Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

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Behavioral Health

Health News & Notes

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Tribal Youth Delegates Meet with Tribal Leaders

Tana Atchley-Culbertson
(Modoc/Paiute/Karuk)
Youth Engagement Coordinator

Tribal Youth Delegates met in person for the first time at the Quarterly Board Meeting in Lummi this past June where they were able to connect with tribal leaders in and out of the board room, meet with local tribal youth, and work together on projects.

During the Board Meeting, they were introduced to the Board and seated with their Tribal Delegate and attended the Youth Committee meeting. They gave a presentation on the Tribal Youth Delegate Program and attended portions of the meeting to learn more about issues faced by regional tribes.

NPAIHB Delegates and Youth Delegates at the Summer Quarterly Board Meeting hosted by Lummi Nation

The Youth Delegates worked together to review the Adolescent Health Tribal Action Plan and provided updates from a youth perspective.

An additional component to the visit was the opportunity to connect with the community and meet with local tribal youth. The Lummi Nation hosted a Youth Day, which allowed the Youth Delegates an opportunity to interact with tribal youth and connect with local tribal leaders. They had the opportunity to participate in traditional food gathering excursions and pull canoe out to Lummi Island. The Youth Delegates attended the cultural night as well, where they networked with Tribal Delegates and enjoyed a meal together.

Since then, the Youth Delegates have been meeting virtually once

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Chairman's Notes

Andrew Joseph, Jr.,
Colville Tribal Council
NPAIHB Chair

Greetings! I hope that you all enjoyed the holidays with your families. I wish that 2019 had not started off in a partial government shutdown. It is our people that suffer when a shutdown occurs which is why we need Congress to approve advance appropriations for the Indian Health Service. The federal government must honor its trust responsibility so that our people never experience lapses in care. We must also keep advocating for full funding for the Indian Health Service.

Since this issue is focused on behavioral health, we must also continue to ask for continued increases and flexible funding for behavioral health services. Many of our people are afflicted with complex mental health issues and substance use issues much of it a result of the harmful federal policies implemented over many generations. These policies displaced many of our people and disconnected them from our traditional ways and ceremonies. Our traditional interventions are critical to the healing process and should always be considered for funding and reimbursement because they work for us.

Serving on the Substance Abuse Mental Health Services Administration (SAMHSA) Tribal Technical Advisory Committee (SAMSHA TTAC) and Community Health Aide Program Workgroup has allowed me to be a strong voice for behavioral health needs. On the SAMHSA TTAC I have been able to advocate for our people to SAMHSA leadership. In 2018, I was pleased to see the significant funding to address the opioid epidemic and SAMHSA's new approach to getting tribes funded. It is not perfect, but it is a start. I am also glad to sit on the Community Health Aide Program (CHAP) Workgroup and look forward, in the future, to having Behavioral Health Aides (BHAs) as part of our care system in the Northwest.

I appreciate all the people, the departments, and our Board for all the work that you do. Your work saves the lives of many of our people both on reservations and in urban communities. I am honored to serve as your Chairman and wish you all a happy and healthy 2019.

Way límˈlímx (Thank you)
Yəx̌ʷyəx̌ʷúɬxn (Badger)

Andrew C. Joseph Jr.
HHS Chair
Colville Tribal Council
NPAIHB Chair
NIHB Member

Indian Health Update

Geoff Strommer
Hobbs, Straus, Dean & Walker, LLP

This article provides behavioral health legislative and funding updates, as well as litigation updates on the national opioid litigation and the current challenges to the Affordable Care Act and the Indian Child Welfare Act.

Behavioral Health: Legislative and Funding Updates

In this section we report on the status of federally enacted fiscal year 2019 Substance Abuse and Mental Health Administration (SAMHSA) funding for behavioral health programs which have a particular focus on Indian tribes and organizations. Unfortunately we are unable to report on final action on programs of such focus in the Indian Health Service or the Indian Affairs agency as they are the innocent victims of the current, now in its third week, partial federal government shutdown. Among the appropriations bills for which Congress and the White House have not reached agreement on fiscal year 2019 funding is for the Interior, Environment, and Related Agencies which funds the IHS and Indian Affairs.

We also report on the upcoming opportunities under a significantly revised Title IV-E (of the Social Security Act) Foster Care, Adoption Assistance and Kinship Guardianship Assistance Act to provide substance abuse and mental health treatment services for families at risk of having their children enter the child welfare system.

The Department of Health and Human Services budget has in recent years provided increased behavioral health funding for tribes and tribal organizations, the result of tribal advocacy and some good friends in Congress. For reference, the FY 2019 Labor-HHS-Education Appropriations is P.L. 115- 245 and the accompanying Committee reports are H. Rept. 115-862 and S. Rept. 115-289. The Conference Report is H. Rept. 115-932.

Substance Abuse and Mental Health Administration **(SAMHSA)** - $50 million was appropriated for grants to tribes and tribal organizations from the State Opioid Response Grants program, the same amount as last year and the second year of such funding. Other tribal-directed funding includes: $2.9 million for American Indian and Alaska Native Suicide Prevention Initiative; $2.2 million for American Indian and Alaska Native Zero Suicide Initiative (a $200,000 increase); $10 million

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Northwest Portland Area Indian Health Board

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Karuna Tirumala, IDEA-NW Biostatistican
Kerri Lopez, WTDP & NTCCP Director
Luella Azule, PHIT/Injury Prevention Coordinator
Mattie Tomeo-Palmanteer, NARCH Asthma Project Coordinator
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Tanya Firemoon, NDTI Project Coordinator

Medications for Addiction Treatment – MAT

David Stephens, RN, BA, Eric Vinson, BA, and Brigg Reilley, MPH

What are Medications for Addiction Treatment (MAT) for opioid use disorder?

While medical options for substance use disorder (a medical and less stigmatizing option for 'addiction'), and more specifically opioid use disorder, are limited, one of the best available tools are Medications for Addiction Treatment (MAT). This approach requires several hours of training by providers for certification, called a DATA Waiver, and allows them to apply for a waiver to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. Providers are trained to prescribe set dosages that reduce deaths; MAT does not 'replace the high,' but rather reduces the symptoms and craving of withdrawal. Reducing the effects of withdrawal can be essential as a bridge to longer term recovery.

Once patients express interest in discontinuing or diminishing drug use, the core of MAT care depends on the same kinds of cognitive behavioral approaches that are used for other chronic conditions, such as hypertension and diabetes. These approaches include working where patients are and to have empathy, to encourage motivation to change, enhance adherence to medication through education, keep motivation high, and teach ways to minimize relapses to drug use; these are all elements of motivational interviewing.

People who may be suffering from untreated opioid use disorder can markedly improve their daily functioning with MAT. This approach uses three major drugs used to treat opioid use disorder: methadone, buprenorphine (Suboxone) and naltrexone. The first two are opioid agonists, meaning they activate the opioid receptors in the brain. Naltrexone is an antagonist, meaning it completely blocks opioids. MAT for opioid use disorder decreases the number of deaths and increases patient retention in treatment - the medications are relatively inexpensive and long-lasting to avoid daily withdrawal. Maintenance goals include improving health, avoiding contaminated needles and risks of HIV or hepatitis C infection, improving interpersonal relationships and the ability to work, decreasing craving and the rewarding effects of illicit opioids, and diminishing crimes committed to pay for illicit drugs. In contrast, short-term treatment where MAT is tapered after a brief period of stabilization has proven ineffective.

MAT maintenance programs should include psychological support, traditional indigenous healing, encouragement to take part in counseling, education about how to deal with pain syndromes without misusing prescription opioids. Maintenance also includes education of patients against misuse of benzodiazepines or other central nervous system depressants while receiving methadone or buprenorphine, as this may increase the risk of sedation or respiratory depression and overdose. It is important to assess for misuse/overuse of other prescribed medication (e.g. gabapentin), and carefully monitor the use of illicit drugs and diversion of opioid treatment medications. Although, theoretically, any long-acting oral opioid might be used for maintenance, the only approved drugs for this use in the United States are methadone and buprenorphine.

Direct comparisons between methadone and buprenorphine show that both approaches improve patient outcomes, but most studies suggest that methadone maintenance might be associated with higher rates of patient retention. Also, buprenorphine is more expensive than methadone, and the private-office charges for buprenorphine might exceed the usual costs of a methadone clinic. However, buprenorphine is safer than methadone during induction and can be administered in outpatient offices of trained clinicians, which improves access to treatment for opioid use disorder. Research determined that patients on doses of buprenorphine (of 16 mg per day or more) were 1.82 times more likely to stay in treatment than placebo-

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Medications for Addiction Treatment – MAT

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treated patients, and buprenorphine decreased the number of opioid-positive drug tests by 14.2 percent.

Is this just replacing one addiction with another, like a band-aid?

Because maintenance medications are themselves opioids and are able to produce euphoria in people who are not dependent on opioids, many people have assumed that this form of treatment just substitutes a new substance use disorder for an old one. This belief has unfortunately hindered the adoption of these effective treatments.

Although it is possible for individuals who do not have an opioid use disorder to get high on buprenorphine or methadone, these medications affect people who have developed a high tolerance to opioids differently. At the doses prescribed, these medications do not produce a euphoric high but instead minimize withdrawal symptoms and cravings. This makes it possible for the patient to function normally, attend school or work, and participate in other forms of treatment or recovery support services to help them become free of their substance use disorder over time.

The ultimate aim can be to wean off the maintenance medication, but the treatment provider should make this decision jointly with the patient and tapering the medication must be done gradually. It may take months or years in some cases. Just as body tissues require prolonged periods to heal after injury and may require external supports (like a wheelchair for a broken leg), brain circuits that have been altered by prolonged drug use and substance use disorder take time to recover and benefit from external supports such as MAT. In cases of serious and long-term opioid use disorder, a patient may need these supports indefinitely.

The VA reported that barriers to opioid agonist medication among providers include lack of perceived patient interest, stigma toward the patient population, and lack of education about opioid agonist treatment. As of 2013, TRICARE (the insurance for military, retirees, and dependents) included coverage for MAT medications, and a 2016 modification included provisions for expanded coverage of opioid use disorder treatment that removed annual and lifetime limitations on substance use disorder treatment and established opioid treatment programs as a newly recognized category of institutional provider.

What can we do do next?

We can help with MAT training and certification, and a telehealth clinic is available to support clinicians who provide this important service. We can also help seek partnerships in recovery support services that are critical to accompany MAT for the best chance of long-term recovery for our patients. One option NPAIHB is using is Project ECHO Substance Use Disorder (SUD) Clinic.

Project ECHO: Moving knowledge, not patients

The Northwest Portland Area Indian Health Board is implementing an innovative and widely applicable model to provide treatment for patients with chronic, common and complex diseases who do not have direct access to specialty health care providers. The model, known as Project ECHO, was developed out of the University of New Mexico and stands for Extension for Community Healthcare Outcomes.

Project ECHO can assist clinicians in diagnosing and successfully treating many chronic illnesses and conditions. Each month, the Northwest Portland Area Indian Health Board's Project ECHO connects Indian Health Service, Tribal and Urban Indian (I/T/U) health care clinicians with disease experts over a telehealth network. The aim is to provide education, training, and support for I/T/U clinicians or other healthcare representatives on the best practice treatment protocols for complex diseases they encounter in their communities.

The heart of the ECHO model is its hub-and-spoke knowledge-sharing network. Led by expert teams at the hub, videoconferencing is used to conduct virtual clinics with community providers who are often thousands of

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Medications for Addiction Treatment – MAT

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miles away. In this way, primary care providers, nurses, and other clinicians learn to provide state-of-the-art specialty care to patients in their communities and provide I/T/U clinicians with interaction and support to enhance their clinical practice and decrease feelings of professional isolation.

Currently, NPAIHB's Project ECHO offers multiple teleECHO clinics with specialists focusing on the management and treatment of patients with multiple chronic diseases including Hepatitis C, diabetes, and will be expanding services to offer an Opioid/Addiction clinic focusing on patients with opioid use disorder and/or substance use disorder. The one hour long teleECHO clinics include an opportunity to present cases, receive recommendations from a specialist, engage in a didactic session and become part of a learning community within Indian Country.

As opioid misuse and injection drug use rates continue to rise across Indian Country, our I/T/U clinicians must consider new and innovative approaches to integrate specialty care services in the primary care setting. I/T/U facilities serve more than 2.3 million patients across Indian Country and are a critical resource for the communities we serve. By incorporating ECHO into the portfolio of healthcare services, I/T/U facilities play an important role in increasing access to care for patients with hepatitis C, diabetes, opioid use disorder, and substance use disorder.

Together, we will manage patient cases so that every patient gets the care they need. In addition, if your health facility, community, or tribal health board need more information to better understand the potential and the limitations of MAT, contact Eric Vinson (evinson@npaihb.org).

Sources: National Institute of Drug Abuse (drugabuse.gov), VA.gov,

Addressing issues associated with opioid use disorder (OUD) is complex and emotionally charged – whether at a personal, family, community or public health systems level. We all are personally touched by this epidemic. Oftentimes, "sides" are drawn in the debate regarding opioid use disorder – largely related to Abstinence vs Medications for Addiction Treatment (MAT). Although this debate is important to have, we think we are wasting too much valuable time, energy and people's lives on this debate. It is important for us all to work together to stop overdose mortality and build a space where people know that we want them to be safe and well - to improve people's lives and build healthier communities.

People who have utilized MAT also utilize behavioral health, counseling and traditional indigenous healing practices, and people who believe in abstinence can teach us a lot about working with people with substance use disorder –they have been doing this work for a long time, they know this problem from a different perspective and they can share valuable insight. MAT and abstinence-based practices are not mutually exclusive, and the best approach may vary by patient. Both solutions have a place at the table.

We need to all work together and say "no more." No more overdose deaths, no more losing our family members to substance use disorder, no more needles on our streets and in our playgrounds. We think it is so important for everyone to come together to build a community to support our collective healing journey.
– Jessica Leston, MPH and Danica Love Brown, MSW, PhD

Northwest Native Adolescent Health Alliance

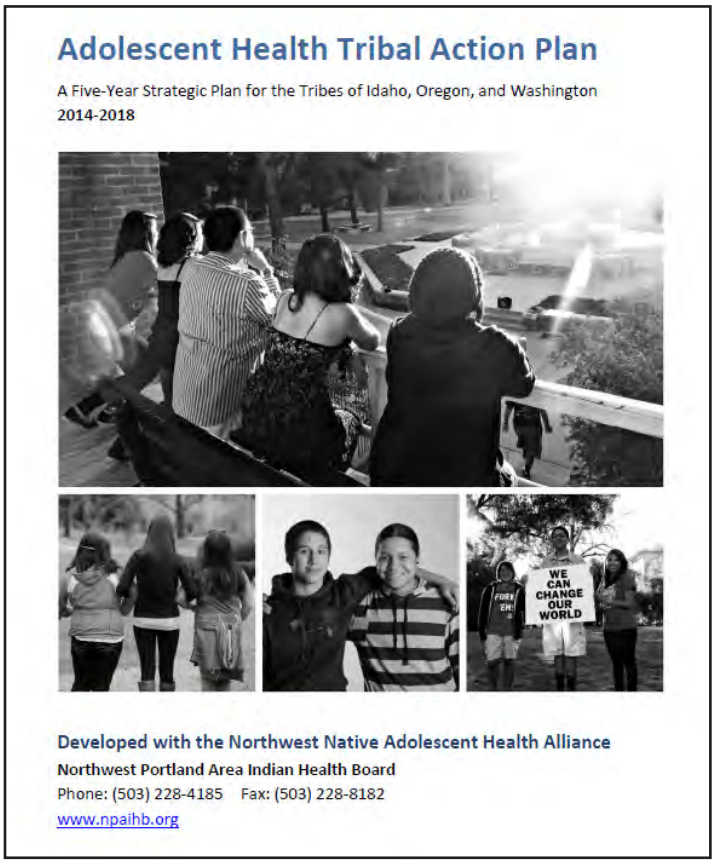
Celena McCray (Navajo), MPH (c)
Project Coordinator - WA DOH
Parenting Teens & THRIVE

The Northwest Native Adolescent Health Alliance is an inclusive, multifunctional group that meets quarterly in OR, WA, and ID to discuss cross-cutting planning and prevention strategies targeting AI/AN teens and young adults (addressing suicide topic(s), teen pregnancy, STD/HIV, substance abuse, and tobacco.) The goal is to support regional action planning, resource development, and sharing.

The alliance's mission is to encourage Native adolescent and young adults to realize and embrace their full potential for health development, and to enhance the capacity of NW Tribes to promote adolescent health, safety and wellbeing.

Over the years meeting attendees included tribal health and prevention staff, Indian Health Service personnel, State Health Department personnel, MSPI funding recipients, and University and Community partners from ID, OR & WA.

Within this multifunctional group, the Adolescent Health Tribal Action plan was designed to aid the development of programs and interventions to improve adolescent health within the 43 federally-recognized tribes in ID, OR & WA . It can be used by program managers, public health professionals, tribal leaders, policy-makers and set agendas for improving the community's health. To review a copy of the action plan you can find it here: http://www.npaihb.org/thrive/



Currently, the Alliance is in the process of updating the action plan with the Alaska Native Tribal Health Consortium with the support from the Health and Human Services Office of the Assistant Sectary for Health Region 10 that includes ID, OR, WA and Alaska. The Alliance would like to invite you to become involved in the process of updating the Adolescent Health Action Plan that will be organized and covered by Region 10. Please share this announcement with staff in your community who work with native youth.

If you have any questions, or would like to receive updates for the next Northwest Native Adolescent Health Alliance Meeting please contact the *THRIVE* project coordinator, Celena McCray, at cmccray@npaihb.org or 503-416-3270.

Substance Abuse and Self-Harm Among Native Youth

Chiao-Wen Lan, PhD, MPH
Epidemiologist
Improving Data & Enhancing Access (IDEA-NW)

Suicide is the leading cause of injury-related death in the United States[1]. In recent data from the CDC, ***suicide was the second leading cause of death for American Indians and Alaska Natives (AI/AN) youth ages 15-24***[2]. Nationwide, the suicide rate for AI/AN youth was 3.7 times higher than the rate for White youth[3]. Furthermore, about 21.8% high-school aged AI/AN had seriously considered attempting suicide and 14.7% attempted suicide at least once in the previous year, higher than the national averages (15.8% and 7.8%, respectively)[4,5].

Self-harm[6], also known as self-inflicted harm or self-inflicted injury, is defined as the intentional, direct injury of body tissue, regardless of suicidal intent[7]. The relationship between self-harm and suicide is complex. Although suicide may not be the intention of self-harm, there is an increased risk of suicide in individuals who intentionally self-harm[8] (See Figure 1).

Adolescent self-harm is a major public health concern. Self-harm in adolescents is the result of a complex interplay between psychiatric, psychological, social, and cultural factors[6]. Research suggests that substance use disorders may signal increased risk for suicide in men and women in the United States[9,10]. Yet, there is a paucity of literature examining the associations between substance use disorders and self-harm among AI/AN youth[11]. To understand this issue, the NPAIHB's Improving Data and Enhancing Access-Northwest (IDEA-NW) project examined the association between hospitalizations for self-harm and substance use disorders among AI/AN youth in Washington. We analyzed Washington State inpatient hospital discharge data between 2011 and 2014 that were corrected for AI/AN racial misclassification. We identified all cases of hospital admissions for self-harm among patients aged 10 to 24 and examined if they had a concurrent substance use disorder diagnosis, including alcohol use disorders or opioid use disorders.

Between 2011 and 2014, there were a total of 13,729 hospitalizations for self-harm in Washington. Of these, 3,399 (24.8%) were among youth ages 10 – 24. The rates of hospitalized self-harm among AI/AN youth and White youth were similar (14.6% vs. 15.6%).

Compared to White youth hospitalized for self-harm, AI/AN youth had a higher rates of substance use disorders (30.0% vs. 27.1%) and alcohol use disorders (17.5 % vs. 12.6%), while having a lower rate of opioid use disorders (3.9% vs. 5.2%, see Figure 1). ***AI/AN youth hospitalized for self-harm were 1.8 times more likely to be diagnosed with substance use disorders than White youth, controlling for gender and age ($p < 0.0001$).***

Fewer AI/AN youth who were hospitalized for self-harm received additional psychiatric treatment (i.e., transferred to a psychiatric hospital or an inpatient rehabilitation facility) than White youth after discharge (19.7% vs 24.5%, respectively).

High rates of co-occurring self-harm and substance use disorders among AI/AN youth highlight the importance of incorporating harm reduction elements into the design of preemptive and integrated interventions. Research has shown that the more successful substance prevention programs were relevant to the values and needs of AI/AN communities, and were either led by or included local leaders and advocates in the planning and implementation process[12].

Youth hospitalized for self-harm only represent a small portion of the population at risk, and do not account for community members who do not seek medical or behavioral health services for self-harm or substance use disorders (See Figure 1). Stigma associated with mental health problems and access to integrated care continue to be major challenges in AI/AN communities. ***There is a strong need for collaboration across agencies concerned with suicide, substance use disorders, and mental health to address this issue.***

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Substance Abuse and Self-Harm Among Native Youth

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Resources available at the NPAIHB:
The suicide prevention project of the NPAIHB is THRIVE, which stands for: Tribal Health – Reaching out InVolves Everyone. Information and resources can be found here: http://www.npaihb.org/thrive/

For more information, resources, or technical assistance on data/statistics, please contact us at: ideanw@npaihb.org

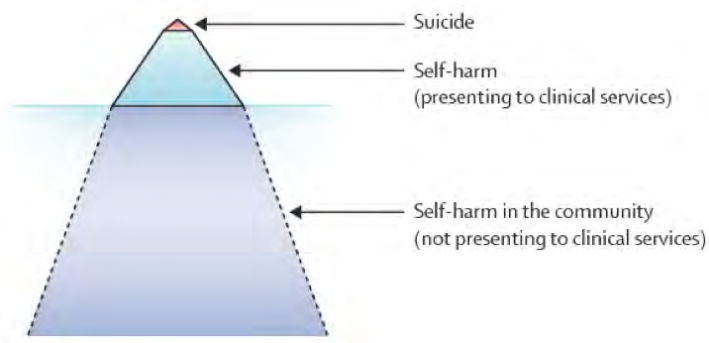

Figure 1: **Representation of the relative prevalence self-harm and suicide in young people**
(Source: Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. The Lancet, 379(9834), 2373-2382.)

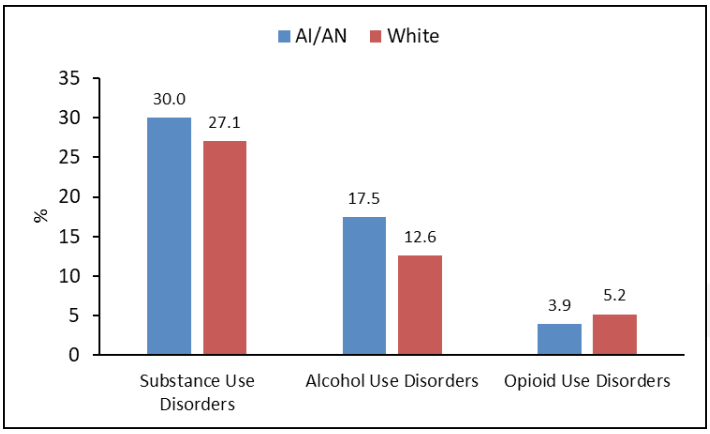

Figure 2: **Rates of Co-occurring Substance Use Disorders among Youth Hospitalized for Self-harm in Washington, 2011 - 2014**

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EpiCenter Youth Programming: Reach and Impact in 2019

Stephanie Craig Rushing, PhD, MPH
Northwest Portland Area Indian Health Board
healthynativeyouth.org
wernative.org

The NW Tribal EpiCenter's Adolescent Health team reached a record number of Native youth and their caregivers in 2018, via the www.HealthyNativeYouth.org website, We R Native's social media channels, and during their annual THRIVE Youth Conference in Portland, OR. Here are just a few of their most impressive numbers:

We R Native is a multimedia health resource for Native teens and young adults (www.weRnative.org). The service includes an interactive website, a text messaging service (Text NATIVE to 97779), Facebook and Instagram, a YouTube channel, a Twitter account, and print marketing materials. Special features include monthly contests, community service grants ($475), and an "Ask Auntie" Q&A service.

- Altogether, our messages addressing mental health, suicide, bullying, and drug and alcohol abuse reached nearly **1.3 million** viewers last year! (Up from 1.1 million viewers the year before).
- Our media helped promote cultural pride, resilience, leadership skills and youth empowerment to over **1.7 million** viewers. (Up from 1.2 million viewers the year before). These posts encouraged viewers to go to the We R Native website for more information about sensitive health topics.
- As a result, www.weRnative.org received over **155,000 site** visits in 2018.

Healthy Native Youth is a one-stop-shop for educators and health advocates who want to expand learning opportunities for AI/AN youth (www.HealthyNativeYouth.org). The site contains curricula, quizzes, handouts and training tools needed to access and deliver effective, age-appropriate sexual health programs.

- In 2018 we expanded the number of culturally-relevant health curricula available on the website – now up to 9. Hip hip!
- We improved website utilization in 2018: website users = 5K, sessions = 7.5K, and curricula page = 10K!
- We launched a monthly Community of Practice virtual learning series (held the second Wednesday of each month at 10am PST) to support the dissemination of HNY curricula with tribal health educators. Join us anytime.
- Last, but not least… We received expanded funding from the Indian Health Service HIV Program to support training and outreach in 2019, and will make updates to several of the sexual health curricula in the coming year.

THRIVE's Reach in 2018:

- In 2018 we reached **200,637** people with our #WeAreConnected suicide prevention campaign for LGBTQ2Ss and Veterans.
- Our messages to prevent teen dating violence, domestic violence, and sexual assault reached **156,638** people. Messages were posted on Facebook, Twitter, Instagram, and through the We R Native text message service (text NATIVE to 97779).

NPAIHB Youth Delegates

In 2018, the Northwest Portland Area Indian Health Board recruited its first cohort of Youth Delegates. These young leaders represent the tribes in Idaho, Oregon and Washington, and are actively working to provide recommendations to the NPAIHB and other state and federal agencies about health programs and policies that affect young people, while learning more about health and wellness careers. The 1st annual cohort includes:

Kirsten Seneca (Chehalis), **William Lucero** (Lummi), **Sadie Olsen** (Lummi), **Nakota Brown** (Quinault), **Jeidah DeZurney** (Siletz), **Maiya Martinez** (Spokane), **Adilia Hart** (Umatilla), **Lark Moses** (Umatilla), **Lindsey Pasena Little Sky** (Pueblo of San Felipe – Umatilla Representative), **Cheydon Herkshan** (Warm Springs), **Josiah Spino** (Warm Springs)

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EpiCenter Youth Programming

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We R Native Youth Ambassadors
In 2018, We R Native recruited its 5th cohort of WRN Youth Ambassadors. Over 100+ youth representing Tribes from across Indian Country were selected to participate. Our Ambassadors are offered monthly Zoom trainings on topics ranging from Indigenous Leadership Styles to Representing We R Native; from Finding Balance and Health to Making Your Voice Heard. Our Youth Ambassadors are the heart and soul of We R Native!

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Tribal Youth Delegates

a month to touch base and work on their projects together. They have been learning about the formal resolution process by creating one themselves, as well as creating bylaws.

The group will reconvene at the January Quarterly Board Meeting in Suquamish, WA. Their work will include presenting a resolution to the Board, working on a digital storytelling project, and site visits with some of the programs at Suquamish.

The inaugural class of NPAIHB Tribal Youth Delegates includes:

Tribal Youth Delegates

Kirsten Seneca (Chehalis), **William Lucero** (Lummi), **Sadie Olsen** (Lummi), **Nakota Brown** (Quinault), **Jeidah DeZurney** (Siletz), **Maiya Martinez** (Spokane), **Adilia Hart** (Umatilla), **Lark Moses** (Umatilla), **Lindsey Pasena Little Sky** (Pueblo of San Felipe – Umatilla Representative), **Cheydon Herkshan** (Warm Springs), **Josiah Spino** (Warm Springs)

Youth Delegates preparing to pull a canoe at Lummi.

The Tribal Youth Delegate Program
The NPAIHB Youth Delegates are the official youth policy body to the Northwest Portland Area Indian Health Board Delegates. Youth Delegates will review NPAIHB programs and policies, and will provide advice about decisions that affect young people. The purpose of the Youth Delegates is to involve youth in all levels of community decision-making.

The program is open to tribal youth from the NPAIHB member tribes who are between the ages of 14-24 and have an interest in health careers. Those interested in applying for the second cohort of Tribal Youth Delegates can submit their applications this spring.

Recruitment Process
On-line applications available via NPAIHB website at http://www.npaihb.org/youth-delegate/ beginning March 19, 2019 and will be accepted through May 31, 2019.

For more information, you can contact the Youth Engagement Coordinator, Tana Atchley-Culbertson at tatchley@npaihb.org or (503) 416-3286.

ANOTHER NEW PROJECT!!!!! The NW Tribal Juvenile Justice Alliance

Danica Love Brown, MSW, PhD
(Choctaw Nation of Oklahoma)
Northwest Native American Research Center for Health (NW NARCH), Fellow Alumni
Indigenous Substance Abuse Medicines, and Addictions Research Training (ISMART), Fellow Alumni
Council of Social Work Education, Minority Program Fellow Alumni
Northwest Portland Area Indian Health Board Behavioral Health Manger

In January 2019, *Danica Brown, MSW, PhD* will be moving into a new position at the NPAIHB, as the Behavioral Health Manager. One of her responsibilities will be to serve as the Project Director for the newly formed *Northwest Tribal Juvenile Justice Alliance*. In response to the Tribal-Researcher Capacity Building Grant opportunity, issued by the U.S. Department of Justice (DOJ) and the National Institute of Justice (NIJ), the NPAIHB will form a new inter-tribal workgroup – the *NW Tribal Juvenile Justice Alliance (NW TJJA)* – that will meet over 18 months to collaboratively design a research study to evaluate and disseminate juvenile justice best practices for AI/AN youth in the Pacific Northwest, aligning with DOJ research priorities.

The need for this inclusive, strategic planning process is significant. While AI/AN youth in the region experience disproportionate rates of juvenile justice involvement, no planning body is presently convening decision-makers to elevate these important health and safety research questions in AI/AN communities. The goal is to establish Tribal-researcher partnerships to:

- Identify, test and expand best practices that improve Juvenile Justice systems for Tribes in the Pacific Northwest,
- Ensure that non-Native justice systems are improving life outcomes for AI/AN youth who interact with their services,
- Build tribal capacity to access and utilize data that support quality improvement at the community-level, and
- Create and administer data collection tools that will identify **Data Sources** that could inform our understanding of Juvenile justice disparities or concerns for our NW Tribes.

Over the 18 months we plan to develop a **final research proposal**, create a **special report**, and submit **publications** to disseminate our findings to Tribal communities. We are excited for this new endeavor to create partnerships and develop a better understanding on how to support our Tribal communities. For more information on this project and how to get involved contact Danica Brown, ABD, MSW (Choctaw) at the Northwest Portland Area Indian Health Board: 503-416-3291 or via email dbrown@npaihb.org.

Behavioral Health Advisory Work Group

Sue Steward
CHAP Project Director
Northwest Portland Area Indian Health Board

A behavioral health aide (BHA) is defined as a counselor, health educator, traditional/spiritual natural helper and advocate. BHAs help address individual and community-based behavioral health needs, including those related to alcohol, drug and tobacco abuse as well as mental health problems such as grief, depression, suicide, and related issues. These unique midlevel providers were added to the CHAP program, a cadre of primary health, oral health, and behavioral health providers delivering wrap around care in remote Alaska, in 2008. The Northwest tribes are working to expand BHA services to our tribal health clinics and organizations much like DHATs.

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Behavioral Health Advisory Work Group

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The Behavioral Health Advisory Work Group is an extensive 30-member team of tribal leaders and Behavioral Health providers in Alaska, Washington, Oregon and Idaho focused on program development as outlined in the Board of Directors for Northwest Portland Area Indian Health Board Resolution 18-03-09. This project is identified as a priority for tribes and current funding sources include Washington tribes Medicaid Transformation Funds, Swinomish SAMHSA funds and North Sound Behavioral Health Organization (BHO).

The workgroup held their first meeting on September 27, 2018 and through the leadership of workgroup chairperson, Marilyn Scott from Upper Skagit many priority tasks are in the works. These priorities include BHA Talking Points for Leaders, and Strength. Weakness.Opportunities.Threats (S.W.O.T.) Analysis to form action plans for future planning, a crosswalk of providers who could matriculate to the CHA or BHA role, a cross walk of the BHA education program in Alaska and what tribal colleges have in Washington, a strong partnership has been developed with the Washington certified peer support counselors for SUD as well as identification of local tribal based practices for inclusion in the BHA education program.

With support from the Washington Tribes Medicaid Transformation Funds, our intent in 2019 is to work closely with partners in Washington to create a BHA education program and identify and support students in a demonstration at a Tribe or Tribes in Washington.

For more information about BHAs please contact Sue Steward, NPAIHB CHAP Project Director at: ssteward@npaihb.org or go to http://anthc.org/behavioral-health-aide-program/

A Glimpse of Domestic Violence in Indian Country

Paige Smith, CPS
(Paiute, Modoc, Wasco, Shoshone)
Project Coordinator– THRIVE & Response Circles
Northwest Portland Area Indian Health Board

Being comfortable with the uncomfortable.

Domestic Violence is an uncomfortable topic for conversation. One that is often left to the legal systems and unaddressed by family and communities. There is a multitude of potential reasons to why this is. We as individuals are taught to look for the best in people, inadvertently ignoring the problem. As part of a Native community I was taught to protect our men, women and children. Sometimes there is a lack of knowledge and understanding of the symptoms and problems associated with domestic violence. Other times we put our faith in a legal system designed to protect and serve. It is important to note that all states made "wife beating" illegal by 1920. However, only since the 1970's has the criminal justice system begun to treat domestic violence as a serious crime and not as a private family matter. Domestic violence can create a ripple effect, resonating from those individuals involved to subsequent generations of Native people. Children who live in homes in which domestic violence has happened run a much greater risk of repeating the abuse cycle as adults. Children who witness or are victims of emotional, physical, or sexual abuse are also at a higher risk for health problems as adults. These can include mental health conditions, diabetes, obesity, heart disease, poor self-esteem. Which all show an association with the top 10 leading causes of death for Native Americans.

Redefining the narrative:

Associate justice of the Supreme Court,[1] Sonia Sotomayor said "Domestic violence is not merely a type of violence; it is a term of art encompassing acts that one might not characterize as violent in a nondomestic context." Domestic violence encompasses many different dimensions of human behavior and impacts far more than someone's physical being. A ten year longitudinal

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A Glimpse of Domestic Violence in Indian Country

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study released in 2015 found that, in addition to their physical injuries, women who are victims of domestic violence are also at a greater risk of mental health problems such as depression and psychotic symptoms.[2] In this same study they found that more than one third of women reported suffering violence from their spouses. These women had a more extensive history of childhood abuse, abuse of illicit substances, economic poverty, early pregnancy and an antisocial personality. They were also twice as likely to suffer from depression, even when controlling for the impact of childhood abuse. Domestic violence had an impact on mood along with other aspects of mental health. These women had a three times higher risk of developing schizophrenia-like psychotic symptoms. The risk doubled for women who were also victims of childhood abuse.[3] Louise Arseneault, a researcher at the institute of Psychiatry, Psychology and Neuroscience at King's College London concluded that "Health professionals need to be very aware of the possibility that women who experience mental health problems may also be the victims of domestic violence and vice versa. Given the prevalence of depression in these victims, we need to prevent these situations and take actions. These acts of violence do more then leave physical damage; they leave psychological scars as well."

Media and stereotypes tend to view women as victims, and males as the perpetrators.[4] A recent study by the National Institute of Justice indicates that more than four in five American Indian and Alaska Native women (AI/AN) (84.3 percent) have experienced violence in their lifetime. This includes nearly half who: have experienced sexual violence (56.1%); have experienced physical violence by an intimate partner (55.5%); have experienced stalking (48.8%) and; have experienced psychological aggression by an intimate partner (66.4%). Overall, more than 1.5 million AI/AN women have experienced violence in their lifetime and AI/AN men also have high victimization rates. The article indicates that more than four in five AI/AN men (81.6%) have experienced violence in their lifetime. This includes 27.5 percent who have experienced sexual violence, 43.2 percent who have experienced physical violence by an intimate partner, 18.6 percent who have experienced stalking, and 73 percent who have experienced psychological aggression by an intimate partner. Overall, more than 1.4 million AI/AN men have experienced violence in their lifetime. This same study found that 38% of female victims were unable to get needed services.[5] A 2010 study found that U.S. Attorneys declined to prosecute 67% of sexual abuse, firearms violations, homicide and other violent crimes occurring in the lives of AI/AN women. This is abhorrent when you consider that 97% percent of female, and 90% of male victims are victims experiencing violence by an interracial perpetrator. Compared to 35% of female and 33% of males are victims experiencing violence by an intraracial perpetrator.

A place to start:

The Response Circles project at the NPAIHB is working to help alleviate the pressure of domestic violence (DV) and sexual assault (SA). NPAIHB offers technical assistance, trainings and webinars focused on DV/SA survivors and care providers but hopes to further address the needs of these groups by advocating for a compassion focused approach and normalizing conversations around DV/SA issues.[6] "Compassion begins with courage, the courage to face the things that make us feel uncomfortable, and the things that scare us the most" Russell Kolts goes on to share in a TedX Talks. Working with this in mind, taking a tribal focused approach to address tribal community's DV/SA needs and program support would be the most beneficial. Each tribe is specific, have specific needs and together our project's hope is work in harmony to help our 43 member Tribes create or adopt an approach to appropriately address this epidemic in their communities. In order to do this, we need your support. We don't want to let the statistics speak for our communities. We will leave that to each of you. Through prevention, action planning and creating healthy platforms of discussion, we believe we can begin to bring attention to domestic violence and sexual assault. These are scary topics for most, let's find the courage to begin our journey to compassion and healing of our communities.

For more information about *Response Circles* or to request trainings or presentations for your community,

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A Glimpse of Domestic Violence in Indian Country

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please contact Paige Smith at psmith@npaihb.org or call 503-228-4185 x 306.

References

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2. https://nouvelles.umontreal.ca/article/2015/03/31/impact-of-domestic-violence-on-womens-mental-health/
3. https://www.eurekalert.org/pub_releases/2015-03/uom-iod033015.php
4. https://nij.gov/journals/277/pages/violence-against-american-indians-alaska-natives.aspx
5. http://www.npaihb.org/sexual-assault-prevention-project/
6. TEDx Talks September 28, 2015 "Anger, Compassion, and What It Means To Be Strong Russell Kolts.

A List of Upcoming Opportunities for Domestic & Sexual Violence Prevention

- At your own pace Online Sexual Assault Nurse Examiner's training http://www.forensicnurses.org/?page=40HourSANE
- January 5, 2019 – Intimate Partner Violence Screening Training https://www.tribalforensichealthcare.org/events/event_list.asp
- January 15, 2019 – ACE-DV Speakers initiative Webinar Series- Webinar 3, "Not One Path: Speaking to our relationships with those who abuse" https://www.nrcdv.org/training/
- January 30, 2019 ¬ – Webinar Part 1 of 5:Vicarious Trauma Prevention and resilience building program: Organizational Toolkit Webinar Series- Vicarious trauma, compassion fatigue and burnout http://app.webinarsonair.com/register/?uuid=2b4bf927cebf4e668128a78f42dc4490
- February 12-15, 2019 – Advanced Domestic Violence and Sexual Assault Training – Las Vegas, NV http://nicp.net/event/las-vegas-nv-february-12-15-2019/

Upcoming Opportunities for Domestic & Sexual Violence Prevention

- February 20, 2019 – Domestic Violence Advocacy Day, Olympia WA https://wscadv.org/calendar/category/in-person-training/
- February 26, 2019 – May 2, 2019 – Sexual Assault Examiner (Pediatric) Online training (registration opens in late 2018) https://www.tribalforensichealthcare.org/page/onlinePSAE
- March 12-14, 2019 – Sexual Assault Demonstration Initiative's Embracing Change & Growth Conference: Strengthening Services for Survivors of Sexual Violence – Chicago, IL https://www.nsvrc.org/embracing-change-growth-conference
- April 3-4 2019 – Advocacy for Rookies Https://wscadv.org/events/advocacy-for-rookies-april-3-4-2019/
- Sexual Assault Response Team (SART) Toolkit – training on your own, check out: https://ovc.ncjrs.gov/sartkit/about.html
- Websites to find more opportunities & dates
- National Center on Domestic & Sexual Violence - http://www.ncdsv.org/ncd_upcomingtrainings.html
- Sexual Assault Forensic Examinations, Support, Training, Access and Resources (SAFESTAR) - http://www.safestar.net/training/
- International Assoc. of Forensic Nurses - http://www.forensicnurses.org/?page=registerforSANE
- IHS Tribal Forensic Healthcare http://tribalforensichealthcare.site-ym.com
- Idaho Coalition Against Sexual & Domestic Violence - https://idvsa.org/
- Oregon Attorney General's Sexual Assault Task Force - http://oregonsatf.org/calendar/trainings/
- Oregon Coalition Against Domestic & Sexual Violence - https://www.ocadsv.org/
- Washington State Coalition Against Domestic Violence - https://wscadv.org/
- Washington Coalition of Sexual Assault Programs - http://www.wcsap.org/

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Portland Area Tribes represented American Indigenous success in fighting diabetes using Indigenous knowledge. The presentation by members of the Tribal Leaders Diabetes Committee took place in Sydney Australia during the Healing Our Spirits Worldwide conference.

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for Medication-Assisted Treatment for Prescription and Drug Opioid Addiction for tribes, tribal organizations, or tribal consortia (a $5 million increase); $20 million for Tribal Behavioral Health Grants under Substance Abuse Prevention (a $5 million increase); and $20 million for Tribal Behavioral Health Grants under Mental Health (a $5 million increase). The House report encourages SAMHSA, when permitted in the authorizing law, to include tribes and tribal organizations, among others, as eligible grantees and to "provide outreach and technical assistance to ensure the maximum level of awareness and participation in new grant announcements." The Senate report encourages SAMHSA, in administering initiatives under the Programs of Regional and Natural Significance, to "exercise maximum flexibility allowed when developing funding opportunity announcements to ensure that all eligible applicants are included". Among eligible applicants are tribes and tribal organizations, health facilities or programs operated by or in accordance with a grant or contract with the Indian Health Service, and other public or private nonprofit entities.

Centers for Disease Control (CDC). Of note is that tribes are eligible applicants for the $475 million

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for Opioid Prescription Drug Overdose Prevention Activities administered by the CDC. Also in the CDC budget is $21 million for the continuation of the Good Health and Wellness in Indian Country initiative.

Family First Prevention Services Act. This Act, signed as part of the Bipartisan Budget Act of 2018 (Division E, Title VII of Public Law 115-123), made major changes to the Title IV-E Foster Care, Adoption Assistance and Kinship Guardianship Assistance Act, shifting its focus from providing resources once a child has been removed from the home to one which will now offer services designed to keep families together. As part of the efforts to keep families intact is that beginning in FY 2020, Title IV-E funds may be used for 12 months of mental health and substance abuse services to parents or kin caregivers when their child is at risk of entering foster care. Additionally, funds can be used for in-home skill-based parenting services and also for family-focused residential treatment for substance abuse where children may be placed with their parent(s) in the center. There is an option to extend the beginning of new activities to FY 2022, allowing more time for required planning and reporting.

Approximately twelve tribes currently directly administer the Title IV-E program but many tribes have entered into tribal-state IV-E agreements. It is optional whether the state or tribal grantee take advantage of the new substance abuse/mental health uses of funds. States and tribes who directly administer the program are now in the process of making decisions about altering their Title IV-E programs. Tribes who are party to tribal-state IV-E agreements will want to be in communication with their states on these matters, including how such agreements will be changed. The Administration for Children and Families (ACF) has been conferring with and providing information and guidance to states and tribes on the Family First Prevention Services Act.

Opioid Litigation

To date, close to 100 tribes and tribal organizations have filed complaints to join the litigation against

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the manufacturers, distributers and retailers of prescription opiate drugs. These cases join the lawsuits that have been filed by states, municipalities, hospitals, and others since 2014. The lawsuits allege that these manufacturers overstated the benefits and downplayed the risks of these medications, while also aggressively marketing opioids to physicians. The lawsuits also allege that distributors and retailers failed to monitor, investigate, and report suspicious orders, resulting in the illegal diversion of prescription pills. The legal claims include violations of racketeering laws (RICO), violations of state consumer protection laws, and various common law claims like public nuisance, negligence, fraud, misrepresentation, civil conspiracy, and unjust enrichment.

All federal court lawsuits have been combined for pretrial purposes as "Multidistrict Litigation" (MDL) under the leadership of Federal Judge Dan A. Polster in the U.S. District Court for the Northern District of Ohio. Judge Polster is supervising pretrial discovery of test cases placed within separate "tracks" he created for local governments, states, hospitals, third-party payors, and Indian tribes.

For each test case (or "bellwether"), the Defendants have filed motions to dismiss, challenging Plaintiffs ability to bring these claims for various reasons. In support for the bellwether Plaintiffs in the tribal track, 448 federally recognized tribes joined an amicus curiae brief, either directly or through membership in an organization that joined the brief, opposing the Defendants' motions to dismiss.

The Judge recently issued an Opinion and Order in the Track One cases brought by municipalities. For those cases, he found that nearly all the claims alleged are sufficient to survive Defendants' Motions to Dismiss. As the claims brought by tribal plaintiffs are similar, this ruling should be indicative of how he might rule on the Tribal Track cases. This Order is not a final determination of liability, and there may be a long way to go before this litigation is resolved. However, it provides good guidance in moving forward.

Texas v. United States Challenge to the Affordable Care Act

The decision of a federal district court holding that the Patient Protection and Affordable Care Act (ACA) is unconstitutional has now been appealed to the United States Court of Appeals for the Fifth Circuit. The district court ruling, issued last December by Judge Reed O'Connor of the United States District Court for the Northern District of Texas, found that Congress' 2017 elimination of the ACA's tax penalty for non-compliance with the "individual mandate" to purchase private health insurance rendered the mandate invalid. Judge O'Connor reasoned that in *National Federation of Independent Businesses v. Sebelius (NFIB)* the Supreme Court had upheld the mandate as a valid exercise of Congress' power to levy taxes; in the absence of any tax, therefore, Congress lacked constitutional authority to issue the mandate.

Critically, Judge O'Connor ruled that the individual mandate is so essential to the rest of the ACA that it is not "severable," meaning the rest of the statute must also be struck down. This is of particular concern to Indian tribes and tribal health organizations because the Indian Health Care Improvement Act (IHCIA) was amended and permanently reenacted as part of the ACA—meaning that the IHCIA could be struck down as well, if Judge O'Connor's ruling is allowed to stand without modification.

The IHCIA, originally enacted in 1976, has provided the primary statutory framework for the delivery of health care services to Indian people since that time. The IHCIA required periodic reauthorization until it was amended and made permanent through Section 10221 of the ACA. The IHCIA amendments enacted by the ACA enhanced authorities to recruit and retain health care professionals, expanded programs to address diseases such as diabetes, strengthened tribal epidemiology centers, improved procedures for construction of health care and sanitation facilities, expanded opportunities for third party collections and established comprehensive behavioral health initiatives, among other provisions benefiting tribes.

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The ACA also provided other beneficial Indian-specific provisions, including, but not limited to "payer of last resort" status for the IHS-funded health system, authorization for tribal health care organizations to make Medicaid and CHIP eligibility determinations, improvements to Medicare reimbursement provisions, and tax exemptions for tribal health benefits.

Judge O'Connor did not specifically consider the severability of the IHCIA or other Indian-specific provisions of the ACA as part of his sweeping decision, and there are compelling reasons why those provisions should be preserved even if the remainder of the law is struck down. Hopefully, the Fifth Circuit will consider these factors if it is otherwise inclined to uphold Judge O'Connor's ruling. In the meantime, the ACA (including the IHCIA) will remain in effect until the appeal has been resolved, due to a stay issued by Judge O'Connor pending the appeal.

***Brackeen v. Zinke* Challenge to the Indian Child Welfare Act**

On October 5, 2018, the same district court judge who in December held that the Affordable Care Act is unconstitutional—Judge Reed O'Connor of the United States District Court for the Northern District of Texas—issued a decision ruling that the Indian Child Welfare Act (ICWA) is unconstitutional in several respects. The decision, which has also been appealed to the United States Court of Appeals for the Fifth Circuit, has major implications not only for the ICWA, but for federal Indian law and policy more broadly.

The equal protection requirements of the United States Constitution are generally construed to prohibit government action that treats similarly situated individuals differently based on certain "suspect classifications," including race. Under the landmark 1974 U.S. Supreme Court decision in *Morton v. Mancari* and other federal case law, federal laws singling out Indians for special treatment are generally treated as exempt from this rule for a variety of reasons, including the fact that such laws are predicated on the unique legal and political status of Tribes and individual Indians in the United States, rather than on the basis of their membership in a particular race.

In B*rackeen v. Zinke*, however, Judge O'Connor found the Supreme Court's *Morton v. Mancari* rule does not apply to ICWA because ICWA extends to Indians who are not formal members of tribes, and must therefore be based on race rather than political status. Finding that the ICWA did not meet the high constitutional bar for classifications based on race, Judge O'Connor went on to strike ICWA down as in violation of equal protection. Further, he held that ICWA violates the Constitution's non-delegation doctrine and the Tenth Amendment's prohibition on commandeering state legislative functions, and struck down the Bureau of Indian Affairs' 2016 regulations clarifying minimum federal standards for implementing the ICWA.

Congress passed ICWA in 1978 in response to abusive child welfare practices that resulted in the separation of large numbers of Native children from their families and tribes. ICWA dictates certain actions be taken when a Native child is involved in custody or dependency proceedings, including giving preference to family members, members of the child's tribe, and members of other tribes in adoptive placements and similar preferences in foster care and preadoptive placements. ICWA applies to children who are members of a tribe and to children eligible for membership whose biological parent is a member of a tribe. In holding that this criteria amounts to a racial classification, Judge O'Connor's ruling has the potential to cast doubt over a myriad of federal laws, regulations, programs, and services that extend to individual Indians who may not be enrolled members of federally recognized tribes—including health care benefits and services. While the ruling goes against decades of application of the *Morton v. Mancari* rule by federal courts across the country, tribes will nevertheless be closely monitoring the Fifth Circuit's review of the decision.

We will continue to monitor these matters and keep you updated on any new developments.

Oregon Health Priorities Survey: Native Voices Needed!

Taylor Ellis
Project Specialist, Public Health Improvement & Training
Northwest Portland Area Indian Health Board

The Northwest Portland Area Indian Health Board (NPAIHB) has partnered with the Oregon Health Authority (OHA) to gather input on top health issues that are most important to American Indian/Alaska Native (AI/AN) residents of Oregon. This information will help OHA as they develop the 2020-2024 State Health Improvement Plan (SHIP), which will identify key focus areas and strategies for improving health across Oregon. AI/AN people were underrepresented in the community input that OHA used to write the current health plan, so we want to make sure that Native voices are clearly heard during this planning process.

You can help by taking a short online survey by the end of January at www.bit.ly/2020SHIP. This survey will take less than 10 minutes, and is open to any AI/AN person 18 or older. Those that complete the survey will have the option to enter a drawing to win a $50 Visa gift card. You can also provide feedback directly to the Oregon Health Authority by emailing publichealth.policy@state.or.us.

NPAIHB is one of seven organizations that received an OHA mini-grant to support SHIP development and encourage feedback from communities most impacted by health disparities. OHA's community-based committee, called the PartnerSHIP, will meet in February to review the survey results and feedback provided by NPAIHB and other community organizations, before selecting the final top health priorities that will be the focus of the 2020-2024 SHIP. You can learn more about the SHIP at www.oregon.gov/oha/PH/about.

If you have any questions or would like more information about NPAIHB's work on this effort, please contact Taylor Ellis at tellis@npaihb.org.

Publications from the Northwest Tribal Epidemiology Center 2018

We are proud to present the published work of staff of the NWTEC for 2018. These 12 articles represent peer reviewed publications by our staff.

Joshi S, Weiser T, Warren-Mears V. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives — Washington, 1999–2015. MMWR Morb Mortal Wkly Rep 2018;67:1384–1387. DOI: http://dx.doi.org/10.15585/mmwr.mm6750a2

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Markham, C.M., Torres, J., **Craig Rushing, S.**, Gorman, G., Jessen, C., **Gaston, A.**, Williamson, J., Addy, R.C., Emery, S.T., Hernandez, B.F., Peskin, M.F., Shegog, R. (2018). Usability and psychosocial impact of decision support to increase sexual health education in American Indian and Alaska Native communities. Journal of Health Disparities Research and Practice, 11(1): Article 7. Available at: https://digitalscholarship.unlv.edu/jhdrp/vol11/iss1/7.

Patricia, Y., Rongwei, F., **Craig Rushing. S, David, S.**, Joan, S. A., & Karen, B. E. (2018). Texting 4 Sexual Health: Improving Attitudes, Intention, and Behavior Among American Indian and Alaska Native Youth. Health Promotion Practice, 1524839918761872. doi: 10.1177/1524839918761872

Craig Rushing, Stephanie (2018). We R Native: Harnessing Technology to Improve Health Outcomes for American Indian and Alaska Native Youth, Journal of Adolescent Health. DOI: 10.1016/j.jadohealth.2017.11.168

Jimenez C, Lapidus J, Lutz T, Smith N. Regional Roundup: Native CARS (Tribal). Northwest Public Health. 2018; 35(1):15.

NEW EMPLOYEES

Michelle Singer (Navajo) is the Healthy Native Youth Project Manager housed in NPAIHB's Northwest Tribal Epidemiology Center in Portland, Oregon.

Michelle's early professional career spans working at Chemawa Indian School, Salish Kootenai College, Northwest Indian College and the American Indian Higher Education Consortium in Alexandria, Virginia.

While in the beltway, she worked on Capitol Hill for ten years in the U.S. Senate as an Indian Affairs policy advisor. To date, she is one of a few Native professionals to have worked on both sides of the aisle in three separate Hill office venues (personal office, authorizing committee and leadership).

Michelle returned to the PNW to begin a nearly 14-year career at OHSU working with the One Sky Center, an American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services, the Center for Diversity & Inclusion, and the Oregon Prevention Research Center-Center for Healthy Communities. As an OHSU Senior Research Assistant, she managed the Native STAND (Students Together Against Negative Decisions) Dissemination, Implementation & Evaluation Project, an unprecedented national community-based participatory research activity of its kind in the area of adolescent health for native youth. Native STAND, a culturally relevant healthy decisions curriculum for enhancing and promoting positive Native youth development, is a part of the Healthy Native Youth initiative for AI/AN educators, tribal leaders and community members. She will manage the HNY expansion in her role with Project Red Talon team.

Heidi Lovejoy recently joined the Northwest Portland Area Indian Health Board as the Substance Use Epidemiologist for the NWTEC Public Health Infrastructure project. Heidi graduated Cum Laude with her Master of Health

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NEW EMPLOYEES

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Sciences from the Vrije Universiteit Amsterdam in the Netherlands, where she also completed an internship performing statistical validation of retinopathy prediction models in diabetes patients. She also holds a Bachelor of Science in Public Health from the University of Washington with a focus on factors affecting life expectancy.

Heidi comes to Portland from Seattle, WA where she worked at the Washington State Department of Health Newborn Screening Laboratory. There she managed a variety of program evaluation and development projects in data systems, outreach campaigns, and contracts. Prior to this, she worked in private healthcare management and at the Washington State Health Care Authority expanding access to medical care for Washingtonians. Throughout her career, she has found her passion is in improving public health data and surveillance infrastructure to create a better foundation for performing epidemiological studies. In her spare time, she enjoys strategy board games, playing piano and ukulele, taking classes, traveling, and spending time with her fiancé, Michael, and their fluffy gray cat, Gandalf.

Ashley Thomas is from Kailua-Kona, on the Big Island of Hawaii. She completed her undergraduate work in Health Promotion at Western Oregon University and earned her MPH in Epidemiology at Oregon Health & Science University. Ashley recently joined the NPAIHB as the NW NARCH Cancer Prevention and Control Project Coordinator. She will be responsible for coordinating the Tribal Researchers' Cancer Control Fellowship Program including recruitment, training, and follow-up support. Ashley comes to us from OHSU where she had worked on Tribal health research projects at the Center for Healthy Communities since 2013. Ashley welcomed a new baby into the family at the end of June. She spends her free time traveling, hiking, and playing at the park with her two kids.

Rosa Frutos is an enrolled member of the Confederated Tribes of Warm Springs and is of Mexican descent. She graduated from the University of Washington with her Masters in Social Work in 2016. She has experience working for American Indian/Alaska Native non-profits, research studies, and tribal organizations.

Rosa most recently worked at Oregon Health & Science University (OHSU) as a Program Coordinator for the Northwest Native American Center of Excellence. At OHSU Rosa coordinated the Wy'east Post-Baccalaureate Pathway, student support activities and cultural programming. Rosa will be joining the Northwest Tribal Cancer Control Project as the Cancer Project Coordinator.

Hello, my name is Megan Woodbury. I am the Opioid Project Coordinator for the Tribal Opioid Response (TOR) Consortium and related Opioid projects at NPAIHB (Northwest Portland Area Indian Health Board). I provide technical assistance to NW Tribes TOR grantees addressing Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) through the SAMHSA TOR grant, as well as technical assistance to ongoing national efforts to address SUD in Indian Country via the CDC Umbrella – Opioid grant. I have a background in healthcare, Public Health and nonprofits, including serving in the AmeriCorps VISTA program. Beyond my professional life, I was born and raised in the Pacific Northwest, which has given me a deep love and appreciation for the natural beauty that surrounds us. Depending on the season, I can usually be found somewhere on Mt. Hood, whether it's skiing to my heart's content or hiking in the Spring and Summer. I am very excited and honored to continue learning and growing in my role as the Opioid Project Coordinator with the Board. Thank you!

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NEW EMPLOYEES

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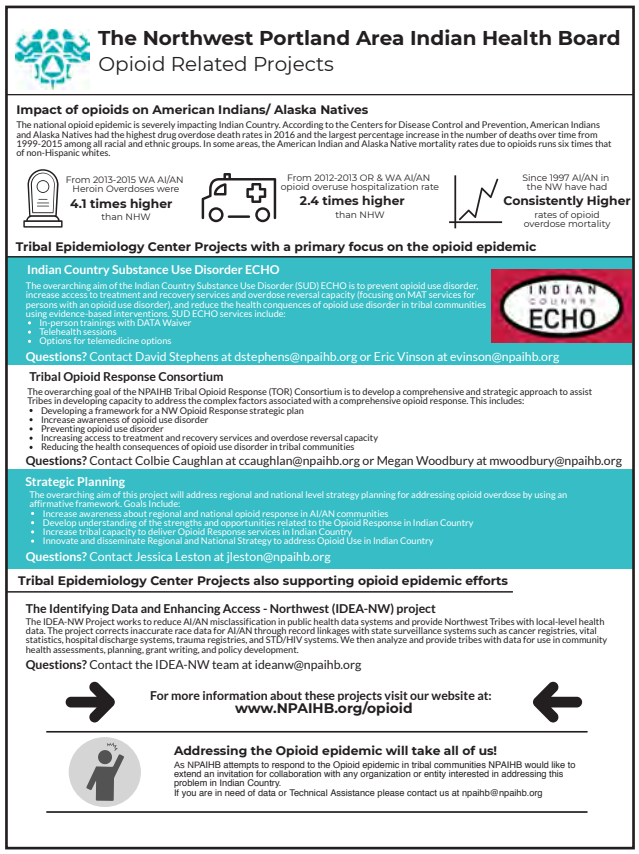
Hello all, my name is Paige Smith; I am Paiute, Modoc, Wasco and Shoshone by way of Warm Springs, OR. The last 10 years of my career has seen me working with our Native youth, in some of their most venerable times. I've worked for the Native American Youth and Family Center, Oregon Youth Authority and finally a part of the Homeless Youth Continuum. About 5 years ago I fell in love with Prevention, which led me deeper into Suicide prevention and Alcohol and Drug prevention/counseling. When I am not at work I am an avid competitor. I've competed in Rodeo, Wrestling, Magic the Gathering, ping pong bowling etc. My biggest competition has been with myself to continually do better. I am excited to take on the role of THRIVE/ Response Circles Project Coordinator, at NPAIHB. I have no doubt.

Upcoming Events

Click on flyer for hyperlink



Upcoming Events

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Upcoming Events

Click on date for hyperlink

JANUARY

January 24-25
2019 Tribal Border Summit
Tucson, AZ

January 28-31
ATNI Winter Convention
Portland, OR

FEBRUARY

February 8
OHA Tribal Monthly Meeting
Salem, OR

February 10-14
NCAI Executive Council Winter Session
Washington, DC

February 12-13
IHS Indian Health Care Improvement Fund Workgroup
Washington, DC

February 25-27
1st Quarter NIHB Board of Directors Meeting & Annual Meeting
Washington, DC

February 25-March 1
Basic EHR Clinical Informaticist
Portland, OR

MARCH

March 5-7
Diabetes Management System (DMS) training - Patch 12 update
Portland, OR


Northwest Diabetes Management System Training

MARCH

March 25-29
Advanced EHR Clinical Informatics
Portland, OR

March 31-April 3
NICWA 37th Annual Protecting Our Children
Albuquerque, NM

APRIL

April 4
All Tribal and Urban Indian Organization Leaders Call
Call-in to IHS

April 15-19
Advanced TIU training
Portland, OR

April 16-18
NPAIHB Quarterly Board Meeting
Anacortes, WA

We welcome all comments and Indian health-related news items.

Address to:
Health News & Notes/ Attn: Lisa Griggs or by e-mail at lgriggs@npaihb.org

2121 SW Broadway, Suite 300, Portland, OR 97201
Phone: (503) 228-4185 FAX: (503) 228-8182

For more information on upcoming events please visit www.npaihb.org

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD OCTOBER 2018 RESOLUTIONS

RESOLUTION #19-01-01
VA Tribal Advisory Committee

RESOLUTION #19-01-02
Medicaid Indian Amendments Act

RESOLUTION #19-01-03
IHS Director Position