STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

CCBHC Technical Assistance

Special Populations

Agenda

- Emphasizing Community Needs
- Children and Families
- Older Adults
- Tribal Populations
- Veterans and Members of Armed Forces

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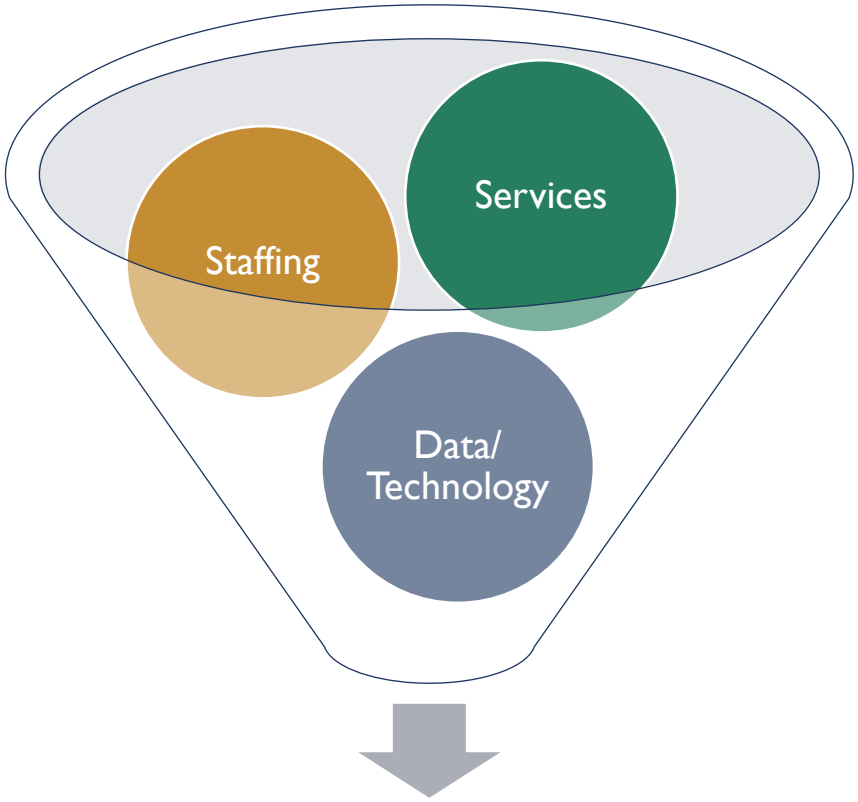
First, a Community Needs Assessment

A systematic approach to identifying community needs and determining program capacity to address the needs of the population being served

Must be conducted in collaboration with other community stakeholders

Why?



CCBHC Strategy to Serve
Target Population

Components of Community Needs Assessment

Geographic details

- A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs.

MH/SUD Data and Service Gaps

- Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose.

SDOH Details

- Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing

Demographics

- Cultures and languages of the populations residing in the service area.

Who is underserved in your area?

Behavioral Health in Iowa Youth

Presented by:
Annalisa Baker, MPH, LCSW
Associate Principal
Health Management Associates

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Topics

Iowa Data on Youth

CCBHC Requirements

Opportunities to Improve Access and BH Care for Children and their Families through the CCBHC Demonstration

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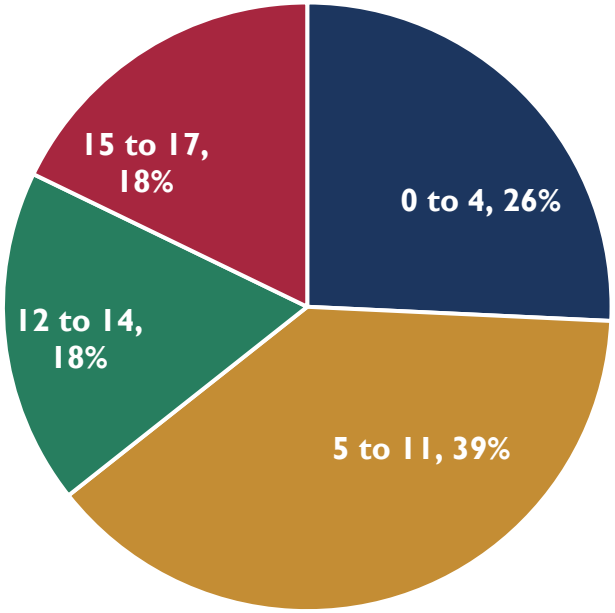
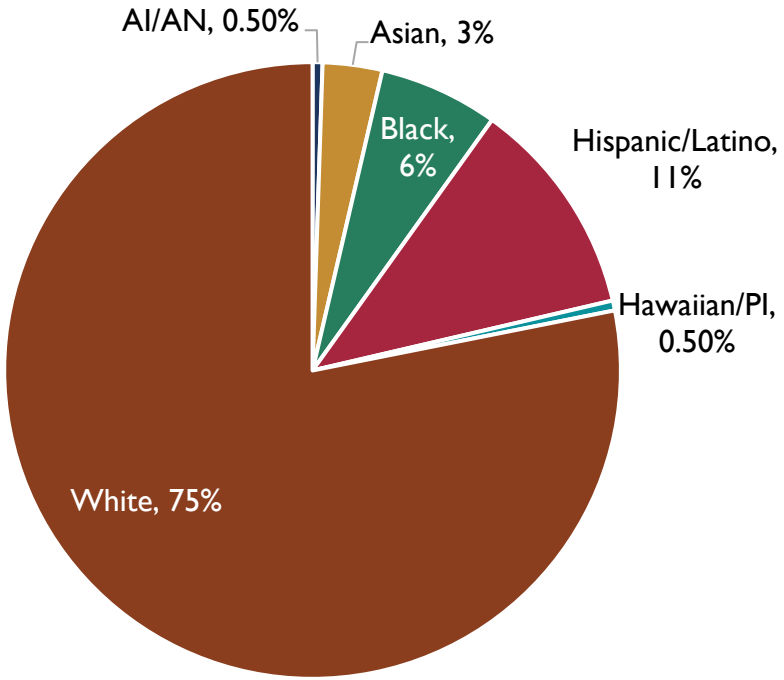
Demographics

724,489 children under age 18 in 2022



Child Population by Race/Ethnicity



Children in immigrant families have grown by 42% (to 94,000) between 2011 - 2021

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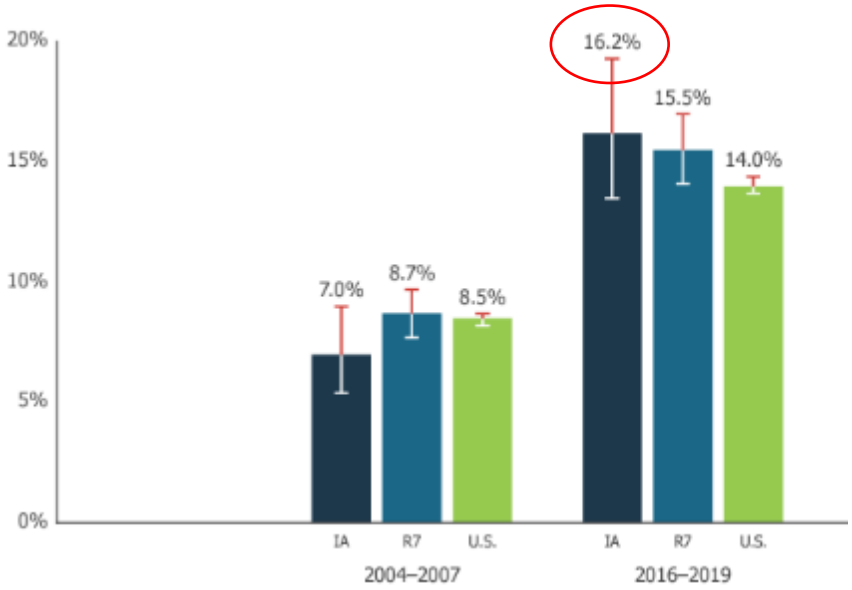
Source: https://datacenter.aecf.org/data/tables/103-child-population-by-race-and-ethnicity?loc=17&loct=2#detailed/2/17/false/1095/68,69,67,12,70,66,71,72/423,424

Iowa Youth Mental Health Trends

Youth aged 12–17, an increase in the annual average percentage with a major depressive episode in the past year



- Only 48.2% of these youth received depression care
- Serious thoughts of suicide and rates of SMI have **doubled** for young adults

Update: In 2019-2020: Younger age groups in Iowa experienced significantly higher estimated prevalence of serious thoughts of suicide, suicidal plans and suicide attempts than their older Iowans.

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Sources:
https://www.samhsa.gov/data/sites/default/files/reports/rpt32832/Iowa-BH-Barometer_Volume6.pdf
https://hhs.iowa.gov/sites/default/files/portals/1/userfiles/133/suicide_data%20brief.pdf

Serious Emotional Disturbance

13.31 per 1,000 of Iowa's youth were identified as having an emotional disturbance affecting their educational performance

About 42,000 children ages 9-17 have an SED

ED visits for youth with SED increased 24% for children aged 5-11 and 31% for those aged 12 to 17

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Sources:
https://mhanational.org/issues/2023/mental-health-america-youth-data#two
https://www.samhsa.gov/data/sites/default/files/reports/rpt39369/adult_smi_child_sed_prev_2021_508.pdf
https://www.unitedwaydm.org/camhi4kids

Iowa Youth SU Trends

- Among young Iowans under 25 years of age, drug overdose deaths increased 120% over the last 2 years (44 in 2021 vs. 20 in 2019)
- Substance use is markedly higher among young adults than other age groups.

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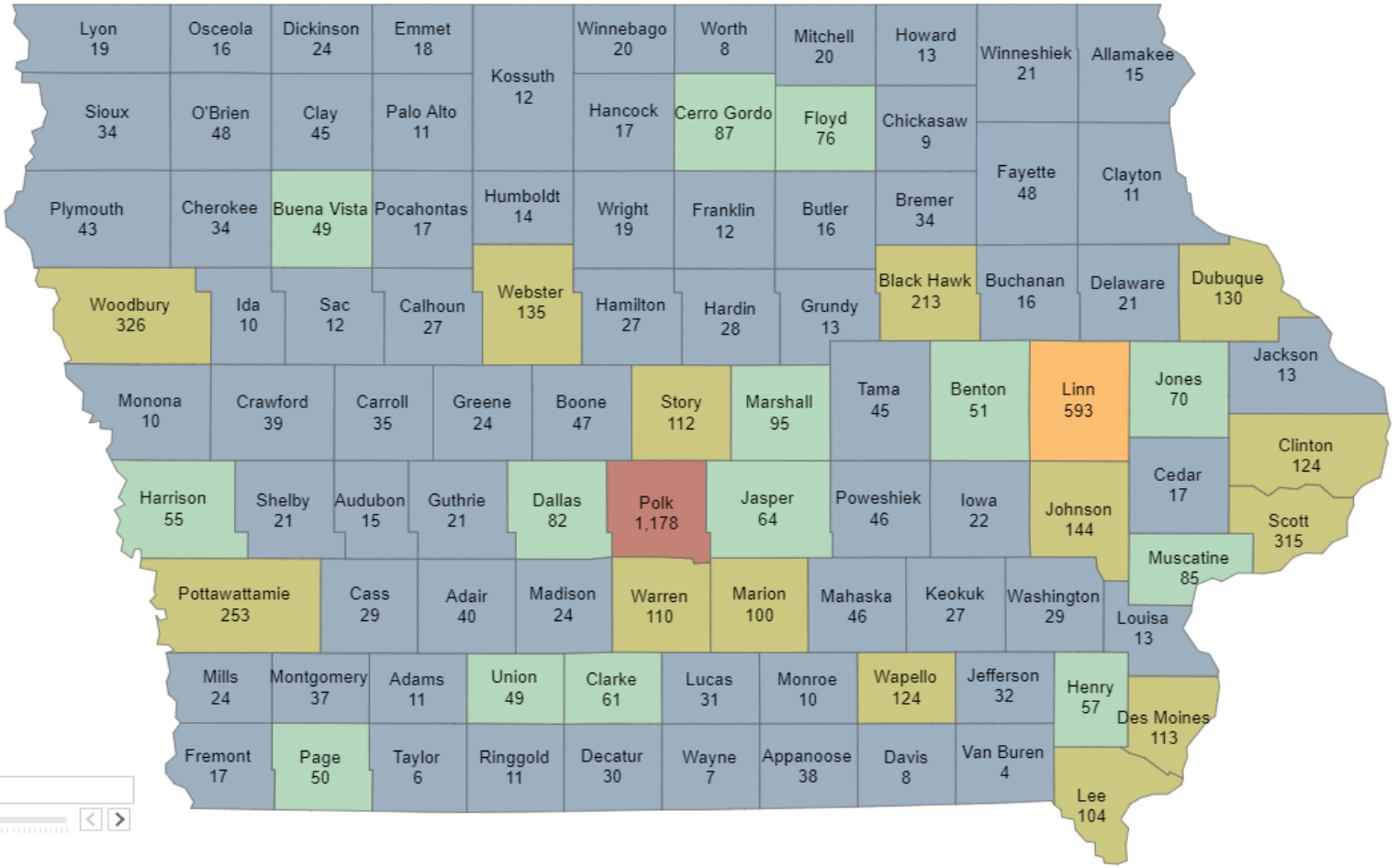
Sources:
https://governor.iowa.gov/press-release/gov-reynolds%C2%A0and%C2%A0officials%C2%A0warn%C2%A0iowans-of%C2%A0dangerous-fentanyl-and%C2%A0fake%C2%A0pills%C2%A0
https://hhs.iowa.gov/sites/default/files/portals/1/userfiles/55/young%20adult%20substance%20use%20data%20brief%20-%20july%202022.pdf

Number of Children in Foster Care in Iowa's Counties: 2022



Year
2022

Children in foster care

- Less than 50
- 50-99
- 100-499
- 500-999
- 1,000 or more

Source agency name: Iowa Department of Health and Human Services, Bureau of Public Health Performance-Quality Improvement
Source agency contact: (515) 281-5232
Source agency release date: March, 2023
Date added to State Data Center Web site: March 21, 2023
State Data Center contact information: State Library of Iowa, State Data Center Program, http://www.iowadatacenter.org 800-248-4483, census@iowa.gov

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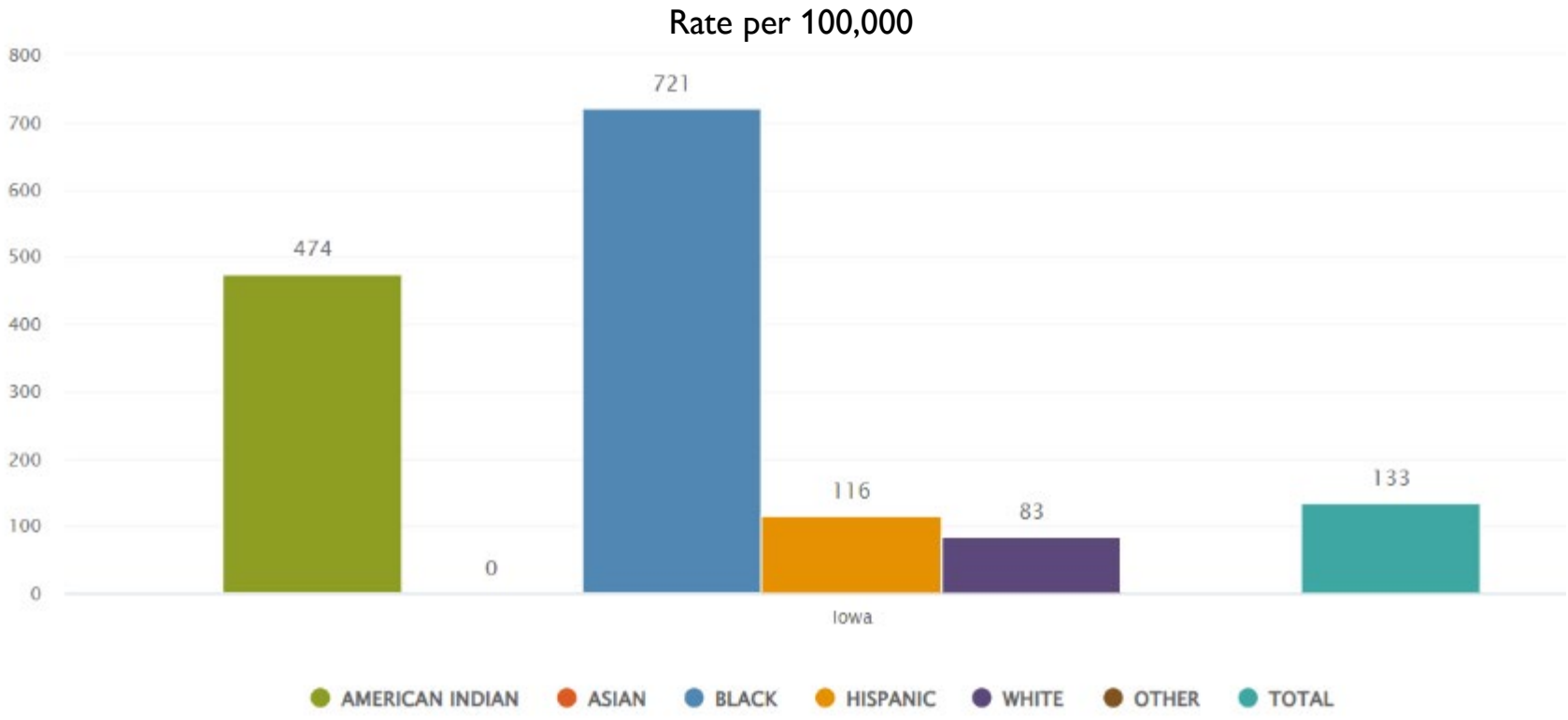
Juvenile Detention

Youth Residing In Juvenile Detention, Correctional And/Or Residential Facilities By Race And Hispanic Origin In Iowa



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Sources:
https://datacenter.aecf.org/data/tables/8391-youth-residing-in-juvenile-detention-correctional-and-or-residential-facilities-by-race-and-hispanic-origin?loc=17&loct=2#ranking/2/any/true/1729/4038/17598

CCBHC Demonstration Requirements for Youth

BH Clinic Collected Measures

- Time to Services (I-SERV)
- Depression Remission at Six Months (DEP- REM-6)
- Screening for Social Drivers of Health (SDOH)
- Screening for Clinical Depression and Follow-Up Plan
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) (optional)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C) (optional)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) (optional)

https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-techincal-specifications-manual.pdf

State-Collected Measures

- Youth/Family Experience of Care Survey (YFEC)
- Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD and FUA-CH)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) (optional)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) (optional)

https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-techincal-specifications-manual.pdf

Scope of Service Requirements

- Evidence Based Practices (State Requirement):
  - Functional Family Therapy (FFT) or
  - Multi Systemic Therapy (MST) or
  - Multi-Dimensional Family Therapy
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Care Coordination Partnerships
  - Schools
  - Child Welfare agencies
  - Juvenile justice agencies and facilities
  - Child Placing agencies for therapeutic foster care
- Crisis Services (intervention, 24/7 mobile crisis, stabilization)
- Family/Caregiver supports

Opportunities to Enhance Support & Services through CCBHC Demonstration

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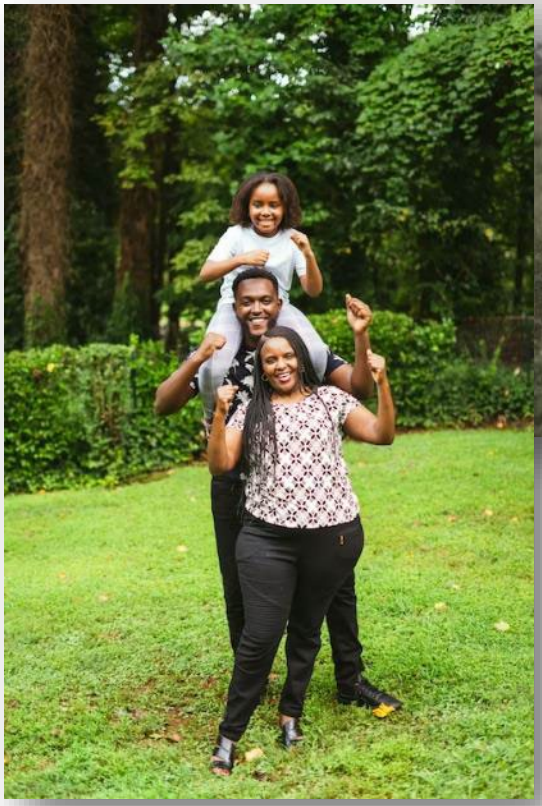
Children in the Context of Family…



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And Their Communities

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Strengthening Partnerships

- Identify key strategic partners
  - Schools
  - Hospitals
  - Family peer networks
  - Pediatricians
  - Child welfare organizations

Going beyond informal referrals to formal arrangements that include data sharing and concrete collaboration

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Strengthening Care Coordination

Go beyond informal and referral relationships

- Integrated communication workflows
- Closed-loop referral tracking
- Formal care team development and interdisciplinary team huddles
- Formal data sharing arrangements
- Co-location of care coordination, peer and/or navigator staff
- Joint measurement-based care efforts
- Become a community-convener to generate forums for collaboration for children with complex needs
- Become an integral part of foster care family team meetings and/or invite the caseworker to your team huddles

Enhancing Access

Tie these back to measures:
Time to Services
SDOH Screening
Depression Screening

- Schools
  - Co-locate staff to facilitate same day screening and short-term intervention
  - Train school staff to recognize signs of crisis and creating trauma informed environments
  - Increase BH screenings
- Training for all front desk staff to recognize crisis and de-escalation techniques
- Partner with acute service providers (hospitals, urgent care) to be the first line call for BH screening and assessment
- Provide intensive care coordination for high-risk youth
- Offer same-day access to treatment for urgent and routine needs, not just same-day access to intake
- Conduct same-day intake post hospital discharge

New Ways to Approach Care

Tie these back to measures:
Time to Services
Follow-up post-ED & Hospitals

- Upstream prevention
- Targeted Outreach and engagement
- How to support a FAMILY as a unit for care
- Offer supportive services to parents and families as an adjunct to school-based mental health and other youth-focused services
- Collaborate with schools to implement evidence-based prevention programs
- Staffing for home visits post crisis to reduce readmissions
- Using family, peer, care navigators and/or care coordinators support connection and engagement in services in schools
- Use of innovative technologies as treatment extenders for youth
- Invest in training for evidence-based practices for youth who have suicidal ideation, i.e., Dialectical Behavior Therapy

Sources

- Leveraging Medicaid to Support Children and Youth Living With Complex Behavioral Health Needs. The Commonwealth Fund. November 2023.

https://www.manatt.com/Manatt/media/Documents/Articles/The-Commonwealth-Fund-Report_2023-11_c.pdf.

- Certified Community Behavioral Health Clinics: A Vision for the Future. National Council for Mental Wellbeing. October 2023.

https://www.thenationalcouncil.org/resources/ccbhcs-a-vision-for-the-future/

Questions

Partnering and Providing Behavioral Health Services for Older Adults

Barry J. Jacobs, Psy.D.

Principal, HMA

Philadelphia

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Today's Talk

- Overview of older adults/BH challenges in the US and Iowa
- CCBHC approach to older adults
- Three typical cases
- Person- and family-centered
- Best practices/EBPs
- Community connections

Our Aging Population

- 2022 US Census Age 65+: US (18.3%); Iowa (17.3%)
- 19th oldest state
- Oldest IA counties (Older Iowans2023: Iowa State Data Center & Iowa Department of Aging): Polk, Linn, Scott, Black Hawk, Johnson, Dubuque, Pottawattamie, Woodbury, Story, and Dallas—some up to nearly 25%
- Poverty rate (Census): 11%
- 44% of older Iowans live alone (Data Center)

Older Adults' Behavioral Health Needs

- CDC: 20% of Americans 55+ suffer BH disorders
- SAMSHA: >50% receive treatment
- Men 85+ have highest rate of suicide (45.23/100,000) compared to national rate (11.01/100,000)
- AARP: rising rates of homelessness
- US Health and Retirement Report: 43% of Americans 60+ report feeling lonely; associated with increased rates of BH/PH disorders

CCBHC Requirements for Serving Older Adults

- Age-appropriate screening and preventive interventions
- CCBHC has agreements in place with community agencies serving older adults--e.g., IA's Aging and Disability Resource Center (ADRC) which has six Area Agencies on Aging (AAAs) in the state

Three Typical Cases

- 82-year-old man with chronic medical illnesses, Alcohol Use Disorder, and Mild Cognitive Impairment. Spouse died and family and friends have moved away or died. Lives in rundown house. Socially isolated and lonely. Stressed by finances. Presents with Major Depressive Disorder with AUD
- 73-year-old woman with long history of Schizophrenia and mild depression. Inconsistent medication adherence. Lives alone in rented room in a house. Mental and physical health appear to be deteriorating. Socially isolated. Doesn't feel comfortable at senior centers.
- 67-year-old man, originally from Mexico, who is a former farm worker. Undocumented. No local family support. Receives church donations of food and money. Unstable housing. Chronic musculoskeletal pain. High levels of anxiety about dying alone.

Best Practices

- **American Psychological Association's Guidelines for Psychological Practice with Older Adults (2024)**
  - Competencies: understanding of adult development, including:
  - Biological aspects (e.g., changes in sensory and other functioning, impact of chronic medical illnesses/medications, cognitive changes, use of MOCA or Mini-Mental Status Exam for cognitive screening)
  - Psychological aspects (e.g., depression/anxiety, maintaining sense of identity with increased dependence upon others, family dynamics)
  - Social aspects (e.g., impacts of social connectedness/isolation, cultural diversity, available community supports)
  - Psychotherapy/pharmacotherapy both effective
- Specific evidence-based therapies: CBT, interpersonal therapy, PST
- **American Psychiatric Association Telepsychiatry Toolkit:** telepsychiatry is widely used and well accepted for older adults

Increasing Social Connectedness

- Facilitate increased connections with:
- Natural supports, including family, neighbors, religious institutions, volunteers, neighborhood hangouts, cultural organizations, current and former work colleagues
- Professional supports, including AAA-run senior centers, adult day care programs, home care aides
- May require transportation

Questions

Partnering and Providing Behavioral Health Services for Veterans and Members of the Armed Forces

Muriel Kramer, LCSW, FNAP

Veteran United States Air Force

Senior Consultant, HMA

Boston

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Discussion

- Case Vignettes
- New Veteran Demographic Profile
- Iowa Specific Considerations
- Evidence-based Treatment Modalities
- Partnering with VA
- Questions

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Case Vignettes

42 year old white male

- Experiencing homelessness
- Polysubstance use disorder with opioid use disorder (OUD) primary
- PTSD, Anxiety Disorder
- Hypertension
- Justice Involved
- Combat Experience
- Honorable Discharge/ Fully qualified for VA benefits
- Refuses VA supports/ refuses to acknowledge military service

38 year old white woman

- Experiencing homelessness
- Opioid use disorder
- PTSD, Severe Anxiety Disorder
- Survivor of military sexual trauma (MST)
- Combat experience
- Honorable Discharge/ Fully qualified for VA benefits
- Connected to VA for Psychiatric services

The Changing Veteran Population

- US Veteran population will evolve over the next 20 years, with a steadily decreasing population, changing demographics, and increasing care demands that will include more complex needs and higher costs of care.
  - Younger and with more complex needs
  - More frequent and longer deployments, with greater combat experience combined with higher survival rates from more serious injuries
  - All veterans report lower quality of life relative to the general population
  - Veterans with behavioral health concerns and/or substance use disorder (BH/SUD) report a 35% worse HRQoL than comparable civilian patient populations
  - Veterans diagnosed with a BH/SUD have a significantly elevated suicide risk, at 57.2% and 90% respectively— nearly six times greater than the civilian population

The Changing Veteran Population, continued

- The prevalence of posttraumatic stress disorder is 5−23% higher
- Suicide rates are much higher for post-9/11 veterans, growing 73% in the last 15 years
- Female veterans attempt suicide three times more often than men
- Veterans subjected to military sexual trauma (MST) during service need specialized services
- Veterans diagnosed with PTSD are at greater risk for many chronic diseases like heart disease, rheumatoid arthritis, asthma, liver, and arterial disease
- Veterans with traumatic brain injury (TBI) are at higher risk for seizures, disorders of neurocognitive functioning, dementia, and other chronic conditions.

Iowa Specific

- About 7% of Iowa's population are Veterans, and 6% live at or below poverty
  - They are likely to have unique health and specifically BH needs
- How do we know an individual is a Veteran
  - Do we ask at intake?
  - If we ask, do we have an understanding of the unique needs they may have
- Rural, how do we serve them first and then potentially connect them to VA services
- Stigma
  - Self / Community / Provider

Evidence-based Practices (EBPs)

- **Cognitive Behavioral Therapy (CBT)**
  - **CBT-D *for depression***
  - **CBT-I *for insomnia***
  - **CBT-SUD**
- **Cognitive Behavioral Conjoint Therapy (CBCT) *with family***
- **Contingency Management (CM)**
- **Eye Movement Desensitization Reprocessing for PTSD (EMDR-PTSD)**
- **Safety Planning (SP)**
- **Suicide Prevention**

Leveraging the Iowa VA System:

Mission: *"… to care for those 'who shall have borne the battle" and for their families, caregivers, and survivors."*

- MH Care Mental Health Care | VA Central Iowa Health Care | Veterans Affairs
  - Locations | VA Central Iowa Health Care | Veterans Affairs
- AnnualReport_2021.pdf (va.gov)
- VA Central Iowa Health Care System
  - COE/ CBO Clinics/ Mobile Clinic
- Iowa City VA Health Care System
  - CBO Clinics
- AnnualReport_2021.pdf (va.gov)

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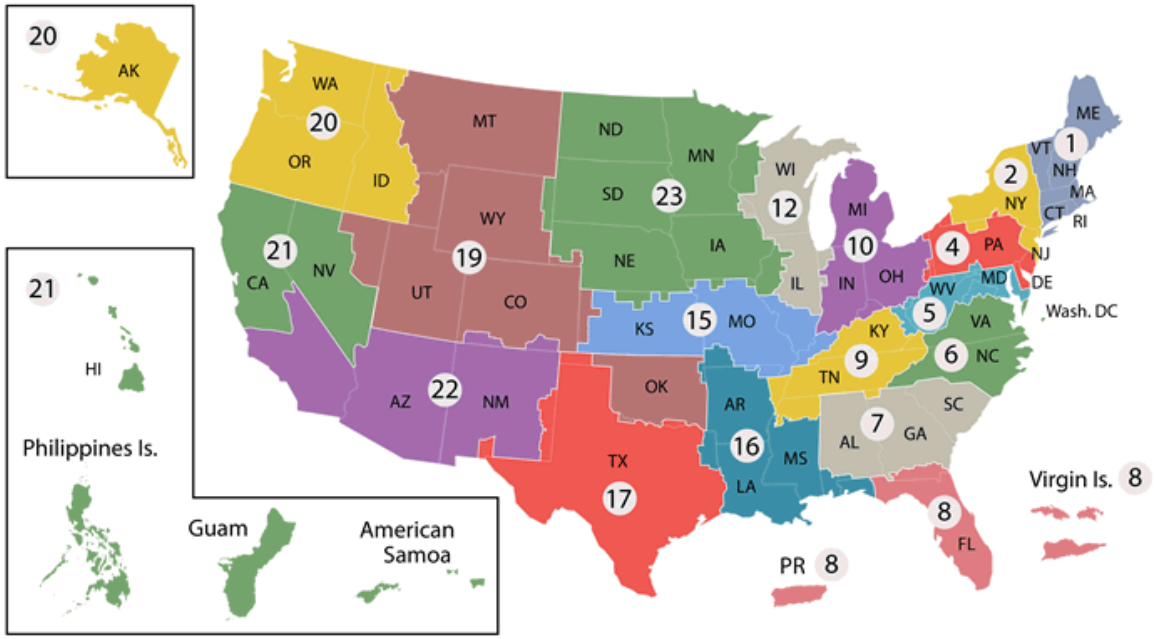
VA Footprint in Iowa

- Des Moines VA Medical Center, a teaching hospital
  - Full range of services, with state-of-the-art technology as well as education and research.
  - Teaching Hospital
  - Affiliated with University of Iowa College of Medicine and other Universities
- Iowa City Veterans Affairs Health Care System (ICVAHCS)
  - Affiliated with the University of Iowa's Carver College of Medicine for residencies and education.
  - Serves more than 50,000 Veterans residing in 50 counties spread throughout Eastern Iowa (33), Western Illinois (16), and Northern Missouri
  - The Research Program at the Iowa City VA Health Care System (ICVAHCS) has been active for over 50 years

VISNs

Veterans Integrated Services Networks (VISNs)

Veterans Integrated Services Network: The U.S. is divided into 18 Veterans Integrated Service Networks, or VISNs — regional systems of care working together to better meet local health care needs and provides greater access to care.



VISN map - click on VISN number for website

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Resources

- Veterans Integrated Services Network EBPs VISN 5 MIRECC-Supporting Veterans in Evidence Based Therapy - MIRECC / CoE (va.gov)
- Evidence-Based Treatment - Mental Health (va.gov)
- PTSD: National Center for PTSD Home (va.gov)
- Veterans Integrated Services Networks (VISNs) - Veterans Health Administration (va.gov)
- Networks (VISNs) - Veterans Health Administration (va.gov)

References

- Military Community Demographics Reports | Military OneSource
- For Veterans Day, facts about the US veteran population | Pew Research Center
- The changing face of America's veteran population | Pew Research Center
- Those Who Served: America's Veterans From World War II to the War on Terror (census.gov)
- Improving the Quality of Mental Health Care for Veterans: Lessons from RAND Research
- Katz LS, Huffman C, Cojucar G. In Her Own Words: Semi-structured Interviews of Women Veterans Who Experienced Military Sexual Assault. JournalJournal of Contemporary Psychotherapy, 2017;47(3):181−189. doi:10.1007/s10879-016-9349-0
- Oppezzo, MA, Michalek AK, Delucchi K, Baiocchi MT, Barnett PG, Prochaska JJ. Health-Related Quality of Life Among Veterans in Addictions Treatment: Identifying Behavioral Targets for Future Intervention. Quality of Life Research : An International Journal of Quality-of-Life Aspects of Treatment, Care and Rehabilitation. 2016;25(8):1949-1957. doi:10.1007/s11136-016-1236-3

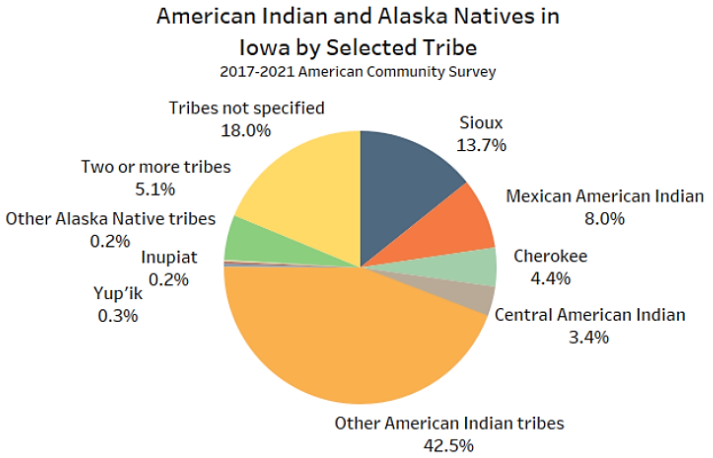
Questions

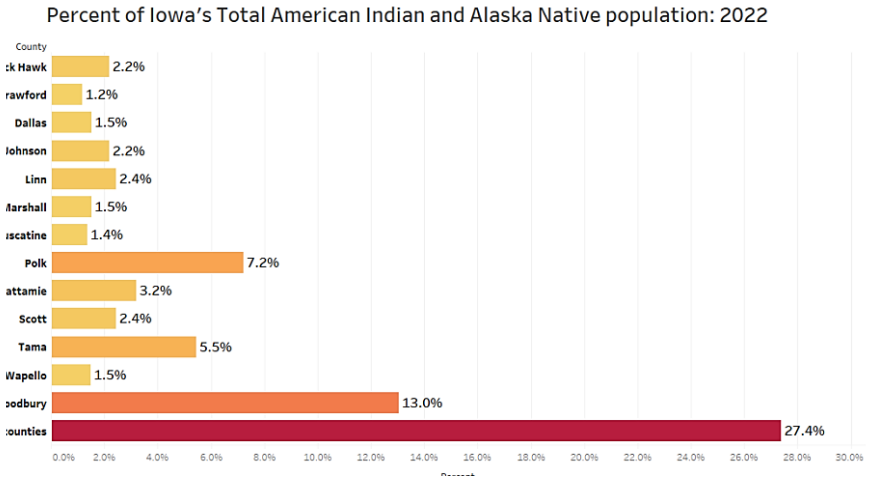
Behavioral Health and Substance Use Disorder Care for Native American Populations in Iowa

Background on AI/AN health systems and orientation to culturally validated care

American Indian/Alaska Native (AI/AN) Demographics in Iowa

- Iowa is home to 18,984 AI/AN individuals and 2,456 AI/AN families, as of 2022.
- **36%** of AI/AN individuals in Iowa experience poverty level living, well above the statewide rate of 11%.
- **10.8%** of AI/AN individuals in Iowa have no health insurance, as of 2022.





Source: Native Americans in Iowa: 2023, State Data Center of Iowa

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Meskwaki Settlement: Native American Sovereign Nation Locked in Iowa

- The Meskwaki currently own more than 8,100 acres in Tama, Marshall, and Palo Alto County. They have more than 1,450 enrolled tribe members and ae the largest employer in Tama County, employing more than 1,200 people.
- Tribally Operated BH/SUD services include:
  - Alcohol/drug use screening/assessments
  - Mental health assessment/treatment
  - Depression and suicide risk assessment
  - Crisis intervention services
  - Psychiatric medication management
  - Consultation with families on an as-needed basis
  - Domestic violence referral
  - Gambling assessment and referrals
  - Tobacco screenings and referrals
  - Play Therapy for children ages 3 and above

Special Protections for American Indian/Alaska Natives (AI/AN)

- Cost Sharing Exemptions
  - AI/ANs who are eligible for, or receive services from, an Indian Health Service Unit, Tribal Health Clinic or Urban Indian Health Clinic (I/T/U) or through referral under the purchased/referred care program are exempt from Medicaid premiums and enrollment fees.
  - If they have ever used one of these programs, they are also exempt from cost sharing.
  - All AI/ANs are exempt from out-of-pocket expenses in the hawk-i program.
- Resource Exemptions/Income Exclusions
  - Certain Native American resources and payments are not counted for Medicaid eligibility.
- Estate Recovery Protections
  - There are additional protections for AI/ANs from estate recovery for persons who have received long-term care and have passed away.
- Managed Care Protections
  - An AI/AN enrolled in managed care can choose to utilize an I/T/U.
  - Managed care plans must pay the I/T/U a negotiated rate or not less than their normal payment for the service to a participating provider.
  - Iowa must assure the I/T/U receives the normal state plan rate for that facility.
  - *Iowa requires AI/AN individuals to enroll in Managed Care in order to receive BH/SUD covered services from Medicaid.*

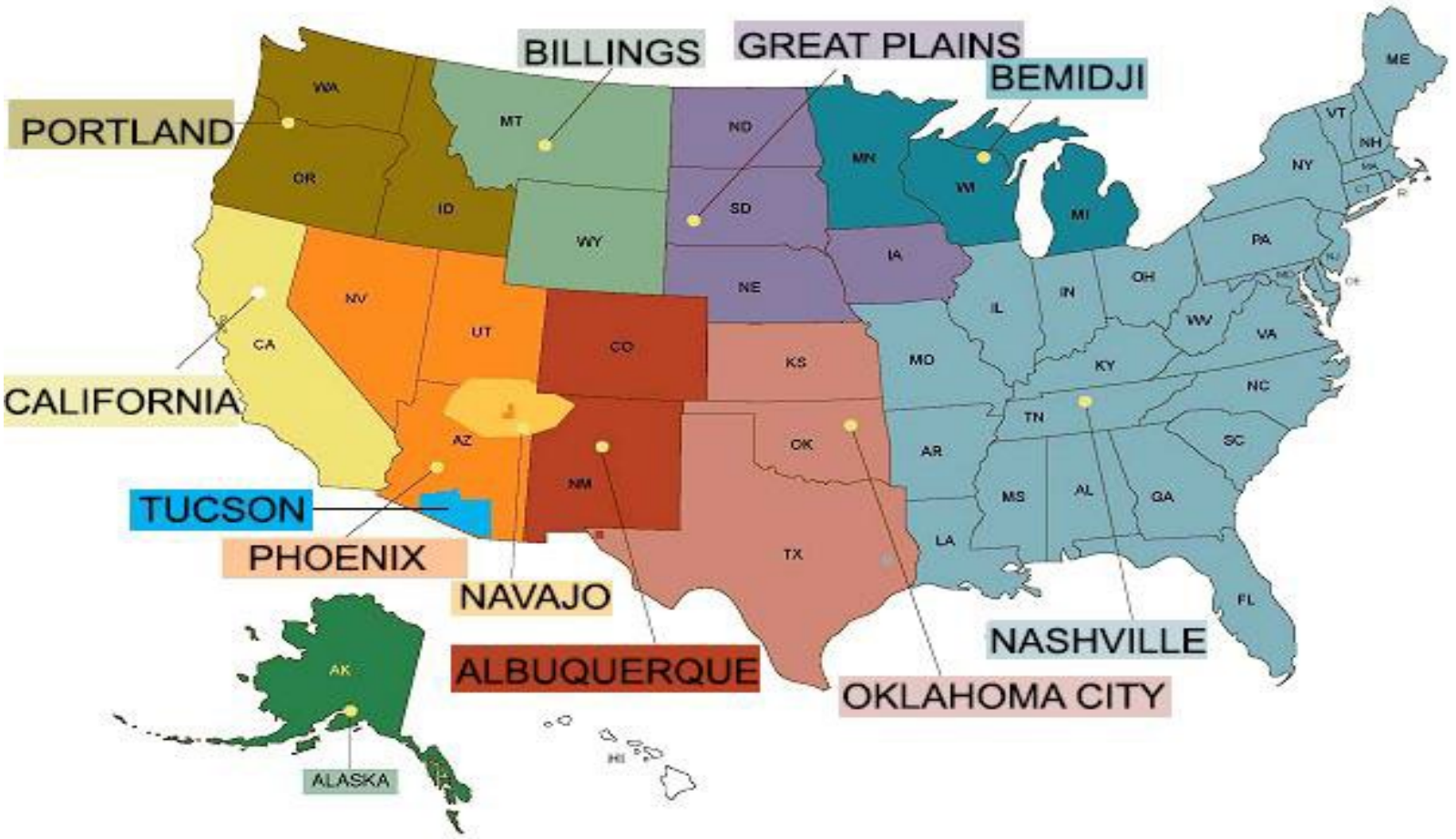
Source: American Indian or Alaska Native Program | Iowa Department of Health and Human Services

AI/AN Health System: Key Points and Background

- American Indians and Alaska Natives (AI/AN) are populations often overlooked by healthcare policy makers, providers and payers.
- Tribes are sovereign nations and their relationship with the U.S. government is government to government.
- As established through treaties and laws, the federal government has responsibility to provide health care to AI/AN through the Indian Health Service (IHS), which resides within HHS.
- IHS services and supports are historically underfunded and chronically fall short of the actual need.
- Health care organizations must recognize the history of trauma and exploitation when serving and partnering with Tribal communities.

Photo credit: https://www.meskwaki.org/about-us/

Indian Health Service (IHS) Regions



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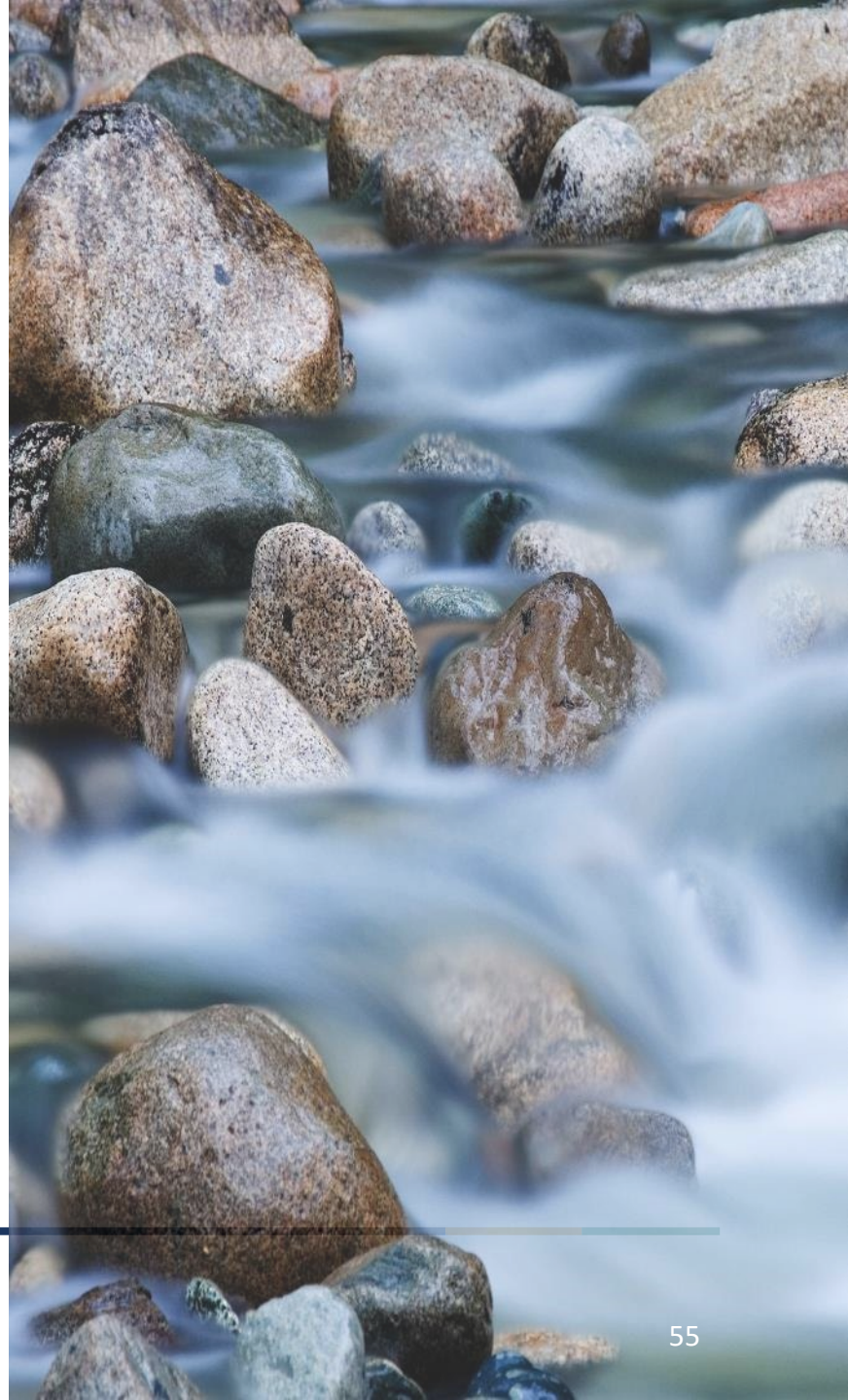
Health Disparities in AI/AN Population

- Prior to the ACA, one in three AI/AN individuals were uninsured.
- AI/AN people also experience disproportionately higher rates of poverty, compared to the rest of the population.
  - In 2020, 24% of the AI/AN population nationally lived in poverty, compared to the national rate of 12%.
- AI/AN people have a life expectancy that is 10.9 years **less** than the total U.S population rate.
- Heart diseases, unintentional injuries, and diabetes are leading causes of AI/AN deaths.
- AI/AN people experience the highest youth suicide rate nationally.



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Source: National Council on Aging Jan 10, 2023

Tribal Health and Indian Health Service 101

- Many tribes take on their own healthcare through what is known as "638" contracts with IHS
  - Tribes use funds from IHS to provide a set of services that IHS otherwise would provide; can range from specific services such as SUD treatment, to all healthcare and behavioral health services.
  - Medicaid funded services receive 100% federal funding if provided through Tribal Health Facilities furnished to Medicaid-eligible American Indians and Alaska Natives.
  - Traditional healing is an important part of many Tribal communities. Practices are unique to each community.

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Photo credit: https://www.postbulletin.com/news/meskwaki-nation-building-a-local-food-system, 2015

Working with Tribes and IHS – Some Key Reminders

- **Every Tribe is a sovereign nation; each hold unique cultures and community identities.**
- Self-determination is very important to Tribes: "nothing about us without us" approach.
- IHS is a complex bureaucracy.
- IHS and most Tribes have strained health infrastructure, systems, staff and processes.
  - There are 3 separate components of AI/AN health systems: IHS, tribal providers & Urban Indian Health Centers (I/T/Us)
- Limited staffing resources and complicated Tribal politics can slow things down. Need to appreciate a different sense of timing for Tribal work.

Working with Tribes and IHS – Building Trust

- History of distrust makes establishing relationships sensitive:
  - Boarding schools with forced assimilation and abuse
  - Federal "termination policy" which ended government-to-government relationship with more than 100 Federally recognized tribes in 1950s and 1960s
  - Federal "relocation policy" in the 1950s and 1960s
  - Exploitation in health care and human subjects research
- Trauma and grief are often significant influences on a Tribal community's culture and sense of identity.
- Engaging with Tribal communities as partners helps programs identify and make use of tribal resources and strengths, such as family ties, large community networks, physical resources, intergenerational knowledge and wisdom, and community resilience.

Working with Tribes and IHS – Respecting Veterans and Elders

- It is important to recognize the role elders play in Tribal communities:
  - It is customary in many Tribal communities to show respect by allowing elders to speak first; listening with patience. Story telling can often precede an answer to a question.
  - In group settings such as a group discussion/interview, people will often defer to an elder to offer an answer and/or ask the elder's permission to speak.
  - Elders are often offered a seat in a room, before others sit and offered food first.

- Veterans are also highly respected and recognized and honored in ceremonies and pow wows. In 2022, there were 1,044 American Indian veterans of the U.S. armed forces living in Iowa.

Cultural Competency in Behavioral Health Care

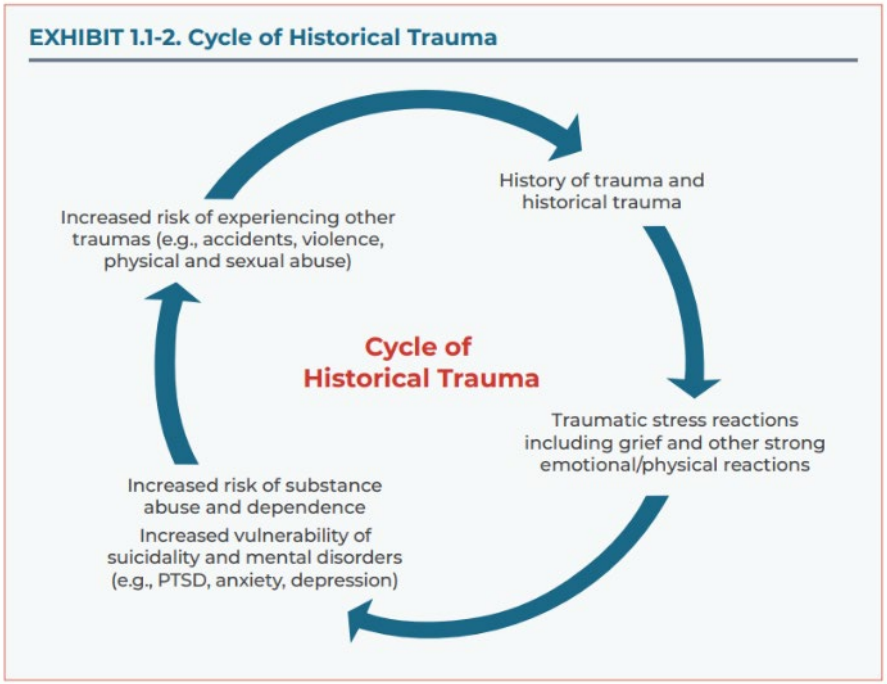
EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Motivational Interviewing (Miller & Rollnick, 2013) MI is client centered and focuses on active listening, stages of change, self-talk, empathy, and other core elements to elicit "change talk."	• Is found to be effective for treating American Indians and Alaska Natives • Is nonconfrontational and noninterfering • Uses active listening skills • Teaches the culturally appropriate idea that what you say to yourself is what will happen • Emphasizes the importance of relationships and empathy	• Have adequate training and use current American Indian and Alaska Native adaptations • Have clients create personal stories for each stage of change • Present stages of change model as a circle • Remember that self-disclosure is not a traditional communication style	• *Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities* (Venner et al. 2006) • *Trainer's Guide to* Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/ Alaska Native Counselor (Tomlin, Walker, & Grover, 2014)

- Learning how AI/AN members identify with their culture will help behavioral health providers support healing and influence the selection of treatment approaches.

- SAMHSA's Treatment Improvement Protocol 61: Behavioral Health Services for American Indians and Alaska Natives can be a useful resource in learning more about culturally validated approaches to treatment. Exhibit 1.1-5 is an excerpt of various approaches covered.

Cultural Competency in Behavioral Health Care



- Understanding how historical trauma plays a role in Tribal communities and AI/AN individuals' lives is an important part of treatment and support.

- Trauma informed care and community and family-oriented strategies are important approaches to consider incorporating.

Graphic Source: SAMHSA Treatment Improvement Protocol 61: Behavioral Health Services for American Indians and Alaska Natives

Working with Tribes and IHS

- Land Acknowledgements are important. They can be added to the beginning of a presentation and spoken by presenter. Example:
  - **Land Acknowledgement Statement** – Grinnell College: We acknowledge that we are on the ancestral territory of the Meskwaki, Sauk, and Ioway Peoples, whose land was taken from them through the encroachment of white settlers and then formally in 1845 through government land concessions. We wish to pay respect to the Meskwaki, Sauk and Ioway elders both past and present and to recognize the Meskwaki Nation that exists today in Tama County, less than 30 miles form Grinnell College.
- Prayer
  - It is common for business meetings to start with prayer – led by a respected member of the group.

Photo credit: https://www.iowapbs.org/education/findiowa/culture/native

IOWA HHS

Resources

- SAMHSA Culture Card: A Guide to Build Awareness: American Indian and Alaska Natives
- SAMHSA Office of Tribal Affairs and Policy
- Treatment Improvement Protocol 61: Behavioral Health Services for American Indians and Alaska Natives

Questions