



**Oklahoma Department of Mental Health and
Substance Abuse Services**

Plan for Special Populations Work Groups

June 28, 2012

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Substance Abuse Services
Plan for Special Populations Work Groups – Native Americans**

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Mvto vcululke.

In the Mvskoke (Creek) language, this means,

“Thank you to our elders.”



Chapter One - The Purpose of the Work Group

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has been awarded a State Prevention Enhancement Grant (SPEG) for planning a five year strategic plan (State Plan) to be submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA).

ODMHSAS is desirous of seeking input from diverse community members in the development of their next State Plan. In particular, staff recognizes that a key to success is to promote collaboration with multiple key stakeholders to seek input, consultation and recommendations for future efforts.

As a result, the ODMHSAS established nine special population work groups, from which they are requesting input concerning SUBSTANCE ABUSE PREVENTION SERVICES. The input from this workgroup is intended to identify data and service gaps among Native Americans, ways to fill these gaps that are culturally sensitive and appropriate, identify new partnerships that should be pursued, or how to improve existing partnerships.

The work group members were asked to remain focused on high impact, system level or environmental changes that are sustainable over time. Members were encouraged to stay focused on substance abuse prevention efforts.

Work group members were asked to focus on the following questions:

- Are our prevention services meeting Native American people's needs?
- What data are available to help us assess, plan, support and/or deliver services that are inclusive of Native American people?
- What data gaps exist?
- What barriers exist?
- How should we address our unmet needs?
- What additional partnerships should be developed?

ODMHSAS indicated that the work group may continue meeting in an advisory capacity following the initial planning period if it is deemed beneficial to the focus population and to the ODMHSAS, and the workgroup decided to work within the established Tribal State Relations Workgroup.

Chapter Two - The Work Group Membership and Meeting Dates



The work group consisted of the following members:

- Lindsley Harry, Behavioral Health Services, Muscogee (Creek) Nation
- Rita Hart, Department of Human Services, Tribal Liaison and member of Jicarilla Apache and Choctaw Nations
- Suzanne Johnson, MSPI Coordinator, Oklahoma City Indian Clinic
- Levi Keehler, Behavioral Health Services, Cherokee Nation
- John Scroggins, Member of the Cherokee Nation
- Dana Miller, Oklahoma Health Care Authority, Tribal Liaison and member of the Redlake Bank of Chippewas and Seminole Nations
- Jade Pech, Oklahoma Health Care Authority, Tribal Liaison

The work group was staffed by the following:

- Sally Carter, Oklahoma State Department of Health, Tribal Liaison - *Facilitator*
- Lucinda Myers, ODMHSAS Tribal Liaison– *Work Group Leader* and member of the Muscogee (Creek) and Seminole Nations
- Deborah Smith, ODMHSAS Prevention Program Manager

The work group met on the following dates from 12:00 pm – 2:00 pm:

- March 22, 2012 – Oklahoma History Center
- April 27, 2012 – Oklahoma History Center
- May 29, 2012 – Oklahoma History Center
- June 28, 2012 – ODMHSAS Training Center, Sheperd Mall

Chapter Three – ODMHSAS Tribal State Relations

The mission of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is to promote healthy communities and provide the highest quality care to enhance the well-being of all Oklahomans. Services available through the ODMHSAS will promote productive lifestyles and set the national standard for prevention, treatment, and recovery for those affected by mental illnesses and substance abuse disorders.

The State of Oklahoma and Oklahoma's Indian Tribes have a range of common interests. Both states and tribes have a shared responsibility to use public resources effectively and efficiently and both seek to provide comprehensive services to their respective citizens. It is understood that each Indian Tribe has its own culture, beliefs, value system, and right to govern itself as a sovereign nation. As residents of the State of Oklahoma, tribal citizens are equally entitled to programs and services available to all residents. Additionally, by virtue of membership in an Indian Tribe, tribal citizens are eligible to access services offered by their respective Tribal Governments.

Given their mutual interests, it is critical that the ODMHSAS and Tribal Governments work together in a collaborative manner to the extent practicable and governed by law. The ODMHSAS is committed to supporting a holistic framework that reinforces the belief that the mind, body, and spirit are all connected to health and that tribes know best how to solve their own problems through prevention activities, community partnership and collaborating with other

agencies in prevention and treatment efforts.

ODMHSAS Tribal State Relations Shared Vision

All American Indian children and youth will have early and easy access to all the behavioral health services and supports necessary in order to remain in their own homes, in their own communities, safely and successfully, with hope for the future

Why Should Tribal Leaders Be Involved?

“Although a direct government-to-government relation with the state and federal government remains a fundamental principle of the trust relationship, it is important that tribes recognize the benefits of understanding state governmental processes and potential avenues for collaboration. In a climate of increased devolution of federal programs, the need for intergovernmental coordination is an inevitable reality. State legislatures are responsible for appropriating funds for state programs that may be of benefit to tribes or tribal members who also are citizens of the state. By increasing knowledge of how a state budget is allocated and how state legislators who represent a tribal community’s district, tribes can maximize the positive effects of state programs and services” (*National Congress of American Indian: Tribal-State Relations, 2006*).

Chapter Four – Oklahoma Native American People

Today, thirty nine (39) tribes call Oklahoma home, but it wasn't always that way. Although several tribes are described as indigenous to Oklahoma at the time of European contact, most of the thirty nine (39) tribes here today were forcibly removed from their ancestral homelands.



Oklahoma Federally Recognized Tribes:

Absentee Shawnee Tribe	Alabama Quassarte Tribal Town	Apache Tribe
Caddo Nation	Cherokee Nation	Cheyenne and Arapaho Tribes
Chickasaw Nation	Choctaw Nation	Citizen Potawatomi Nation
Comanche Nation	Delaware Nation	Delaware Tribe of Indians
Eastern Shawnee Tribe	Fort Sill Apache Tribe	Iowa Tribe
Kaw Nation	Kialegee Tribal Town	Kickapoo Tribe
Kiowa Tribe	Miami Nation	Modoc Tribe
Muscogee (Creek) Nation	Osage Nation	Otoe-Missouria Tribe
Ottawa Tribe	Pawnee Nation	Peoria Tribe of Indians
Ponca Nation	Quapaw Tribe	Sac and Fox Nation
Seminole Nation	Seneca-Cayuga Tribe	Shawnee Tribe
Thlopthlocco Tribal Town	Tonkawa Tribe	United Keetoowah Band of Cherokees
Wichita and Affiliated	Wyandotte Nation	Note: The Euchee Tribe has

Tribes		filed for federal recognition
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According to the 2010 Census, 5.2 million people in the United States identified as American Indian and Alaska Native, either alone or in combination with one or more races. Out of this total, 2.9 million people identified as American Indian and Alaska Native alone.

Census 2010 Oklahoma Population	
Total Population	3,751,351
Population by Race	
White	2,706,845
African American	277,644
Asian	65,076
American Indian and Alaska Native	321,687
Native Hawaiian and Pacific Islander	4,369
Other	154,409
Identified by two or more	221,321
www.census.gov	

Three of the ten places with the highest percentage of American Indians and Alaska Natives are located in Oklahoma (2010 Census). They are as follows:

1. Oklahoma City
2. Tulsa, Oklahoma
3. Norman, Oklahoma

Additionally, they make up a significant portion of the population in five Oklahoma counties – Adair, Caddo, Cherokee, Delaware and Mayes, which are mainly rural communities.

OVERALL LIFE EXPECTANCY

The Indian Health Service (IHS) publication titled *Trends in Indian Health* provides basic statistical information including but not limited to general mortality and community health statistics. Table 1 compares American Indian/Alaskan Native death rates (age-adjusted per 100,000 population) as reported in IHS *Trends* for data years 1999-2001 and 2002-2003. These death rates varied most notably in drug-related deaths from data years 1999-2001 to 2003-2005, which nearly doubled. The American Indian /Alaskan Native drug-related death rate (17.4) has increased 255% since drug-related rates were first introduced for AI/ANs in 1979.

Table 1. Comparison of AI/AN Death Rates between Data Years 1999-2001 and 2003-2005

(Age-adjusted rate per 100,000 population)	DATA YEARS 1999-2001	DATA YEARS 2003-2005
CAUSE		
<i>Alcohol-related</i>	43.21	43.32
<i>Drug-related</i>	9.21	17.42
<i>Suicide</i>	17.01	18.82
<i>Males (all ages)</i>	29.61	30.32
<i>Males ages 15-24</i>	45.93	55.23
<i>Males ages 25-34</i>	55.33	58.03
<i>Homicide</i>	11.41	11.32

Even with the slight decrease in homicide-related death rates reflected in Table 1, AI/AN death rates continue to increase alarmingly for suicide, especially for males ages 15-24, and for drug-related deaths, which nearly doubled. In addition, AI/AN death rates continue to significantly surpass U.S. all-races death rates, as reported in the most recent IHS *Trends* publication. Table 2 shows death rates for AI/AN populations as compared to the U.S. all-races rate for behavior-related causes.

Table 2. AI/AN Death Rates Associated with Behavior-Related Causes Compared to U.S. All-Races Rates

(Age-adjusted rate per 100,000 population)	DATA YEARS 1999-2001	DATA YEARS 2003-2005
CAUSE		
<i>Alcohol-related</i>	1,562% greater	519% greater
<i>Accidents</i>	153% greater (unintentional injuries)	149% greater (unintentional injuries)
	212% greater (motor vehicle crashes)	209% greater (motor vehicle crashes)
<i>Suicide</i>	64% greater	73% greater
<i>Homicide</i>	97% greater	92% greater

ALCOHOL AND OTHER DRUGS

Alcohol and tobacco consumption is a significant problem among Native American people living in Oklahoma. According to data from the *2009 Behavioral Risk Factor Surveillance System (BRFSS)*, 14.2 percent of American Indian/Alaskan Native adults reported binge drinking, and 4.0 percent reported heavy drinking; both percentages exceed those reported by any other race.

Data from the *Oklahoma State Bureau of Investigation* show Oklahoma’s AI/AN population had substantially greater alcohol related arrests (i.e. driving under the influence, liquor law violations and drunkenness) at 44 percent; lower drug law violation arrests (i.e., all drug arrests reported as robbery, aggravated assault, burglary, larceny, and motor vehicle theft) at 10 percent, compared to all races combined (29 percent, 14 percent, 13 percent respectively).

From fiscal years (FY) 2001-2008, Oklahoma’s Native American people had consistently high rates of persons served in substance abuse treatment facilities compared to whites and people of all races combined.

When studying the differences in illicit drug use rates among Oklahoma and Non-Oklahoma Indian youth, interesting results were uncovered. According to *Tragesser* and her research partners, they determined that demographic factors may

serve as risk or protective factors for drug use in American Indian communities. After studying 1,928 7th to 12th graders from non-Oklahoma schools and 1,938 Indian students from schools in Oklahoma over a three year period, Oklahoma youth showed lower rates of drug use, later ages of initiation of drug use, and great levels of perceived harm from using drugs.

In a 2006 paper, the *National Congress of American Indians* (NCAI) stated that methamphetamine —has disproportionately devastated Native American Tribal communities||6 and urged a comprehensive, coordinated response to address this threat to the stability of American Indian communities. The spread of methamphetamine is putting Tribal public health and community well-being at risk because this powerfully addictive drug devastates the mind and body, and also leads to a myriad of other social problems such as child abuse and neglect, domestic violence, and skyrocketing crime rates.

CO-OCCURRING DISORDERS

Alcohol and other substance abuse can co-occur with mental health disorders, complicating the diagnosis and treatment of these conditions for individuals who suffer from both and adding another layer of complexity to treatment within behavioral health care systems.

Behavioral health research and practice indicate it is very common for alcohol or substance abuse and mental health disorders to overlap. In a survey of research on co-occurring disorders, SAMHSA found that persons in treatment for one condition (either a substance abuse disorder or a mental health disorder) had a co-occurrence of an additional condition at rates from 20% to 73%.⁹ According to SAMHSA's *National Survey on Drug Use and Health*, there is a high rate of co-occurring substance abuse and mental health disorders within AI/AN communities. Substance use disorders can coincide with a variety of mental health conditions, ranging in severity from temporary emotional disturbance to chronic mental

illness, but an especially important condition to recognize is substance-induced disorders. Substance-induced disorders are mental health conditions that result from (rather than co-occur with) substance use. While substance-induced disorders are the direct result of substance use, their presentation can be clinically identical to other mental disorders. An example of a substance-induced disorder may be the increased suicide risk, described above, that appears to accompany methamphetamine use.

When co-occurring disorders are left untreated, or if only one disorder is treated, both disorders usually become more acute, resulting in additional complications. These complications include the risk for physical health problems, unemployment, homelessness, incarceration, separation from families and friends, premature death, and suicide. The toll on AI/AN families, schools, communities, and workplaces is significant.

MENTAL HEALTH CONCERNS

According to the *National Alliance on Mental Illness*, cultural differences exist in seeking mental health services and in reporting distress. Concerns relevant to Native American people reflect the following issues.

- An historical distrust of the outside population exists among many American Indian communities.
- Individuals tend to have negative opinions of non-Indian health service providers, and traditional healing is used by a majority of Native Americans.
- Compared to the general population, American Indian individuals tend to underutilize mental health services, have higher therapy dropout rates, are less likely to respond to treatment.

- The words “depressed” and “anxious” are absent from some American Indian and Alaska Native languages. Different expression of illness, such as *ghost sickness* and *heartbreak syndrome*, do not correspond to DSM diagnoses.

SUICIDE

Suicide in Indian Country is a significant behavioral health issue, and the suicide rates for AI/ANs are even more alarming than the rates for the general population. In fact, suicide rates for AI/ANs of all ages are 1.7 times higher than the U.S. all-races rate for all ages, impacting populations across the life cycle.¹¹ Alaska Natives commit suicide at rates four times the national average. It is the second leading cause of death for Indian youth between the ages of 15 and 24 (3.5 times higher than the national average).¹² For Alaska Native males of all ages, the

suicide rate is six times higher than the national average, with teen suicide rates nearly six times the rate of non-AI/AN teens.

Integrated behavioral health care systems and a holistic understanding of wellness are also critical in addressing the problem of suicide. The need for integrated care is highlighted by statistics from the U.S. Department of Health and Human Services indicating that the health conditions most consistently associated with suicide are mental illness and substance use and alcohol use disorders, which affect up to 90% of all people who die by suicide.¹⁷ Given the significant role of other behavioral health factors in suicide, provider shortages and the fragmented behavioral health service delivery system is even more tragic.

DATA LIMITATIONS

The reporting and analysis of health statistics necessary to create a representative picture of any health issue is a complex process. Concerns particular to behavioral health needs in AI/AN communities cause further obstacles to reporting and analysis. While reported statistics can begin to describe current behavioral health needs in Indian Country, underreporting may occur because of many factors, including stigma around seeking behavioral health care services, a lack of access to professional services, and a lack of culturally acceptable practices.

Along with obstacles in reporting, there are important limitations in statistical validity present in any source for health statistics. The current section explains data limitations to the health statistics used in this strategic plan. It also presents and evaluates alternative data sources from which readers can gather additional information to gain a more comprehensive picture of behavioral health issues in

Indian Country.

Chapter FIVE - The Process



ODMHSAS initiated the process by first identifying the specific populations they wanted to make special efforts to reach and seek their input. Then group leaders and facilitators were named to each work group.

Facilitators and group leaders received orientation and training from ODMHSAS staff in the purpose of the work group, the questions that needed to be answered and a suggested process. The group leader then began to recruit work group members and meeting dates and locations were established.

The first meeting was focused on encouraging the group to come together and to provide work group members with information about the process and specific data related to their work group.

From that point forward, three additional meetings were conducted to dialogue about Prevention efforts in Oklahoma and to answer the questions posed by ODMHSAS.

It should be noted that not all work group members were able to attend every meeting due to conflicts in schedules. However, all work group members had uniform opportunity to review and comment on this report.

Chapter SIX – Findings and Recommendations

Work group members deliberated for hours and engaged in vigorous discussion about the issues and concerns at hand. Work group members decided that recommendations should be strongly worded to the ODMHSAS with clear guidance about specific actions needed and next steps. Therefore, work group members are hopeful the ODMHSAS leadership will take these recommendations to heart and understand how important they are to improving substance abuse prevention services to the Native American community.

Work group members initiated the process by agreeing on the following definition:

***Substance Abuse Prevention:** A proactive process by which conditions that promote wellbeing are created; empower individuals and communities to meet the challenges of life events and transitions by creating conditions and reinforcing individual and collective behaviors that lead to healthy communities and lifestyles; reiterating the definition of prevention and environmental strategies.*

Most tribes represented on the work group indicated that data is obtained from the *Oklahoma Prevention Needs Assessment (OPNA)*, as many participate in the survey. At times tribal nations will also collect data themselves through key informant surveys, the *Adult Tobacco Survey*, and the Behavioral Risk Factor Surveillance System (BRFSS).

When discussion turned to issues of best practices used in tribal communities, mention was made that evidence-based programs have not been typically translated to native languages or even created or tested with Native American people. Primarily, materials are used that have been designed for Native Americans (such as in the states of California or Alaska) and reflect imagery that is associated

with Pacific Northwest Tribes, the Navajo Nation, and do not necessarily resonate with the Southern Plains Tribes located in Oklahoma.

For example, if consumer materials reflect pictures of salmon, Oklahoma tribal people will perceive that it does not address their cultural needs. Because Oklahoma has many of the largest federally recognized tribes in our state, it is important that the ODMHSAS invest in materials that specifically address Oklahoma's needs. When writing grant applications or creating new programs, extra efforts should be made to seek the formal input of Oklahoma tribal nations during the development of the grant and or programs. When federal agencies seek input from Oklahoma officials, extra efforts should be made to educate and inform federal partners about these types of nuances.

ODMHSAS is strongly encouraged to invest in staff development to enhance their knowledge, skills and abilities related to Native American cultural competency.

For example, one of the laws of the native universe is *order and trust*. There needs to be knowledge of traditional values of providers (including doctors, religious people and preventionists).

Native Americans communicate in different ways than the western cultures. Many times, messages are communicated through stories versus a direct approach. Providers need to inquire of tribal leaders and have a translator from the tribe present during the delivery of prevention services. This aids in tribal communication and acceptance.

It takes longer in Native American culture to introduce something new and to build trust before asking for something from them. It is important to include elders from

a community when presenting new programs and materials because of the different dialects with the tribe. The elders are respected and have great influence within the community. Please remember that while we may label Native American people as one people, they represent many different languages, customs and traditions (It should be noted that three of the top ten languages spoken in Oklahoma are American Indian languages - Cherokee, Muscogee, and Choctaw). Tribal communities have many similarities but also have differences. It's important that ODMHSAS take time to learn and understand about these differences.

One suggestion that ODMHSAS may consider is asking their prevention staff to attend Native American events to become more familiar with the culture thereby breaking down old ideas/barriers, which brings unity.

Work group members also recommend that ODMHSAS consider strengthening their ties with the Director of Behavioral Health at the Indian Health Service.

ODMHSAS was commended for establishing a tribal liaison position for the Systems of Care and for working towards the development of a tribal consultation policy.

ODMHSAS should assure the tribal liaison has adequate funding to perform all the duties necessary to connect with the vast Native American community living in Oklahoma. It should be noted that tribal headquarters are located over a broad geographic area, have diverse governments and numerous people involved in behavioral health and prevention programs. One staff member cannot be expected to perform all of these duties.

ODMHSAS should look to her sister agencies, such as the Oklahoma Health Care Authority and the Oklahoma State Department of Health, and take notice of the fact that they employ multiple staff members in the Offices of the Tribal Liaison and that they are focused on not only building meaningful relationships with tribal leaders and members, but other critical duties as well.

ODMHSAS should continue to support collaboration among the tribal liaisons with the Oklahoma State Department of Health, Oklahoma Health Care Authority and the Department of Human Services. When given the opportunity, ODMHSAS should encourage all other state agencies to adopt a tribal consultation policy.

ODMHSAS should encourage all tribes to identify a tribal member specifically designated to work with the tribal liaisons to enhance opportunities for communication and to promote better collaboration.

ODMHSAS should continue to encourage the entire leadership team to attend and participate in meetings, workshops, and conferences. Native American people need to see State leaders, and only face-to-face communication will build deep and lasting relationships.

ODMHSAS should also assure the tribal liaison receives adequate funding to promote cultural competency training for staff and have the resources needed to conduct multiple tribal consultation sessions across the state when needed. Staff should be educated on issues such as tribal sovereignty, forced removal, historic trauma, the boarding school system, the differences between the tribes in Oklahoma and other locations around the nation, Oklahoma's non-reservation

system of land ownership, and holistic medicine that often includes traditional ways of healing.

ODMHSAS should help their own staff realize there are many myths, such as casino money going directly to tribal members, that tribal people get large sums of money from the federal government, or that tribal members should only be served by IHS.

ODMHSAS should help their own staff understand that tribal members have “dual citizenship.” Native Americans pay taxes on their wages, pay property taxes for privately-owned land that is not under tribal jurisdiction, pay sales taxes, and other local fees like all other citizens of Oklahoma. Native Americans have voting rights and elect local county officials as well as tribal representatives. Therefore, all state programs should adequately meet the needs of a significant population of people living in the state, such as Native Americans.

ODMHSAS staff should be encouraged to develop program elements designed for consumers on a level that people can understand. But should not patronize Native American people. They should learn about what is going on in their communities, and if mistakes are made, should make amends immediately. This reflects true regret and establishes a foundation for forgiveness and healing.

When asked about service gaps, work group members indicated that there seems to be a lack of awareness of substance abuse prevention services available to tribal members. This led to the suggestion that greater efforts need to be made to either make more prevention services available to Native American people or to enhance the agency’s resources to promote the availability of prevention services.

ODMHSAS should be aware that tribal communities are often reluctant to accept new programs because of the short-term funding made available to programs. In other words, programs are usually only funded for three to five years. Once the funding is gone the program, the staff and the services disappear. It is difficult to trust that new programs are worth the effort if they will simply go away in the near future. ODMHSAS should attempt to work towards sustainable programs and sustainable funding.

ODMHSAS should consider adding to their budget, social marketing and advertising funds to send positive and healthy messages to Native American people. In order to be sure these messages resonate with Oklahoma tribal nations, efforts should be made to conduct focus groups (or *talking circles*) with multiple tribal nations. Efforts should be made to include messaging to tribal leaders and elders as well as specific populations that may need to create change.

ODMHSAS should continue its efforts to collaborate with the Oklahoma State Department Health, specifically the Turning Point Initiative. Many tribal representatives serve on Turning Point Coalitions around the state. At times, the very issues that will improve mental health and substance abuse issues will also enhance the overall health of Native American people. Efforts should be collaborative in nature and programs should not work in silos. Therefore, ODMHSAS should make better utilization of existing resources especially in rural communities.

ODMHSAS should consider adding more programs that meet the needs of young children and their families. It should be noted however, that oftentimes the western view of “family” is not necessarily congruent with the Native American

perspective. Many family members are involved in raising Native American children, not just the parents. Efforts should be made to address inter-generational needs and a broad view of the family should be taken in program development.

ODMHSAS should understand the “*sphere of influence*” within a Native American family and develop programs for families in that context. Therefore, efforts should be made to include helping uncles, aunts and grandparents, as an example.

ODMHSAS needs to encourage prevention workers to gain great credibility by seeking advanced training. Efforts should be made to establish core competencies for staff to assure consistent quality in all the programs across the state.

Work group members spent a significant amount of time reflecting on the existing collaborations between ODMHSAS, other agencies and programs as well as tribal nations. While great progress has been made to enhance collaboration efforts in recent years, more work needs to be done.

ODMHSAS should advocate for a *Native American Work Group on the Oklahoma Prevention Policy Alliance*.

ODMHSAS should require Regional Prevention Coordinators to have *advisory groups*, not simply filled via cronyism but with capable, fair individuals, to ensure services are culturally competent and ensure fidelity.

ODMHSAS should make greater efforts to ensure that their reporting and data gathering systems reflect the number of Native Americans served and how providers ensure cultural competence to that group through evaluation and validation efforts.

ODMHSAS should assure fair and equitable funding goes to tribal prevention programs and that at times, tribes should be funded directly rather than money going to a community in hopes that services will reach the Native American people living in the community.

Work group members concluded by commending ODMHSAS for their tribal liaison forming the “*Tribal State Relations Work Group*.” This group could serve as an important touch point when additional input from tribal nations is needed in the future.

The work group also wanted to extend appreciation to ODMHSAS staff for the kind and gracious staffing and the time spent seeking input on these important issues. It is hoped that continued improvements will be made in State/Tribal relationships with improved measurable outcomes for Native American people living in the State of Oklahoma.