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# American Indian and Alaska Native Issues Regarding Disparities Impact Statements: National Indian Child Welfare Association Briefing Paper

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## Introduction

The following paper was developed to provide American Indian and Alaska Native (AI/AN) federal grantee tribes and organizations with information that might be helpful for meeting the grant award conditions regarding disparities impact statements (DISs).

In 2011, the Department of Health and Human Services (HHS) issued the Action Plan To Reduce Racial and Ethnic Health Disparities (Action Plan). According to the Office of Minority Health (2011), the Action Plan defines *health disparities* as "differences in health conditions and health outcomes among specific populations. Social, economic, and environmental disadvantages directly or indirectly contribute to these inequities. Such disparities are considered 'unnecessary, avoidable, and unfair or unjust'" by the World Health Organization (2008).

The HHS Action Plan calls for disparity impact statements as a way to address these issues. In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) began to require grantees to develop a DIS as a special condition of award. Today each grantee must submit a DIS that includes a plan for reducing specific behavioral health disparities. SAMHSA recognizes that disparities also have a system response component and are not dealt with equitably by communities. Disproportionate response to needs can also be addressed in a DIS.

A DIS, according to SAMHSA, addresses disparities based on racial, ethnic, and sexual minority status across three domains: access; use, and outcomes. The policy of the federal government, enforced through its power to attach conditions to funding, is to systematically reduce disparities wherever possible. *Disparities* and *disproportionality* are both defined in terms of relationships or comparisons. In other words, a disparity can only be described as a relationship between two comparison groups. Describing these relationships requires defining the comparison groups and data that can be compared from group to group, usually in comparisons of the White population with the ethnic/racial population.

In practice, this concept can be especially challenging for AI/AN grantees for the reasons discussed in this paper.

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**American Indian and Alaska Native Disparities and Disproportionality**

Health and social disparities are well known to AI/AN tribes. AI/AN people suffer some of the most pronounced disparities of any ethnic or racial group. As a group, AI/AN people are more likely to be impacted by poverty, severe mental health disorders, substance abuse, violence, and trauma. For the purposes of this discussion, ***Disparities*** refers to the variation in incidence, prevalence, and burden of social and/or health conditions among specific populations of people (National Institutes of Health, 2000). For example:

- AI/AN people have the highest poverty rate of any racial group in the nation (U.S. Census Bureau, 2016).
- AI/AN families are more than twice as likely to live in poverty as the general population (U.S. Census Bureau, 2016).
- AI/AN children are served by the Individuals With Disabilities Education Act (IDEA) at a higher percentage than any other group of children (National Center for Education Statistics, 2016).
- AI/AN children and youth experience the trauma of child abuse and neglect at higher rates than the general population (U.S. Department of Health and Human Services, 2012).
- AI/AN youth have more serious problems with mental health disorders (Substance Abuse and Mental Health Services Administration, 2010).
- AI/AN adolescents and young adults aged 15 to 34 commit suicide at a rate 1.5 times that of the general population (Centers for Disease Control and Prevention, 2013).

Tribal populations also experience disproportionate responses to their social needs. This is known as ***disproportionality,*** which refers to the overrepresentation or underrepresentation of specific groups in various services or types of interventions, such as suspension and expulsion rates (Martinez, Francis, Poirier, Brown, & Wang, 2013). For example, nationwide, AI/AN children are overrepresented in foster care at a rate 2.4 times that of the general population (Summers, 2015). However, the national average of overrepresentation of AI/AN youth cited above can be misleading because of the wide variation in disproportionality rates for AI/AN children in various states. With the consideration of the wide variation, a different picture emerges. Just 16 states account for all disproportionality. Of those 16, 6 have disproportionate placement rates ranging from 4.5 to almost 15 times that of White children (Summers). In addition, when parental substance abuse is involved, the placement rate is 8 times greater than that of White substance-abusing families. (Carter, 2009). Although overrepresented in out-of-home placement, AI/AN families receive fewer poverty reduction services, housing-related services, mental health services, or substance abuse treatment services. (Sarche & Spicer, 2008)

In juvenile justice, AI/AN youth are 20% more likely to be placed outside the home after adjudication (Puzzanchera & Adams, 2010). AI/AN youth have their cases transferred to adult court 8 times more often than White youth (Puzzanchera & Adams), and 79% of all youth in federal confinement are AI/AN (Motivans, 2011).

## Context

### *SAMHSA Granting and AI/AN Populations*

Since the 1990s, AI/AN tribes have had increasing access to SAMHSA grant programs and far more success in securing these funds. For example, the Comprehensive Community Mental Health Services Program for Children and Their Families, enacted in 1993, has provided 46 tribal grants, or about 15% of all awards, since its inception. The term *tribal grants* is used here to include a tribe or tribal organization directly receiving a grant, or a city, county, or state grantee focused specifically on the AI/AN population through a partnership/contract with an AI/AN nonprofit.

Tribal communities often have limited access to culturally competent mental health care for their populations and experience significant shortages in mental health workforce. Tribal grantees work to overcome a lack of basic infrastructure to support a range of services and supports for their communities. Historic and intergenerational trauma is compounded by ongoing trauma, such as abuse, violence, deaths, and economic stress for individuals and families. Compounded traumas pose additional challenges to tribal grantees when creating plans to meet the needs of their populations because typical western concepts of disease and treatment may not align with cultural concepts of holistic wellness and healing.

Since 1999, SAMHSA has invested in helping tribal grantees overcome significant obstacles to develop culturally appropriate responses to behavioral health needs through technical assistance and tribe-specific grant programs, including 49 Circles of Care grants. In Fiscal Year 2015 (FY2015), SAMHSA awarded 113 grants to tribes and tribal organizations.

As of the date of this writing, 108 SAMHSA Center for Mental Health Services (CMHS) tribal grants (18 Garrett Lee Smith Suicide Prevention grants and 90 Native Connections grants) are for youth suicide prevention. Twenty-six tribal grants are to develop and/or implement comprehensive service systems for children, youth, and young adults with mental health issues and their families. These include 14 Systems of Care, 11 Circles of Care, and 1 “Now Is the Time” Healthy Transitions. Nine tribal grants are for promotion of early childhood mental health (Project LAUNCH). Two grants are for child traumatic stress treatment (National Child Traumatic Stress Initiative).

In FY2017, CMHS will experience more than a 125% increase in tribal grants awarded—mostly because of the budget increase in the Native Connections grant program, which will result in 94 new tribes or tribal organizations receiving funding for youth suicide prevention. Potentially more than 200 tribal grantees will soon be developing a DIS as a condition for funding. The following discussion examines the challenges and offers some possible strategies for AI/AN grantees to consider.

### *DIS Issues for Tribal Grantees*

As mentioned above, a disparity is stated as a relationship between two comparison groups. The SAMHSA policy was developed from a perspective in which grantees would serve communities with subpopulations considered to be “minorities” as compared with the larger society. However, tribal grantees serve primarily a homogenous population. For tribal grantees, the DIS requirement can be confusing. Does a tribal grantee look for internal disparities within

the tribal population, or does a tribal grantee compare its total service population to the outside population? SAMHSA has provided little guidance for tribal grantees, and thus they are developing their own responses to the challenges.

Some tribal grantees have taken the internal disparities approach and defined subgroups on the basis of geographic location, LGBTQ status, or language. Some tribal grantees exhibit service area diversity—for example, when the grantee is urban or does not have a tribal land base. However, in such cases, tribal grantees are still serving only their own, largely homogenous population. In most cases tribal grantees are distinct tribal nations with a geographic and population base that is separate and distinct from the general society. When tribal grantees take an internal disparities approach, the DIS is focused on self-defined internal disparities and disproportionality. An example is when one geographic location on a reservation is miles from available tribal services and disproportionate service utilization may result.

Another approach is to compare the aggregate tribal grantee service population with a nontribal comparison group. In this case, the grantee is comparing itself with a different (and perhaps even diverse) cultural population and taking the perspective that, as a grantee, it will reduce a disparity within its own group, as compared with the outside population. This approach would seem to be most closely aligned with the spirit or intent of the DIS policy but also comes with significant challenges.

Either approach requires data that are comparable across at least two groups and that are consistently available over a relevant time interval consistent with grant activities. Both approaches run into significant challenges in this regard.

***DIS Measurement and Data Challenges***

There are several issues that affect tribal programs' use of data to measure disparities. The AI/AN population is small, with both a racial status and a unique political status as citizens of tribal nations. Data quality is compromised when data gathering is conducted over political units that do not match the tribal services populations. Data are often aggregated by county, by state, or nationally—but not by tribe. Further, many different federal and state agencies use different definitions of *Indian*. Federal Indian education programs are far more inclusive than the Indian Health Service, for example. The U.S. Census is also problematic with regard to the definition of *Indian* but is often the only source of information available to tribes (National Congress of American Indians Policy Research Center, 2016).

Problems with sample sizes and the complexities of determining who is AI/AN "frequently render AI/AN experiences indiscernible in data" (Curry-Stevens, Cross-Hemmer, Maher, & Meier, 2011). This is especially problematic at the local level. The disparities experienced by local AI/AN communities get lost when data reported by race leave out an "AI/AN" category altogether (Curry-Stevens, Cross-Hemmer, Maher & Meier, 2011).

The implications for tribal grantees needing to track disparities is that there are very few routinely reported data sources available to simply cite. Even when local data may be available, from a school district for example, the time period during which data are gathered or reported may not match the reporting time frames for a tribal grant. Connecting grant activities with increases or decreases in disparities will be difficult if the time frames are not well aligned. In

some cases, tribal grantees may be able to establish memorandums of agreement with public entities that gather data, so that tribal data can be gathered appropriately and disaggregated for tribal purposes. Any such arrangement would likely require a government-to-government negotiation, which would need to be negotiated prior to a grant application.

Measurability of progress toward goals to reduce disparities is problematic, given the data context described above. The primary solution to this issue is to choose modest and measurable goals for which local- and most likely program-level data can be used to track progress. For some tribal grantees, service utilization data may be the only reliable source of data available for tracking reductions in disparities.

### *DIS Strategies for Tribal Grantees*

Keeping It Local With Community Participation

It is important that a DIS and quality improvement plan be responsive to local needs and not just created to satisfy a grant requirement. Local participation in developing the statement and plan can be helpful particularly in tribal areas where access to data is limited. Local service providers, advocates, and families receiving services will know the gaps and be able to advise the project staff on defining the subpopulations and what to measure.

Defining the Disparities Comparison Approach

Tribal grantees that have already developed DISs and engaged in tracking their goals have taken two primary approaches: looking at disparities among internal subpopulations and comparing the tribal service population with the surrounding population.

Where there is a homogenous service population, some tribal grantees have chosen to treat the entire service population as the subpopulation and to set goals to reduce the disparities that the AI/AN community experiences in comparison with the surrounding non-Indian population. This approach has both challenges and strengths. Tribes may have a difficult time defining and obtaining data on the comparison population and/or producing tribal data that are comparable to the comparison population. Service utilization data need to be tracked internally in a way that can be put side by side with available data from the comparison population.

Other tribal grantees have defined local subpopulations in order to measure disparities. As was discussed earlier, many tribal communities are quite homogenous. Others can be quite diverse. However, even in tribal areas with diverse populations, the tribal project service population will likely be limited to tribal members and descendants, thereby creating a homogenous service population even if the community is diverse. Disparities in tribal areas with diverse populations may be present but, by design, not relevant to measurement because subpopulations likely have similar disparities to start with. The grantee would need to identify subpopulations that are part of the tribal service population and that experience disparities in comparison with the rest of the tribe. Such subpopulations may include a geographic area that is isolated from service providers, a particular age group, children with a particular disability, unemployed families, and LGBTQ youth.

Identifying Relevant Data

Access to relevant data is extremely limited. Relevant data are those that are specific to the tribal service population and that can be measured against a comparison population, either

within the service population or outside. Unfortunately, none of the usual sources of data (for example the Office of Civil Rights Data Collection, Youth Risk Behavior Survey, 2015 KIDS COUNT Data Book: State Trends in Child Well-Being) that states, counties, or cities rely on will yield data that can be disaggregated by tribe. Some data may be available from the local offices of the Bureau of Indian Affairs, the Indian Health Service, or tribal services. Geographic service population utilization data may be the most accessible.

Existing tribal data, both quantitative and qualitative, may be available and relevant. For example, if there has been a tribal needs assessment conducted within the last 3 years, subpopulations and relevant disparities may have already been identified. A local needs assessment may determine that children with fetal alcohol spectrum disorder have little access to appropriate educational services. Other local sources can also be important. If local school districts, housing programs, early childhood programs, or health programs routinely collect data for reporting to funders or for planning purposes, such resources may be used to track disparities. Access to such data may require an interagency agreement.

Where quantitative data are not readily available, using qualitative data to inform decision making is appropriate. Qualitative data may include environmental scans, focus groups, or interviews. Clearly, defining the disparity being measured will make a qualitative approach more manageable and reliable, and less time consuming. Qualitative approaches that rely on focus group or interview data can only reasonably handle a few distinct topics well. Trying to measure too many or ill-defined disparities will make data gathering, analysis, and reporting difficult. Keeping qualitative processes simple and narrowly focused is advisable.

Selecting a Disparity to Address and Measure

Once the data have been secured, they can be used to understand the disparity or disparities, to inform setting one or two goals, and to define a measure or measures to track progress. For example, a disparity may exist when a remote community does not have access to services. The goal would be to increase access, which can be tracked via service utilization data. Focus on one disparity, such as access, is both sufficient and advisable, as the intent of the policy is local and concrete change. If more than one or two disparities are identified, it is important to prioritize them on the basis of the feasibility of affecting that disparity and measuring progress.

If the choice is to draw a comparison between the tribal services population and the mainstream population, a decision has to be made regarding the level of comparison. This decision will often be driven by what data are available at what intervals. A tribal grantee needs to use a publically available source of data at the county, state, or national level, or negotiate an agreement with the holder of relevant data. For example, a tribal grantee may be able to compare service utilization rates from its own program records with county-level data from published reports of the state mental health system. Keeping the approach simple, local, and measureable will yield defensible results.

Alignment With the National Standards for Culturally and Linguistically Appropriate Services

The Office of Minority Health has set standards for providing culturally and linguistically competent services that are aligned with the DIS. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) are designed to help achieve the reduction of disparities and disproportionality. These standards are as valid for

tribal grantees as for any other jurisdiction. For example, 15% of a tribal grantee's service population may speak an indigenous language and yet the grantee has staffed its program with English-only employees. A DIS intervention could focus internally on increasing indigenous speakers on staff. In this case, the approach would align with CLAS Standard 6: "Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing;" and with Standard 3: "Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area." A simple goal might be to increase the number of providers that speak the indigenous language or increase service utilization by indigenous speakers through the use of qualified interpreters.

Aligning Interventions with Disparity Reduction

Once the approach, disparity, and measurement decisions are made, the tribal grantee will need to determine the way its interventions will address and ideally reduce the chosen disparity. For this reason, it is important to develop any program application with the DIS clearly in mind. Proposals often list disparity data when they are available. Proposed services should be developed with the reduction of disparities in mind. According to the disparity the grantee chooses, the grantee will need to determine which service, intervention, policy change, or other factor will help the grantee achieve the desired outcome. If the measure is internal, such as the language example above, the method will be an organizational change. If the measure is external, as in reducing the number of suspensions of AI/AN students compared with those of White students in a reservation border town serving the tribal population, then the interventions may include an institutional universal best practice, such as Positive Behavioral Interventions and Supports or other culturally and linguistically appropriate and relevant interventions with students and teachers. For example, a grantee may teach AI/AN students problem-solving skills and provide cultural competence training for school teachers and administrators.

## Conclusion

Although tribal grantees face some unique challenges addressing the DIS, it is still a valuable investment of time and resources when the result is information about what works in addressing the needs of the tribal service population. The key is to structure the DIS so that it will benefit the tribal community. When the DIS process is conducted with that end in mind, the knowledge gained will be of value in developing future projects. The grantee will have some good information about the impact of the funded project and be able to determine whether the intervention should be sustained. Good data can support advocacy for setting internal priorities and seeking external funding.

Tribal grantees will also benefit from other tools developed by the National Resource Center for Mental Health Promotion and Youth Violence Prevention for a broad audience and intended to support the development of a DIS. This document is intended to illuminate the unique issues faced by tribal grantees.

**References**


Black, M. C., & Breiding, M. J. (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence—United States, 2005. *Morbidity and Mortality Weekly Report 57*(5), 113–117. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm

Carter, V. (2009). Comparison of American Indian/Alaskan Natives to non-Indians in out-of-home care. *Families in Society: The Journal of Contemporary Social Services*, *90*(3), 301–308.

Centers for Disease Control and Prevention. (2013, 2011). Web-based injury statistics query and reporting system (WISQARS). National Center for Injury Prevention and Control, CDC (producer). Retrieved from http://www.cdc.gov/injury/wisqars/index.html

Curry-Stevens, A., Cross-Hemmer, A., Maher, N., & Meier, J. (2011). The politics of data: Uncovering whiteness in conventional social policy and social work research. *Sociology Mind, 1*(4), 183–191.

Martinez, K., Francis, K., Poirier, J., Brown, L., & Wang, M. (2013). *A blueprint for using data to reduce disparities/disproportionalities in human services and behavioral health care*. Retrieved from http://www.tapartnership.org/COP/CLC/

Motivans, Mark, et al. "Summary: Tribal Youth in the Federal Justice System." *Washington, DC: Bureau of Justice Statistics* (2011). Retrieved from www.bjs.gov/content/pub/pdf/tyfjs.pdf.

National Center for Education Statistics, U.S. Department of Education. (2016). *The condition of education*. Retrieved from https://nces.ed.gov/programs/coe/indicator_cgg.asp

National Institutes of Health. (2000). *NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities*. Retrieved from http://health-equity.pitt.edu/74/1/NIAMS-Rev.pdf

National Congress of American Indians Policy Research Center. (2016). *Disaggregating American Indian & Alaska Native data: A review of literature.* Princeton, NJ: Robert Wood Johnson Foundation.

Puzzanchera, C., & Adams, B. (2010). An interpretation of the national DMC relative rates indices for Juvenile Justice System processing in 2007. *National disproportionate minority contact databook.* Prepared by the National Center for Juvenile Justice for the Office of juvenile Justice and Delinquency Prevention. Retrieved from http://www.ojjdp.gov/ojstatbb/dmcdb/pdf/dmc_interpretations.pdf

Sarche, M., & Spicer, P. (2008). Poverty and health disparities for American Indian and Alaska Native children: Current knowledge and future prospects. *Annals of the New York Academy of Sciences*, *1136*, 126–136. Retrieved from http://doi.org/10.1196/annals.1425.017

Substance Abuse and Mental Health Services Administration. (2012). *Results from the 2011 National Survey on Drug Use and Health: Summary of national findings* (NSDUH Series H-44, HHS Publication No. (SMA) 12-4713). Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration. (2010). Mental health disparities: American Indians and Alaska Natives. (American Psychiatric Association). Retrieved from http://www.integration.samhsa.gov/workforce/mental_health_disparities_american_indian_and_alaskan_natives.pdf

Summers, A. (2015). *Disproportionality of children of color in foster care: Fiscal year 2013*. Reno, NV: National Council of Juvenile and Family Court Judges. Retrieved from https://www.ncjfcj.org/sites/default/files/NCJFCJ%202013%20Dispro%20TAB%20Final.pdf

Urban Indian Health Institute, Seattle Indian Health Board. (2012). *Addressing depression among American Indians and Alaska Natives: A literature review.* Seattle, WA: Urban Indian Health Institute. Retrieved from http://www.uihi.org/wp-content/uploads/2012/08/Depression-Environmental-Scan_All-Sections_2012-08-21_ES_FINAL.pdf

U.S. Census Bureau. (2009). American Community Survey 1-year estimates, American Indian Reservation and Trust Land—Federal Tribe: Poverty status in the past 12 months. Retrieved from http://factfinder.census.gov/servlet/STTable?_bm=y&qr_name=ACS_2009_1YR_G00_S1701&-ds_name=ACS_2009_1YR_G00_&-gc_url=010:89|&-CONTEXT=st&redoLog=false&-geo_id=01000US&-_showChild=Y&-format=&-_lang=en

U.S. Census Bureau. (2010–2012). American Community Survey 3-year estimates, S0201, Selected profile in the United States. Retrieved May 15, 2014, from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

U.S. Census Bureau. (2016). American Indian and Alaska Native heritage month: November 2016. CB16-FF.22. Retrieved from http://www.census.gov/content/dam/Census/newsroom/facts-for-features/2016/cb26-ff22_aian.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child maltreatment 2012*. Rockville, MD: Author. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

U.S. Dept. of *Health* and Human Services, *Office* of Minority Health. HHS Action Plan To Reduce Racial and Ethnic Health Disparities: Office of Minority Health (2011). https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf

World Health Organization. (2008). Commission on Social Determinants of Health's Final Report. http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf