 describes federal and state Medicaid money between the state's general population and Native Americans for the 1997-1999 biennium. Keeping in mind that the state is reimbursed 100 percent for services provided to Indians, and approximately 50 percent for non-Native Americans, the table reveals that the

general population receives over a $14.5 million federal match, which is greater than the Native American $500,000 match. In addition, the general population receives a state match of over $13.7 million.

MHD

For the comparison of spending within MHD, we show the total for the entire population versus money spent for Native Americans. MHD's funding structure is based on a capitated rate, that is, a set fee is established, which is an estimate of the cost of delivering treatment services. For each person receiving services, a dollar amount is paid to the RSN delivering the service.

Table 10: FY 1998-1999 Total Dollars for MHD Community Outpatient Services

	General Population	Native Americans
Federal	$438,753,175[*†]	$13,139,975[†]
State		$0

[*] Combined State & Federal funds from all sources

[†] Includes Medicaid Title XIX Dollars

Source: C. Hirsch, personal communication, May 22, 2000 & May 2, 2000

Table 10 shows total funding based on combined state and federal funds for the general population, including Native Americans for FY 1998-1999. For the general population, the $438,753,175 million comes from both state and federal funds, including Medicaid. For Native Americans, the $13,139,975 million represents all federal funds, including Medicaid.

Certification Process/ similarities & differences

The interpretation of both MHD and DASA of the relevant state laws is that tribal programs must adhere to state certification standards (RCW 70.96A). These standards are often more strict than tribal and federal certification standards and leave little flexibility for the tribes to self-determine their tribal programs.

The state requires certification in an effort to better serve the citizens of Washington by creating clear standards and fiscal accountability. The state believes that tribal programs should be upheld to the same regulations as other programs in the state. In accordance with the MOA, HCFA and IHS agree that

tribal-based programs should meet the criteria under Title XIX Medicaid statute and they have suggested that the tribes undergo state certification process in order to meet nationally recognized treatment standards. Although DASA and MHD both require tribal programs to become certified, each division approaches certification differently. MHD allows for more options specific to Native American programs while DASA uses a standard certification method for all tribal and non-tribal programs (See Appendix D).

For mental health programs, state certification may be achieved through one of four options. The first method is available to programs that have previously established contracts with the IHS in American Indian Mental Health programs set up through the Indian Self-Determination Act, better known as 638. The second method is to obtain state certification through special provisions of the Washington Administrative Code; three tribes have exercised this option. The third method is to be processed through MHD. The fourth option is through certification with a national organization, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

Native American alcohol and substance abuse treatment programs become certified by DASA in accordance with state regulations. There is an application fee of $500 for a new agency obtaining certification with DASA (D. Curts, personal communication, May 12, 2000). The application process is standard among all Indian and non-Indian treatment programs throughout the state.

Tribal leaders we spoke to were dissatisfied with certification requirements of DASA because its certification requirements are inflexible and extensive (S. Gobin, personal communication, April 17, 2000).

Native American Access to Services

An argument can be made that Native Americans at the present time do not access available treatment services. If there is unlimited pool of federal Medicaid dollars accessible for tribal members, then why is it under-utilized? One reason is that the individual who wishes to receive service must endure unpleasant bureaucratic paperwork on behalf of the state. Another reason is that Native Americans feel

they have a treaty right with the federal government and object to negotiating with the state to receive services. Yet another reason could be the limited availability of resources at the tribal and county program levels; these programs have limited staff, money and long wait lists that prevent access to services for Native Americans (K. Stark, personal communication, May 4, 2000; L. Mattson, personal communication, May 5, 2000).

Conclusions

The funding picture for Native Americans was explained by the investigation of the DSHS budgets for MHD and DASA. The evidence demonstrated that although Native Americans are served by state programs, they do not receive state funds for services like other state residents. This reinforces our first hypothesis that there is no state dollar investment for Native American services.

Also in support of our first hypothesis is the ratio of dollars spent and clients served for Native Americans and other citizens of the state for MHD. However, under DASA, the data shows that dollars spent on Native American treatment services are slightly higher and the percentage of clients served is twice as high compared to other ethnicities. Although these DASA figures do not support the clients served/dollars spent criteria of our first hypothesis (outlined on p. 9) other portions of our criteria still hold true.

As outlined in this chapter, attempts to give tribes more discretion in allocating funds and determining tribal needs have been successful. These alternate funding methods lessened the burden of tribes to meet strict state regulations for receiving funds. This evidence seems to support the view that the absence of state involvement facilitates better tribal alcohol/substance abuse and mental health treatment programs, which backs our second hypothesis. One example includes 638 funding arrangements that allow tribes to bypass the state for funding and another example could be federal pass-through grants that are given to the tribes with few restrictions.

We also discussed MHD and DASA certification requirements. One major difference between the two divisions was that DASA applied a general certification process for all Native and non-Native American programs, while

MHD provides more options to tribes. We also discussed Native American access to treatment services. Access can be impeded by state regulations imposed on Native Americans seeking services. Both the issues of certification and access supported our second hypothesis that state involvement in tribal funding for mental health and alcohol/substance abuse services restricts access for Native Americans.

Also supporting our second hypothesis was the section in this chapter that discussed Native American access to services. We found that although Indians are entitled to unlimited federal Medicaid treatment funding, that source is not tapped to the degree that might have been expected. Native Americans are less likely to access services because of state paperwork requirements and don't feel obligated to deal with the state to receive services since the trust responsibility lies with the federal government.

CHAPTER VIII: FINDINGS

Introduction

At the start of our research project, we identified two hypotheses. In this chapter, we present our hypotheses and findings. We also provide an analysis of the data we presented in previous chapters.

Hypothesis 1:

Native Americans do not receive equitable state funding for mental health and alcohol/substance abuse services compared to other citizens of the state.

State Investment

DSHS receives funding for Native American mental health as well as alcohol and substance abuse treatment programs almost entirely from federal sources. For all non-Native American state residents in Washington, a matching federal grant of approximately 50 percent combines with a 50 percent state funds to pay for services. Native Americans receive 100 percent federal funds. This makes more state funds available for other state residents in need of services. We find that virtually no state funds are allocated to Native Americans for MHD and DASA services. Although this fact alone does not prove that tribes are not a drain on the state's economy, we hope that current perceptions will begin to take this important fact into account. It substantiates to a remarkable degree this dimension of the first hypothesis. (See pp. 47-49, 56-60, 65, 68-70, 78, 80-81, 89; Table 4; Figure 1 & 2)

Need for Services

We found that greater incidences of mental illness and alcohol/substance abuse among Native Americans are explained in part by the ways in which the European-influenced American culture has severely affected Indians. Native Americans have the largest percentage of need for alcohol/substance abuse and mental health treatment services among the state's racial and ethnic groups. They also experience greater incidences of having both mental illness and alcohol/substance abuse issues concurrently. Though Native Americans receive a high percentage of treatment compared to other population groups, they continue

to be under-served in view of their higher need level. (See pp. 18-24, 40-42, 61-62, 71-72; Table 5, 6; Figure 3)

Clients Served & Dollars Spent

For Native Americans treatment services, the ratio of dollars spent and number of clients served compared with ratios for other citizens of the state show inadequate funding through MHD, which also lends supports to our first hypothesis. However, under DASA, the data shows that dollars spent on Native American treatment services are slightly higher and the percentage of clients served is twice as high as other ethnicities. This can be explained by the greater needs for treatment services by Indians. (See pp. 61 & 77; Tables 5 & 8; Figure 5)

Hypothesis 2:

State government involvement in tribal funding for mental health and alcohol/substance abuse programs impedes access for Native Americans to receive services.

Access

There are no federal restrictions on the amount of federal funds available for Native American services, and each treatment service for Native Americans is reimbursed completely by the federal government. Unfortunately, this vast pool of funding is not fully utilized due to stringent state application and eligibility requirements on the part of the individual applying for services. Native Americans feel that they should not have to deal with state requirements since all of their Medicaid dollars are provided by the federal government as an entitlement based on the federal trust responsibility. Also, accessibility may be compromised when culturally competent services are not addressed. (See pp. 55-56, 65-66, 69 & 83)

Certification Processes

Through the process of federal devolution of administrative responsibility, the state is more accountable for the disbursement of federal pass-through dollars. Therefore, the state agencies try to ensure the proper use of tax dollars when providing services for the citizens of Washington. This has led to rules and regulations governing the implementation of funds allocated for Native

Americans. Since the state is accountable for federal funds, state policy makers tend to interpret certification requirements as "state certified" when the rules imply only that programs be "certified" by the state or by another nationally recognized standard. In some cases, the state certification process is more stringent than federal and tribal regulations. Since the funding received for mental health and alcohol and substance abuse is completely federal, state certification requirements place an unnecessary barrier for tribes seeking funds for programs created by tribal governments and Native American people. We found differences with certification requirements between DASA and MHD. DASA applies a general certification process for all Native and non-Native American programs, while MHD provides more options to tribes. (See pp. 56, 68 & 81-83)

State regulation and certification processes can violate the essence of tribal sovereignty and self-determination. Certification requirements tend to require uniformity in compliance, which conflicts with the uniqueness and individuality of each of the tribes located within the state boundaries. (See pp. 33-37, 56 & 68)

Alternative Tribal Treatment Service Funding

Alternate funding methods for tribal mental health and alcohol/substance abues programs lessen the burden of tribes to meet strict state regulations for receiving funds. One example includes 638 contracts—Native Americans can utilize tribal clinics instead of state and county facilities, which bypasses the state bureaucratic layer that creates bottlenecks impeding efficient delivery of services to Native Americans. Other examples are federal pass-through grants that are granted to the tribes by the state with few restrictions. This evidence supports our second hypothesis that the absence of state involvement facilitates better tribal alcohol/substance abuse and mental health treatment programs. (See pp. 68 & 79)

CHAPTER IX: RECOMMENDATIONS

Introduction

This chapter offers nine recommendations to improve tribal/state intergovernmental relationships and the delivery of social and health services to Native Americans. These recommendations flow from our research effort. Some of the recommendations may apply to MHD more than DASA, or vice versa. We include some recommendations that may seem contradictory, however, we include them for two reasons: 1) we realize that if changes were to occur, they will most likely not occur instanteneously, and 2) are intended to serve as an alternative if another is not implemented. Many of the recommendations are based on the substantive findings of our research while others emerged from a variety of our conversations with interviewees. Still others flowed from the interaction between the two.

Recommendation 1:

Improve state/tribal relationships by facilitating an alternative payment method to allow federal funds to go directly to tribes.

States do not have a trust responsibility with tribes and, therefore, should not be required to administer federal pass-through dollars. Historically, states and tribes have not established formal intergovernmental relationships. Although states and tribes have improved their communication and understanding, states don't have the trust responsibilities or experience that the federal government has. (See Chapter 3)

Tribes are moving in the direction of requesting direct funding for tribal mental health as well as alcohol and substance abuse programs to eliminate problems encountered with state administration of federal funds detailed earlier in this project. This enhances tribal self-determination by allowing the tribes more discretion in deciding the direction of social services to Native Americans. This recommendation supports the alternative program funding process through DSHS proposed at the recent Tribal Summit held in Leavenworth this past fall. (See Appendix F)

Recommendation 2:

Approve alternative certification processes for tribal-based mental health and alcohol/substance abuse programs instead of state regulatory, administrative, and legal requirements.

Some state certification processes tend to be homogenous, blending requirements for tribes into a work plan that treats all individual sovereign tribes as one. This fails to recognize that each tribe has a unique set of values.

DASA and MHD each have their own certification requirements for tribal programs. DASA's certification requirements are the same for all alcohol/substance abuse treatment programs across the state whether they are tribal or non-tribal based. MHD requirements are geared toward each tribe's program as tribal mental health programs have four options for certification. DASA certification requirements should recognize other means of certification to acknowledge tribal self-determination similar to MHD. Although MHD's certification process is more accessible to tribes continued research and dialogue should continue to facilitate alternatives that allow tribal programs easier access to certification. (See Appendices D & E; Chapters 6, 7, & 8)

Recommendation 3:

Promote distinct policies and procedures for state interaction between each of the tribal governments as recognition of their individual sovereignty.

Washington State policies, such as the Centennial Accord, have made efforts to improve state/tribal relationships; however, more emphasis should be given to recognize the distinctiveness of each tribe. Current policies, such as some 7.01 plans and certification processes, create work plans for dealing with "tribal governments", not with individual tribes. These policies may overlook the uniqueness of each individual tribe and create rigidity in state and tribal relationships that cannot bend to meet individual needs. There can also be ramifications on tribal sovereignty and self-determination because tribes are not subject to state agencies.

Recommendation 4:

Provide a comprehensive, on-going statewide program on 7.01 Policy and the Centennial Accord.

State management of federal funds for tribes can be very effective when tribes and state systems work together. Many tribes have created successful working relationships with the state and county entities charged with delivering mental health and alcohol and substance abuse services.

Centennial Accord and 7.01 training programs should be formally developed that include the history of tribal governments, tribal sovereignty, as well as state/tribal intergovernmental relationships. Also, training programs should require implementing the Centennial Accord and the 7.01 Policy as a continuing process instead of one that occurs twice a year. This should be required for all DSHS employees who have contact with the tribes. Implementation could be accomplished through an orientation program for all new department employees, quarterly in-service training to update all new and existing staff, and making resources available frequently. This would help to improve intergovernmental relations between state and tribes. (See Appendices A & B)

Recommendation 5:

Promote increased understanding of fiscal issues faced by the state and the tribes in order to create better comprehension of each side's situation. Provide on-going training to the tribes regarding fiscal issues and how they impact service delivery development opportunities.

States and tribes have not had the experience of relating to each other since treaties and trust relationships were established at the federal level. With increasing federal devolution, tribes and states have been placed in the awkward situation of understanding the role and scope of both sets of government. Increased efforts by state policy makers, agencies and tribal entities are necessary to improve intergovernmental relationships, and ultimately the health and safety of Native Americans.

It is important for tribes and states to improve their communication in matters of fiscal policy. It is important for tribes to comprehend the role of the state in processing federal Medicaid dollars established by the MOA between HCFA and IHS, and for the states to understand tribal sovereignty rights with

respect to federal funding. On-going training on the part of the tribes could be offered to persons who work for an individual federally recognized tribe and could act as a representative in tribal/state fiscal issues. This open communication on fiscal issues can prevent misunderstandings and minimize future conflicts. (See Appendix C).

Recommendation 6:

Empower tribal governments through the development of a House and Senate Indian Affairs Committee in the State Legislature.

In an effort to increase legislative and public support and awareness for tribal and state issues, a legislative committee equipped to address Native American concerns would be useful. An increased understanding and participation on the part of the tribes and the state will foster better policies and decision making among the state and tribes on Native American issues. This recommendation supports the proposal for the establishment of such committee on Indian affairs proposed by the recent Tribal Summit held in Leavenworth in the fall of 1999 and to the Washington State Legislative Session held this past winter of 2000. (See Appendix F)

Recommendation 7:

Direct funding for services and programs that are specific to the needs of different racial and ethnic groups.

It has been shown that there are distinct needs among different ethnic groups. Specifically among the Native American population, there is high occurrence of mental illness and alcohol/substance abuse. By recognizing the particular need of each group, we can better understand how to provide services. If a certain group is at high risk for alcohol abuse, then funding can be specified for treatment and prevention. If the same group has less susceptibility to a particular health concern, funding could be directed to the more pressing issue. This is an important concern because as the ethnic minority populations increase in Washington State, it will be imperative that services be directed appropriately.

Recommendation 8:

Foster collaboration, coordination, and sharing of information between the individual tribes and the state.

While allowing tribes more discretion in obtaining and using federal funding, communication and collaboration between the state and the tribes should be continued and encouraged. This should happen regardless of whether or not tribes use state programs or provide their own tribal program. More than ever, state and local treatment programs should continue to collaborate and coordinate with one another as partners to provide the best support possible for the Native American population in Washington State. The effort of DSHS policy 7.01 is an example of increased collaboration between the state and the tribes. (See Appendix B)

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