

Bolstering the Behavioral Health Workforce:

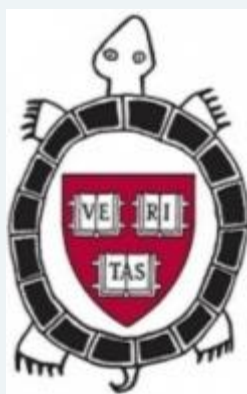
Supporting Suicide Prevention and Postvention
in Indigenous Communities

Prepared By:

Kimberly Fabian, Mia Fernandes, Madison Esposito



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Summary

There are four Tribes and nineteen Pueblos in the state of New Mexico. All sovereign entities have unique interests, cultures, relationships, and approaches to life. This paper aims to address suicide prevention and postvention programming in the state of New Mexico through on the ground efforts in Tribal communities. The focus on behavioral health workforce development provides an opportunity to shed light on issues surrounding recruitment, retention, and internet connectedness from the perspective of Indigenous groups. Research and interviews with directors, specialists, and community leaders from Albuquerque First Nations Community Healthsource, Pueblo of Acoma's Behavioral Health Department, and Zuni Nation Teen Health & Family Wellness Clinic are discussed. Highlights will include: common themes and patterns on shared strengths, challenges, and existing programming from respective tribes. Recommendations center on the expansion of programs, and supports in four major categories: 1) recruitment of Tribal citizens to behavioral health training programs; 2) behavioral health training programs located in Tribal communities; 3) financial and professional incentives for behavioral practice in Tribal communities; and 4) access to tele-services including tele-behavioral health services and tele-supervision for behavioral health providers.

Introduction

Problem Statement

Suicide and suicidal behaviors are serious health issues affecting many - including youth - in the Indigenous community of New Mexico. Since 2008, the incidence of suicide among Indigenous youth has been the highest of all racial and ethnic groups in the US, and as of 2018, the suicide rate for Indigenous adolescents (aged 15-24 y.o.) is 242% higher than non-Hispanic white communities¹. This trend is also reflected in the inflated rates of adolescent death by suicide in Indigenous communities across New Mexico, where suicide is the second leading cause of death for Natives between the ages of 10 and 19².

While there are a number of risk factors that increase the incidence of suicidal behaviors (including gender, sexuality, and socioeconomic status³), a number of protective factors have also been identified. Cultivating a strong cultural identity, forming relationships with community elders, and receiving emotional support from adults all reduce the risk of suicide among Indigenous youth^{4,5}.

Research Approach

Our approach to all work privileges Indigenous voices, knowledge, and ways of knowing. We recognize that knowledge is embodied, socially situated, is never politically neutral, and cannot be owned or discovered, but only revealed and shared. Our primary objective as researchers is not to make judgments of validity or reliability, or determine what is better or worse, but to fulfill our obligations to all our relations. Our relations include not only the people and communities we work with, but also the land they inhabit, and the animals, plants, and other beings with whom they live in community.

Our obligation in this work is to guarantee that research processes and outcomes are used to critique and transform dominant and colonial power structures. We acknowledge that our work is implicitly situated within existing power structures and remain diligent in assessing whose interests shape the research topics, processes, and outcomes at hand. In addition, we recognize the ways in which research has been, and continues to be, used as a tool of colonialism. We seek ways to transform this practice. In particular, we see data as a gift that participants bestow to us and work to respect those gifts through practices that build data sovereignty.

¹Suicide Prevention Resource Center. (2019). *Racial and Ethnic Disparities*. (Education Development Center, Inc.) Retrieved October 19, 2019, from Suicide Prevention Resource Center: <https://www.sprc.org/racial-ethnic-disparities>

²New Mexico Department of Health, Indicator-Based Information System for Public Health Web site: <http://ibis.health.state.nm.us>

³ *ibid*

⁴ Gone, J. P., Hartmann, W. E., Pomerville, A., Wendt, D. C., Klem, S. H., & Burrage, R. (2019). The impact of historical trauma on health outcomes for Indigenous populations in the USA and Canada: A systematic review. *I(74)*, 20-35.

⁵New Mexico Department of Health, Indicator-Based Information System for Public Health Web site: <http://ibis.health.state.nm.us>

Current Work

There are 29 different agencies across the state of New Mexico providing behavioral health services to Indigenous communities, and many of them are currently working to address youth death by suicide through innovative and locally-informed programs. In order to better understand the strengths these programs demonstrate, as well as the challenges they face, the New Mexico Indian Affairs Department ([IAD](#)) and students from the Harvard University Native American Program ([HUNAP](#)) spoke with three stand-out programs providing suicide prevention & intervention services for Indigenous youth.

First Nations Community Healthsource

For more than 47 years, First Nations Community Healthsource ([FNCH](#)) has provided an integrated and culturally competent health delivery system that addresses the physical, social, emotional and spiritual needs of community members. In order to directly serve youth, they partner with five Albuquerque public high schools and operate clinics from within the school, in addition to their three clinics in the metro area.

FNCH takes a preventive focus to their work; they screen every student who attends their clinic for depression and advocate for the importance of mental health care to their teen clients. They also have a deep emphasis on the importance of cultural identity. Several of their case managers speak Tribal languages, and they currently run a traditional wellness program, in which traditional values and ceremonies are incorporated into Western counseling models.

Zuni Nation Teen Health & Family Wellness Clinic

The Zuni Nation Teen Health & Family Wellness Clinic (the Clinic) provides a safe place for youth to gather, interact with each other, and form a sense of community with the Zuni Pueblo. Like FNCH, the Clinic has a strong focus on both prevention and intervention services. The Clinic provides training to teens in Mental Health First Aid and incorporates suicide prevention education into New Hope, their annual summer youth camp. Since 2009, the Clinic has also created and distributed Yellow Ribbon cards, which list key contact information for mental health crisis situations.

The Clinic partners closely with the local schools and provides screening and treatment to youth who are referred by school staff and teachers. Youth who visit the Clinic are able to receive screenings for depression, as well as one-on-one CBT and DBT counseling sessions. Staff at the Clinic believe that cultural identity is key to serving Indigenous youth. As program director Marnella Kucate-Yepa shared, “*We integrate both Western and cultural ways, because we need both of them in order to heal.*” The Clinic has worked closely with an elder and cultural practitioner, who have translated their promotional materials into a traditional context; these efforts have helped to engage the community more deeply and break down barriers around suicide prevention work.

Acoma Pueblo Behavioral Health Department

Pueblo of Acoma Behavioral Health Department (the Department) provides a wide array of services to over 5,000 citizens, including services that work to prevent suicide among Indigenous youth. The Department’s health promotion team has worked extensively over the years to build out a series of culturally-based programs for the community, including basket-making workshops, traditional language classes, and healing nature walks. The team also operates the Seeds of Resilience program, which involves community planting and integrated therapy sessions in the community garden. Produce from the garden is then used in traditional cooking and teaching classes. As the team shared, “*Growing food is suicide prevention.*”

The Department staff place a special emphasis on integrating the behavioral health department into all other departments within their division, in order to create a strong safety net for their community and to streamline care. By working in close collaboration with community members and leaders, they have worked to mobilize the community in collective efforts around suicide prevention. While only ten people attended the Pueblo’s first suicide prevention awareness walk/run in 2009, over 800 participants from the Acoma community and Indian Country at large were in attendance at the most recent walk/run in 2019.

Voices from the Community

Shared Strengths

While each program described above has a unique and locally-specific approach to how they provide services, leadership from the programs described similar strengths among their program staff. All three programs highlighted the importance of having staff who are culturally competent. These programs have recognized the protective value of a strong cultural identity for Indigenous youth and have incorporated cultural values into their services. For example, at Pueblo of Acoma, all new staff go through an orientation to Acoma language, culture, and way of life, as well as intensive training in Indigenous ethics.

Programs also highlighted the importance of staff who are both passionate and compassionate. As Kucate-Yepa from the Zuni Nation Teen Health & Family Wellness Clinic shared, ***“All our staff do a good job of building trust and orienting patients to how services work. They help our patients feel like they want to come back here.”*** In addition, leadership talked about the high levels of intra-organizational collaboration between their staff. Isaish Curtis, a case manager from First Nations Community Healthsource commented, ***“Everyone here is a good teammate and asks one another for help.”***

Shared Challenges

Because of the importance of staff in these programs, finding the right “fit” for the position is even more important. The Acoma Behavioral Health Department shared how important it is that staff have a genuine understanding and cultural connection with the community; as they explained, ***“Clinicians who are not comfortable with a Native environment may not connect well with the clients or the work team.”*** FNCH shared the importance of having clinicians who are Native and able to speak Tribal languages and who also have the skills to work through crisis situations with youth. The Zuni Teen Health Clinic commented that for some positions, advanced degrees and previous experience are crucial.

All three programs also shared that recruiting and retaining the right staff has frequently been a challenge. FNCH commented that the longest time they had retained a staff member was for two years. All three programs also identified location as a major issue within their recruitment and retention efforts. The Zuni Teen Health Clinic and Pueblo of Acoma Behavioral Health Department shared how their rural location can be a disadvantage. ***“It’s hard to get non-Zuni people to live in the area because there isn’t a Walmart or a mall,”*** Kucate-Yepa shared. FNCH also reported that location can be difficult to negotiate, since their clinics are located in ***“undesirable”*** parts of the city.

Without a complete staff, programs have been unable to provide the full range of services necessary to address all aspects of suicide prevention and intervention. FNCH shared that they are frequently limited to only spending 15 minutes with each patient, and they do not currently have the capacity for providing after-care for any youth who attempt suicide. In Zuni Pueblo, youth who are experiencing severe distress have to be flown to Albuquerque or even Las Cruces, which causes additional stress and trauma for both youth and their families.

Recommendations

The challenges highlighted by the Tribal behavioral health programs above are shared by many Tribal and rural health organizations in New Mexico. All rural counties in New Mexico are designated as Behavioral Health Professional Shortage Areas (BHPSAs) by the US Department of Health and Human Services⁶. A survey of behavioral health organizations (BHO) in New Mexico by the U.S. Department of Health & Human Services (DHHS) Office of Inspector General found that a majority of rural BHOs report that they need additional staff to meet the needs of patients in their area. As a result, these organizations cannot always ensure timely access to services and report difficulty arranging referrals and managing continuity of care for services that they currently cannot provide⁷.

Higher level positions, such as psychiatrists and psychologists, and independently licensed behavioral health providers, are in particular demand. In order to adequately treat mental health issues in all New Mexico counties, the state requires an additional 108 psychiatrists, and there are no child psychiatrists in 28 out of the 33 New Mexico counties⁸. Only 29% of the State's licensed providers are in rural and frontier counties, despite nearly half of the State's Medicaid managed care enrollees residing in these counties⁹.

Finally, of the behavioral health professionals that do serve New Mexico, only a limited number of them are Indigenous. Although 10% of the New Mexico population is AI/AN, only 2% of psychiatrists and independently licensed behavioral health professionals are AI/AN¹⁰. Racial disparities in health care professions can lead to excess behavioral health burdens for racial/ethnic minorities¹¹, and racial concordance (when patients and clinicians share a similar racial background) can influence both patient satisfaction and their use of health care services^{12,13}. As recommended by the [New Mexico Health Care Workforce Committee](#) (HWC), it is important to actively recruit and retain healthcare professionals from AI/AN backgrounds to address health disparities and provide culturally and linguistically competent care.

Below, we have outlined a number of recommendations for addressing a major challenge raised by Tribal behavioral health programs providing suicide prevention and intervention services for Indigenous youth: supporting a sufficient behavioral health workforce in Tribal communities. While the high rates of Indigenous youth suicide highlight the importance of these recommendations, many of our recommendations are applicable both to Tribal programs focusing on youth suicide prevention/intervention, and also behavioral care services for Tribal communities across the state of New Mexico.

Our recommendations center on the expansion of programs, and supports in four major categories:

1. Recruitment of Tribal citizens to behavioral health training programs
2. Behavioral health training programs located in Tribal communities
3. Financial and professional incentives for behavioral practice in Tribal communities
4. Access to tele-services including tele-behavioral health services and tele-supervision for behavioral health providers

⁶ Rural Health Planning Workgroup. (2019). *New Mexico Rural Health Plan*. <https://nmhealth.org/publication/view/report/5676/>

⁷ Office of Inspector General. (2019). *Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care*. <https://oig.hhs.gov/oei/reports/oei-02-17-00490.pdf>

⁸ New Mexico Healthcare Workforce Committee. (2019). *NMHWC 2019 Annual Report*. https://www.nmhanet.org/files/NMHCWF_2019Report_FINAL.pdf

⁹ *ibid*

¹⁰ *ibid*

¹¹ Alegría, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., & McPeck, S. (2016). Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care. *Health Affairs*, 35(6), 991–999. <https://doi.org/10.1377/hlthaff.2016.0029>

¹² Street RL, O'Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. *Annals of Family Medicine*. 2008;6:198-205. doi: 10.1370/afm.821

¹³ Association of American Medical Colleges. (2019). *Reshaping the journey: American Indians and Alaska Natives in medicine*. https://store.aamc.org/downloadable/download/sample/sample_id/243/

Recruiting from Within Tribal Communities

Rationale

Research has shown that the strongest predictor of whether health care practitioners work in rural communities is whether or not they are from a rural community^{14,15}. Health care practitioners who grow up in rural communities are familiar with the cultural values and norms of a community and often have positive relational and personal ties to rural areas. Tribal citizens in particular are commonly motivated to enter health care positions by a desire to serve Native people, traditional beliefs and spirituality, and connectedness to their community¹⁶.

In addition, promoting and building interest in healthcare related careers in Indigenous groups is a crucial strategy for addressing the needs of cultural matches in communities. Patient trust, communication, and likelihood to adhere to treatment are heightened when patients perceive that their beliefs, values, and communication styles are like those of their physicians¹⁷. “Having familiarity with the cultural values, lifestyles, and spiritual beliefs of a patient can enhance the doctor-patient relationship. Physicians with knowledge of, and sensitivity to, the traditions of these communities can improve the health care that is delivered” shared Aaron Robinson, MPH, president of the Association of Native American Medical Students¹⁸. Indigenous health care workers bring their cultural histories and backgrounds to each patient encounter and often have the unique perspective to understand, relate to, and empathize with Tribal patients¹⁹.

Pipeline Programs for Indigenous Middle School & High School Students

Starting at a young age, pipeline/pathway programs can expose youth to the variety of career opportunities available to them. A recent survey of national efforts to recruit behavioral health workforce found that many states are enthusiastic about pipeline programs, as they represent an opportunity to reach out to the youngest generations. A 2012 review of best practices for recruiting Indigenous health workforce inequities included comprehensive pipeline programs as one of their top recommendations²⁰, and a 2018 report from the Association of American Medical Colleges (AAMC) and the Association of American Indian Physicians (AAIP) titled [Reshaping the Journey: American Indians and Alaska Natives in Medicine](#) highlighted a number of promising programs across the US for introducing Native youth to careers in the health sector, including the popular [We Are Healers](#) video outreach program.²¹

Currently, however, opportunities focused on Indigenous youth pipeline programs focused on behavioral health are more limited. The University of New Mexico [Dream Makers Health Careers Program](#) currently offers a pipeline program for middle and high school students to expose them to careers in the health sector; despite this, there is little mention of a focus on behavioral health on their website. However, the annual Behavioral Health Workforce Careers Summit, which specifically aims to reach American Indian and Alaskan Native high school students, includes relevant healthcare collaborative discussions and highlights employment and internship opportunities²². Coordination between the Summit and Dream Makers could result in increased exposure for Indigenous youth. In addition, coordination with Montana’s “[Heads Up](#)” camp, which exposes young adults, including those living in reservation communities, to behavioral health

¹⁴ Strasser, R. & Neusy, A.J. (2010). Context counts: Training health workers in and for rural and remote areas. *Bull World Health Organ.*, 88.

¹⁵ MacQueen: Recruiting Rural Healthcare Providers: a Review of Training Program Success & Determinants of Geographic Choices (2018)

¹⁶ Hollow WB, Patterson DG, Olsen PM, Baldwin LM. American Indians and Alaska Natives: how do they find their path to medical school? *Academic Medicine.* 2006;81(10):S65-69

¹⁷ Office of Minority Health, U.S. Department of Health and Human Services. National Stakeholder Strategy for Achieving Health Equity. <https://minorityhealth.hhs.gov/npa/files/Plans/NSS/CompleteNSS.pdf>. Accessed July 9, 2018.

¹⁸ Association of American Medical Colleges. (2019). *Reshaping the journey: American Indians and Alaska Natives in medicine.*

¹⁹ *ibid*

²⁰ Curtis, E., Wikaire, E., Stokes, K., & Reid, P. (2012). Addressing Indigenous health workforce inequities: A literature review exploring “best” practice for recruitment into tertiary health programs. *International Journal for Equity in Health*, 11, 13. <https://doi.org/10.1186/1475-9276-11-13>

²¹ Association of American Medical Colleges. (2019). *Reshaping the journey: American Indians and Alaska Natives in medicine.*

²² Nanez, J., Gomez, T., & Bonham, C. (2018, August 9). Strategies to Increase Behavioral Health Clinicians in AI/AN Communities.

<https://www.nihb.org/docs/08092018/Wednesday/Building%20a%20Behavioral%20Health%20Workforce%20in%20New%20Mexico.pdf>

careers could provide helpful guidance for building out New Mexico's behavioral health pipeline programs for Indigenous youth.

Recommendation 1: Promote the development and enhancement of pipeline programs for Indigenous youth, specifically focused on behavioral health careers, including a potential expansion of the Dream Makers Health Career Program.

Scholarships & Support for Indigenous Youth in Undergraduate & Graduate Programs

The Indian Health Service sponsors the [American Indians Into Psychology Program](#) (INPSYC) and [American Indians Into Medicine Program](#) (INMED). These programs enable and promote American Indians and Alaskan Natives interested in studying psychology and healthcare by means of raising awareness, recruiting and training, and providing scholarships and financial aid. The programs are displayed by ways of grant utilization at many universities, including: Oklahoma State University, The University of North Dakota, and The University of Montana, among others. The importance of these types of programs is that they support the pursuit and enrollment of Indigenous Peoples in fields their communities may need.

Demonstrating a tangible institutional commitment to equity is also included as a best practice for increasing the number of Indigenous health care workers²³. The University of New Mexico currently serves as an INMED center, demonstrating a commitment to supporting Indigenous primary care workforce development. By seeking funding in the future for an INPSYC program, they could further reaffirm their commitment to political and racial equity within the behavioral health workforce as well.

Recommendation 2: Promote the development and enhancement of institutional supports for Indigenous undergraduate & graduate students studying behavioral health, including a potential INPSYC program at the University of New Mexico.

Grow Your Own & Remote Learning Programs

Grow Your Own (GYO) programs are a particularly salient pathway to increasing access to behavioral health training for Tribal citizens. GYO programs are operated in many ways, but in essence, they identify promising students already working or living in an underserved community who may not be able to leave their community for further training, and then bring the training to the worker, usually through a hybrid of in-person and distance learning²⁴. GYO programs can be particularly effective for behavioral health workforce development in rural and Tribal communities, as they allow local individuals with cultural knowledge to become employed in their local behavioral health positions^{25,26}.

A GYO social work program through the [University of Alaska: Fairbanks](#) (UAF) may serve as a particularly relevant model, as the program focused on increasing recruitment of Alaska Native citizens. Students enrolled in the program travel to Fairbanks for one week at the beginning of the semester and an additional three days at the end of the semester for intensive face- to- face classroom instruction. During these on-campus times, an Alaska Native elder is present in the classroom as a co-facilitator for each course. The structure of the program is specifically designed to bring students together in a supportive environment to start off the semester and end the semester. The presence of the elder during these times creates a safe environment for learning and healing and helps to ground the students in their culture and context, which is a foundation and lens from which students learn and apply the social work material.

In between on-campus meeting periods, students complete the remainder of the course through audio/Web conferencing. The distance delivery program relies on systems that integrate audio-conference with online

²³ Curtis, E., Wikaire, E., Stokes, K., & Reid, P. (2012). Addressing Indigenous health workforce inequities: A literature review exploring "best" practice for recruitment into tertiary health programmes. *International Journal for Equity in Health*, 11, 13

²⁴ Manthorpe, J., Harris, J., & Hussein, S. (2012). Employers' experiences and views of grow your own social work programmes: a qualitative interview study. *Social Work Education*, 31(5), 637-650.

²⁵ Stotzer, R. L. (2012). Serving rural communities with distance education degree programs. *Journal of Technology in Human Services*, 30(2).

²⁶ Roberts, L., Smith, J., McFaul, M., Paris, M., Speer, N., Boeckmann, M., & Hoge, M. (2011). Behavioral health workforce development in rural and frontier Alaska. *Rural Mental Health* (Winter/Spring), 10-16.

Web conferencing technology, but many students in rural and remote communities still do not have access to reasonably priced and reliable Internet services. However, as discussed further in this paper, increased access to broadband services in Tribal communities would make the implementation of distance learning smoother.

A recent study of the UAF program found it is graduating Indigenous students at rates higher than the overall population, demonstrating that the program is reaching Tribal members who likely carry cultural knowledge essential to practicing in Tribal communities²⁷. UAF's model could serve as a potential framework to guide the development of a similar program through UNM.

Recommendation 3: Promote the development and enhancement of remote behavioral health graduate programs, including a potential distance learning program with strong cultural foundations for aspiring Indigenous social workers/counselors.

Recruiting Through Placements in Tribal Communities

Rationale

While a rural/Tribal background is the strongest predictor of whether health care professionals will work in rural/reservation settings, a placement in a rural setting during training and early career can also increase the likelihood of a given professional continuing to practice in a rural area. When students are exposed to content about rural practices, not only are they more inclined to consider a position in a rural agency, they are also more prepared to work with clients from these environments and are more likely to have a longer tenure in their positions²⁸. Recommendations to increase opportunities for psychiatric residencies and psychology post-doctoral internships in New Mexico have recently come from a number of sources, specifically including the NM Healthcare Workforce Committee (HWC)²⁹, the New Mexico Rural Health Planning Workgroup (RHPW)³⁰, and the US DHHS Office of the Inspector General³¹.

Tribal placements in particular also offer benefits to providers in training, as they may have first-hand experiences learning about traditional medicine and the integration of traditional and Western primary care. In our interviews with the Zuni Nation Teen Health & Family Wellness Clinic, leadership explained how their employees are able to educate providers from IHS who rotate in once a week, particularly about traditional ways of trauma healing. *“They always love to come down here, because they learn so much.”* Marnella Kucate-Yepa explains.

Psychiatric Residencies

In 2019, Graduate Medical Education (GME) Expansion Grant Program was formed through [House Bill \(HB\) 480](#) to create and expand primary care physician residency programs, including those focusing on general psychiatry. The program hopes to capitalize on the [Teaching Health Center Graduate Medical Education \(THCGME\) program](#), which provides grant funding and technical assistance to new and expanded primary care medical residency programs in community-based primary care settings, such as federally qualified health centers, rural health clinics, and Tribal health centers. While only one Teaching Health Center currently exists in New Mexico ([Hidalgo Medical Services](#)), the GME Review Board and Advisory Group's [Five Year Strategic Plan](#) (released December 2019) outlines New Mexico's Department of Human Services' (DHS) plans to support the development of additional residency programs that focus on psychiatry, as well as Teaching Health Centers located in rural areas³². With coordination and collaboration, this could present an opportunity to host psychiatric residents in a Tribal health center.

²⁷ Brocious, H., Demientieff, L., Renfro, C., & George-Bettisworth, R. (2019). A Grow-Your-Own Approach in Social Work: Shaping Alaska's Workforce. *Journal of Baccalaureate Social Work, 24*(1), 211–228. <https://doi.org/10.18084/1084-7219.24.1.211>

²⁸ MacQueen, I. T., Maggard-Gibbons, M., Capra, G., Raaen, L., Ulloa, J. G., Shekelle, P. G., Miake-Lye, I., Beroes, J. M., & Hempel, S. (2018). Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices. *Journal of General Internal Medicine, 33*(2), 191–199.

²⁹ New Mexico Healthcare Workforce Committee. (2019). *NMHWC 2019 Annual Report*.

³⁰ Rural Health Planning Workgroup. (2019). *New Mexico Rural Health Plan*.

³¹ Office of Inspector General. (2019). *Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico*

³² NM Human Services Department. (2019). Graduate Medical Education Expansion in New Mexico Five Year Strategic Plan.

Recommendation 4: Facilitate connections between DHS, hospitals, and Tribal leaders to see if there are opportunities to fund a new GME residency in a Tribal health center, and if possible, one that has a focus on psychiatry.

Psychology Internships

In addition, the NM Behavioral Health Service Department (BHSD) is currently partnering with the Western Interstate Commission for Higher Education (WICHE) [Behavioral Health Program](#) to create a clinical psychology internship consortium. WICHE has partnered with several other states to help them form accredited psychology internship consortiums in rural and underserved areas with great success, finding that typically 50-80% of the interns stay and work in the states where they interned³³. As of April 2019, BHSD and WICHE were in the process of reaching out to providers to discuss participation in this new project, with information about agency responsibilities, costs, and benefits of joining the consortium³⁴. Tribal health centers who would be interested in hosting a psychology intern could benefit from collaborating and coordinating with the development of the consortium.

Recommendation 5: Facilitate connections between BHSD and Tribal leaders to see if there are opportunities for Tribal health clinics to be included in the developing post-doctoral psychology internship consortium.

Incentivizing Practice in Tribal Communities

Rationale

While recruiting from those with rural background and experience lays the groundwork for finding those most likely to stay in rural communities, additional incentives can increase providers' desire to work in rural and Tribal communities. There is mixed research on the efficacy of various incentives, including both financial and professional/personal incentives, which are described in more detail below.

Financial Incentives: Loan Repayment & Tax Credits

In 2019, members of the Rural Health Planning Workgroup identified increasing financial incentives for rural health workers as its top priority for action and advocacy, specifically focusing on the expansion of loan repayment and tax credit programs³⁵.

The New Mexico [Health Professional Loan Repayment Program](#) offers substantial loan repayment funds for healthcare providers who commit to working for two years in New Mexico. Strategically, preference is given to those practicing in federal Health Professional Shortage Areas (HPSAs), which includes all rural counties of New Mexico, and in 2017, the Higher Education Department (HED) reported that mental health providers were also given preference for funds³⁶. While this program is a necessary lifeline for many providers, appropriations funded only half of eligible applicants in FY2017. Both the Rural Health Planning Workgroup (RHPW) and Healthcare Workforce Committee (HWC) recommend increasing funding for this program, with the HWC specifically recommending that funding be doubled in the next fiscal year.

In addition, the New Mexico [Rural Health Care Practitioner Tax Credit](#) offers \$3,000-5,000 tax credits to qualifying health professionals working in rural areas. While this program is available to some of the behavioral health workforce (psychiatrists and psychologists), it is not currently extended to social workers or counselors, who make up roughly 80.6% of the state's behavioral health workforce³⁷ and provide critical behavioral health care services in many Tribal communities. Rural behavioral health tax credits have been named as a promising practice by experts in the field³⁸, and the New Mexico Healthcare Workforce Committee has recommended extending the state's credit to social workers and counselors each year since

³³ Behavioral Health Collaborative CEO Report. (2019).

³⁴ Behavioral Health Collaborative CEO Report. (2019).

³⁵ Rural Health Planning Workgroup. (2019). *New Mexico Rural Health Plan*.

³⁶ New Mexico Healthcare Workforce Committee. (2019). *NMHCW 2019 Annual Report*.

³⁷ *ibid*

³⁸ Baum, N., & King, J. (2020). The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy.

2014³⁹. [House Bill \(HB\) 275](#), proposed during the 2020 legislative session, would have extended this tax credit, but unfortunately, still remained in committee at the end of the session.

Recommendation 6: Advocate for the enhancement of financial incentives for the behavioral health workforce, including increased funding for the Health Professional Loan Repayment Program and the inclusion of social workers and counselors in the Rural Health Care Practitioner Tax Credit.

Professional Development & Personal Support Incentives

Beyond financial incentives, research has shown that personal and professional aspects of rural behavioral health positions are crucial to both recruiting and retaining staff. A perceived lack of opportunities for training and career advancement is a common factor in the preference for work in urban areas⁴⁰, and a review of state efforts to recruit behavioral health professionals found that opportunities for career development and learning collaboratives were some of the most effective retention strategies⁴¹. In addition, regular supervision is critical for rural workers to feel supported, to process challenges, and to receive guidance⁴². As discussed later in this report, expanding opportunities for tele-supervision may help to address this issue.

Behavioral health providers may also be more or less motivated to take positions in rural or Tribal communities based on the personal opportunities available to them. A review of state efforts to recruit behavioral health workers found that spousal employment and community amenities were critical⁴³. Tribal communities may be in the unique position to offer clinicians the opportunity to experience the cultural value of working with Indigenous people. For example, in Pueblo of Acoma's Behavioral Health Department, new employees are greeted with orientation that includes meeting the community, visiting cultural sites, and having the opportunity to get a feel for their mother language.

Recommendation 7: Promote strategies and techniques for providing professional and personal incentives to work in Tribal communities. Disseminating materials from the [IHS Retention Strategy Resource Board](#) may prove particularly helpful.

Increasing Access to Tele-Services

Rationale

While the sections above outline strategies to increase an “on the ground” workforce, technological advancements have made possible the remote delivery of tele-services and remote training at a reduced cost when compared to in-person services. These resources can bridge the gap in behavioral health care access for Indigenous peoples living in secluded and under-resourced areas, while also providing a means to support the development of the “on-the-ground” workforce through remote training opportunities.

Direct Tele-Behavioral Health Services

Currently, issues exist in the funding and support of programs and initiatives that facilitate tele-behavioral health services where such services are possible. [PSYPACT](#), an interstate compact that increases access to behavioral health services to individuals living in isolated locations, allows for patients to remotely access behavioral health specialists in participating states. All states surrounding New Mexico have adopted the PSYPACT model legislation and several behavioral health authorities in the state support the adoption of this compact, but despite continued recommendations from the NM Healthcare Workforce Committee⁴⁴, the legislature has yet to be introduced.

³⁹ New Mexico Healthcare Workforce Committee. (2019). *NMHCW 2019 Annual Report*.

⁴⁰ MacQueen, I. T., Maggard-Gibbons, M., Capra, G., Raaen, L., Ulloa, J. G., Shekelle, P. G., Miake-Lye, I., Beroes, J. M., & Hempel, S. (2018). Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices. *Journal of General Internal Medicine*, 33(2), 191–199.

⁴¹ Covino, N. A. (2019). Developing the Behavioral Health Workforce: Lessons from the States. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689–695. <https://doi.org/10.1007/s10488-019-00963-w>

⁴² MacQueen, I. T., Maggard-Gibbons, M., Capra, G., Raaen, L., Ulloa, J. G., Shekelle, P. G., Miake-Lye, I., Beroes, J. M., & Hempel, S. (2018). Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices. *Journal of General Internal Medicine*, 33(2), 191–199.

⁴³ Covino, N. A. (2019). Developing the Behavioral Health Workforce: Lessons from the States. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689–695.

⁴⁴ New Mexico Healthcare Workforce Committee. (2019). *NMHCW 2019 Annual Report*.

It is worth noting however, that although research has shown that Indigenous patients do not have a preference of in-person care over remote care⁴⁵, anecdotal comments throughout our interviews revealed that some patients reported difficulty and frustration in the process. This frustration stemmed from participants in tele-behavioral health not feeling comfortable with disclosing their personal problems and intimate details of their lives through a virtual medium. These reports emphasize that tele-behavioral health is not a one-size fits all solution, and efforts, like those described in the previous sections, should be continued in order to build a robust on-the-ground behavioral health workforce, even if the implementation of tele-health services is successful.

Recommendation 8: Advocate for the adoption of the PSYPACT model legislation, with the recognition that tele-health services will not be a one-size-fits-all solution for all Tribal communities.

Tele-Supervision

Due to the limited number of independently licensed social workers and counselors in rural areas, recent [legislative](#) and policy changes have made tele-supervision a viable option for rural clinicians hoping to work towards independent licensure. However, opportunities to access tele-supervision are currently limited. [Project ECHO](#) is an existing online platform focused on providing workforce development and training support, including the provision of behavioral health consultation from psychologists, psychiatrists, social workers, and counselors to primary care practitioners. With additional funding, Project ECHO could be expanded to allow ECHO consultants to also provide remote supervision for non-independently licensed behavioral health providers. Project ECHO has received funding in previous years, but the provided funding has not been adequate for the full operation of the program and has, in fact, decreased from year to year due to reductions and cuts.

Recommendation 9: Advocate for the full funding of remote support programs, like Project ECHO, in an effort to provide structure for tele-supervision and thus increase the number of independently licensed social workers and counselors in rural and reservation communities.

Increasing Tribal Broadband Connectivity

In recognition that a number of recommendations we have made hinge on access to tele-services, it is important to consider access to broadband connectivity in Tribal communities, a key challenge highlighted in our interviews with leading Tribal behavioral health programs. The issue of broadband connectivity is particularly relevant in rural Tribal communities; in 2019, the Federal Communications Commission (FCC) reported that, although urban Tribal lands and urban non-Tribal counterparts enjoy roughly the same access to advanced broadband services, there exists a 27-point gap between rural Tribal and non-Tribal lands (46.6% and 74% respectively)⁴⁶. The expansion of internet access is imperative for the continued success and sustainability of Tribal nations in not just healthcare but a multitude of other important areas (i.e., education, economic development, emergency services, etc.). Efforts to expand these services and create up-to-date infrastructure, such as the [Bridging the Tribal Digital Divide Act of 2020](#), have been initiated, but the gap persists. The current political climate, given the COVID-19 pandemic, presents an opportune moment to further push this specific policy recommendation.

Recommendation 10: Advocate for the sustained support of legislature and interventions to guarantee the expansion of advanced internet services into Tribal communities.

⁴⁵ Shore, J. H., Brooks, E., Savin, D., Orton, H., Grigsby, J., and Manson, S. M., Acceptability of telepsychiatry in American Indians. *Telemed. J. E Health* 14(5):461–466, 2008.

⁴⁶ Federal Communications Commission. (2019). *Report to the Federal Communications Commission from the Tribal Members of the Task Force*. https://www.fcc.gov/sites/default/files/nncif_Tribal_broadband_report.pdf.

List of Recommendations

1. Promote the development and enhancement of pipeline programs for Indigenous youth, specifically focused on behavioral health careers, including a potential expansion of the Dream Makers Health Career Program.
2. Promote the development and enhancement of supports for Indigenous undergraduate & graduate students studying behavioral health, including a potential INPSYC program at the University of New Mexico in the next grant cycle (FY2024).
3. Promote the development and enhancement of remote behavioral health graduate programs, including a potential distance learning program with strong cultural foundations for aspiring Indigenous social workers/counselors.
4. Facilitate connections between DHS, hospitals, and Tribal leaders to see if there are opportunities to fund a new GME residency in a Tribal health center, and if possible, one that has a focus on psychiatry.
5. Facilitate connections between BHSD and Tribal leaders to see if there are opportunities for Tribal health clinics to be included in the developing post-doctoral psychology internship consortium.
6. Advocate for the enhancement of financial incentives for behavioral health workforce, including increased funding for the Health Professional Loan Repayment Program and the inclusion of social workers and counselors in the Rural Health Care Practitioner Tax Credit.
7. Promote strategies and techniques for providing professional and personal incentives to work in Tribal communities. Disseminating materials from the IHS Retention Strategy Resource Board may prove particularly helpful.
8. Advocate for the adoption of the PSYPACT model legislation, with the recognition that tele-health services will not be a one-size-fits-all solution for all Tribal communities.
9. Advocate for the full funding of remote support programs, like Project ECHO, in an effort to provide structure for tele-supervision and thus increase the number of independently licensed social workers and counselors in rural and reservation communities.
10. Advocate for the sustained support of legislature and interventions to guarantee the expansion of advanced internet services into Tribal communities.

Proposed Next Steps

1. Establish a permanent Indian Country Behavioral Health Workforce.
2. Continue conversations with leaders in the Indigenous behavioral health workforce development field, including but not limited to: Montana Heads Up, INPSYC Programs, University of Alaska Fairbanks School of Social Work, WICHE, and PSYPACT.
3. Continue conversations with key behavioral health players in New Mexico, including but not limited to: UNM Dream Makers Program, UNM Project ECHO, NM Healthcare Workforce Committee, NM Rural Healthcare Workgroup, the NM Graduate Medical Education Review Board and Advisory Group, NM Department of Health Services, NM Department of Behavioral Health Services, and the NM Higher Education Department.

Final Project Reflections

On Tuesday, April 28th, the HUNAP student team presented the results of their research, as well as a set of 10 recommendations for further action. The presentation and recommendations stimulated multiple hours of conversation among the professional team, including Secretary Lynn Trujillo, Eldred Lesensee, Jennifer Nanez, Teresa Gomez, and Eric Henson. Insights from this discussion are summarized below.

Expanding broadband: the professional team expressed profound interest in this recommendation. The current political climate, given the COVID-19 pandemic, presents an opportune moment to further push this specific policy recommendation.

Increased direct tele-behavioral health services: the professional team expressed interest in the expansion of direct tele-behavioral health services, commenting that it has been a useful modality in the past. However, there are a number of concerns to be addressed in this area.

- Before investing in PSYPACT, more research about barriers to use, necessary clinical infrastructure, and the reimbursement process, will need to be conducted.
- While some tele-health providers have a contract for hours of tele-service, this may not include the hours needed to access medical record systems through a VPN.
- In order to have successful tele-service integration, there needs to be strong on-the-ground coordination and crisis services.
- Issues of privacy should be considered as discrete access to tele-services can be difficult when clients are living in multigenerational and/or multi-family settings.

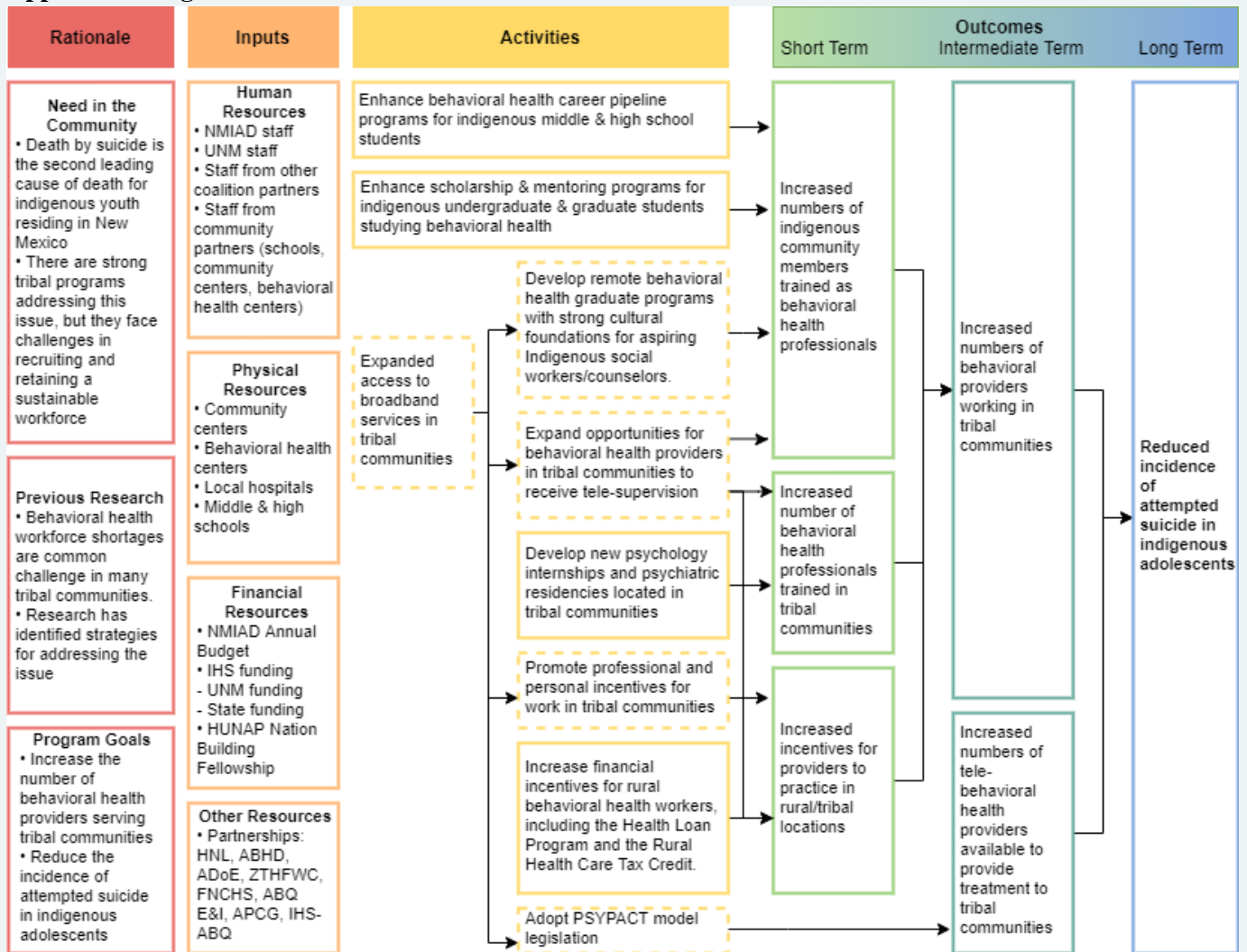
Training the workforce: this was a popular recommendation, and the professional team shared thoughts on work already being done in this area that could be integrated and/or expanded.

- **Tele-supervision:** this service is provided by UNM Community Behavioral Health. Discussion took place about how to promote, expand, and/or replicate this model, and how this could be useful.
- **Licensing exams:** supervision is not the only barrier to independent licensure. Challenges around taking the licensing exams were also mentioned as a major barrier for Indigenous social workers/counselors.
- **Programs in progress:** several other programs trying to get off the ground were discussed, including a program at Southwestern Indian Polytechnic Institute (SIPI) and New Mexico Highlands University (NMHU).

Advocacy committees: while the student team suggested the formation of a new committee to pursue the recommendations discussed, the professional team shared how this could be done in an efficient way.

- Program oversaturation was discussed and strategies to establish, resurrect, or realign overarching, collaborative bodies, such as Native American Sub-Committee (NASC), were contemplated.
- With Tribal voices speaking as one, there could be more united support for advocating for the recommendations seen as basic needs satisfied in other communities but lacking in Indigenous settings. This is a testament to what is missing from Indian Country and emphasizes the basic needs of Indigenous people that have long been ignored and minimized by non-native legislature.
- With fractionated Indigenous representation on the state governmental levels, advocacy efforts are disproportionately mired in educating non-Native committee members about the scope of Indigenous health issues and Indigenous cultural realities, instead of discussing and employing healthcare solutions.

Appendix 1. Logic Model of Recommendations



Appendix 2. Infographic of Recommendations

BOLSTERING THE BEHAVIORAL HEALTH WORKFORCE

Supporting Suicide Prevention and Postvention in Indigenous Communities

RECRUITMENT OF TRIBAL CITIZENS

Instilling interest in health focused careers to youth presents the long-term opportunity of representation of Indigenous Peoples within their respective Tribal communities.



Pipeline Programs

Foster interest in health careers to Indigenous middle and high schoolers through pipeline programs



Scholarships

Support for Indigenous youth in Undergraduate & Graduate Programs through access to institutional scholarship & aid



Grow Your Own

Opportunity for existing cultural matches study further by means of remote hybrid distance learning



Promote the creation & enhancement of pipeline programs. Advocate for institutional support, scholarships & remote distance learning & training

PLACEMENT IN TRIBAL COMMUNITIES

Opportunity for providers in-training to be placed in Tribal communities can present the chance of retaining these practitioners later.



Residencies

Opportunity to tribal communities to develop residency consortiums & host psychiatric residents Tribal health centers



Internships

Opportunity to tribal communities to develop consortium & host psychology interns in Tribal health centers



Facilitate connections between tribal health centers and DHS/DBHS toward residency & internship programs

TELE-BEHAVIORAL SERVICES

Although not a one-size-fits-all solution, affordable remote services & training can bridge the gap in behavioral health care access for rural Indigenous communities.



Direct Services

Present option for patients to remotely access behavioral health specialists



Tele-Supervision

Opportunity to provide workforce development & training support through online platform



Connectivity Expansion

Promoting of internet access & creation of up-to-date infrastructure



Advocate for expansion of internet services into tribal communities & full funding of remote support programs for tele-supervision

INCENTIVIZING PRACTICE

Additional financial and professional/personal incentives can increase providers' desire to work & remain in rural and Tribal communities.



Financial Loan

Loan repayment & tax credit opportunities for workforce retention



Professional/Personal

Present opportunities for training/career advancement & cultural value of working with communities



Advocate for the enhancement of financial professional and personal incentives to work in tribal communities.

Appendix 3. Tele-behavioral Health Policy Memo

To: Secretary of Indian Affairs Lynn Trujillo

From: Madison Esposito B.S., Mia Fernandes B.S.B.A, Kimberly Fabian B.S.

Re: Reducing the incidence of death by suicide among Indigenous youth requires the expansion of tele-services for behavioral health access in Tribal nations and communities.

Date: April 28, 2020

Executive Summary

Suicide is the second leading cause of death for Indigenous adolescents (aged 10-19 y.o.) in the Native nations whose borders are crossed by New Mexico (NM).¹ The current behavioral health workforce available to Indigenous peoples living in NM cannot address this crisis due to the lack of mid-level and independently licensed providers in residence within these communities.² Tele-behavioral health services, such as those provided through PSYPACT, have been documented as effective in treating behavioral health needs in Tribal communities struggling with workforce shortages.³ In addition, remote guidance programs, such as the ECHO program, could provide tele-supervision to existing behavioral health providers, increasing the number of independently licensed providers.⁴ It is imperative that you advocate for the adoption of the PSYPACT model legislation and expand remote supervision in clinical training for non-independently licensed behavioral health providers.

Background

Indigenous peoples experience the highest rates of death by suicide of all ethnic/race groups in what is now the United States.¹ Over 60% of counties in NM reported that more than 15% of Indigenous youth in their county had attempted suicide in 2017, with 2 counties reporting rates as high as 25%.⁵ The high prevalence and incidence rate of suicide in Indigenous youth has been identified as a major public health crisis by federal entities like Indian Health Services (IHS) and local governments, like Navajo president Nez-Lizer and NM governor Michelle Lujan Grisham, yet the issue still persists.⁶

Issues

There are two major issues in behavioral health workforce development that influence the high rate of death by suicide among Indigenous youth:

1. **Lack of Access.** Workforce shortages contribute significantly to negative behavioral health outcomes.⁷ As of 2018, only 5 counties in NM are at or above the national benchmark of one psychiatrist per 6,500 residents.² In addition to the atrophied behavioral health workforce across NM, the geographic isolation of rural Tribal communities results in a health access desert as the licensed professionals who do choose to practice in NM, opt for more urban locals.³ Supporting measures to remotely connect Tribal citizens with BH practitioners could alleviate these obstacles to healthcare.
2. **Training Barriers.** Many Tribal behavioral health centers report elevated numbers of non-independently licensed clinicians, an indicator that licensed behavioral health clinicians are not available to conduct the required hours of supervised training necessary to transition to independent care.² Such a lack in the BH workforce has far reaching impacts on the behavioral wellness of Tribal nations and communities and must be addressed.⁷

Recommendation

To address the issues of behavioral health practitioner shortages in NM Indigenous nations and communities, the following actions are recommended. These recommendations are listed according to importance with 1 being the most important and most highly recommended.

The specific actions I am proposing are as follows:

1. **Advocate for the adoption of the PSYPACT model legislation.** By adopting this compact, Tribal citizens and community members would have access to licensed behavioral health clinicians from participating states.⁸ All states surrounding NM have already enacted this legislation.⁸ This adoption is supported by the New Mexico Psychological Association, the New Mexico Board of Psychologist Examiners, and the New Mexico Health Care Workforce Committee.²
2. **Advocate for the full funding of Project ECHO.** This program provides remote guidance and assistance to primary care providers in resource poor locales. With full funding ECHO, could expand its services to provide supervision to non-independently licensed behavioral health providers, allowing them to complete their training in workforce limited locations when appropriate in their career path.⁴ Attempts to bolster project ECHO funding have been approved in the past, but have not been sufficient in fully funding the program.²

Counter Arguments

The changes proposed above do not come without opposition.

1. **Limited internet connectivity in Indian Country.** Unreliable or nonexistent tele-communication infrastructure has been identified as a major obstacle in providing tele-behavioral health and remote training in rural Tribal communities.³ An initial budget for outfitting behavioral health providers with the equipment necessary is accounted for in the PSYPACT operational costs estimate and would be enshrined in the legislature upon adoption.⁸ Furthermore, legislature has been introduced on the federal level to support Tribal advanced broadband connectivity, namely the Bridging the Tribal Digital Divide Act of 2020, which if passed will have a significant impact on internet access in Tribal communities while maintaining Tribal sovereignty throughout the process¹⁰. The cost to establish up-to-date tele-communication infrastructure is significant but is outweighed by the benefits of tele-behavioral health services.³
2. **Limited funding in Indian Country.** In accordance with the Health Coverage Via Telemedicine Act, S.B. 354, healthcare services provided remotely are entitled to identical coverage as services provided in-person.⁹ In situations where a health plan does not cover a specific behavioral health service, the lower cost of tele-behavioral health services alleviate a measure of the financial pressure incurred by these costs.³

Conclusion

To reduce the incidence of death by suicide among Indigenous youth residing in New Mexico, I urge you to advocate for the adoption of the PSYPACT model legislation and expand systems that support remote supervision in clinical training by advocating for the full funding of the ECHO program.

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Appendix 4. Rural Health Provider Tax Credit Reform Policy Memo

To: Secretary of Indian Affairs Lynn Trujillo

From: Madison Esposito B.S., Mia Fernandes B.S.B.A, Kimberly Fabian B.S.

Re: Reducing the incidence of death by suicide among Indigenous youth requires the revision of the New Mexico Rural Health Professional Tax Credit program

Date: May 04, 2020

Executive Summary

Suicide is the second leading cause of death for Indigenous adolescents in the Native nations whose borders are crossed by New Mexico (NM),¹ and many rural Native nations struggle to address this crisis while faced with shortages in behavioral health providers.² Legislation to expand the Rural Health Care Tax Credit to include licensed social workers, therapists, and counselors will help address this crisis.

Background

Suicide is the second leading cause of death for Indigenous adolescents in New Mexico, with some counties reporting that as many as 1 in 5 Indigenous adolescents attempted suicide in the past year.³ In the face of this epidemic, many rural Native nations struggle to provide comprehensive mental health services, as the number of behavioral health professionals working in rural communities is limited.⁴

Research has shown that financial incentives can enhance the recruitment and retention of healthcare providers to rural areas.⁵ To this end, New Mexico offers the [Rural Health Care Practitioner Tax Credit](#), which provides a \$3,000-\$5,000 tax credit to primary care and behavioral health professionals who practice in rural areas. However, under current legislation, social workers, therapists, and counselors, who represent over 80% of the state's behavioral health workforce, are not eligible for the credit.^{6,7}

Recommendation

Expanding the Tax Credit program to include social workers and mental health counselors could increase the number of behavioral health professionals available to serve Indigenous youth, and ultimately, could help reduce the incidence of youth suicide in New Mexico.⁸ Therefore, it is recommended to: **Advocate for the revision of New Mexico's Rural Health Care Tax Credit to include licensed social workers, therapists, and counselors.**

Counter Arguments

Since 2010, New Mexican state representatives have annually proposed legislation to expand the Tax Credit to additional healthcare professionals, including social workers and mental health counselors. While each bill has been recommended by committee, none have passed.⁹⁻¹⁷ However, advocacy from Native nations and their representatives could provide the political pressure necessary to pass similar legislation in a future session.

Conclusion

To reduce the incidence of death by suicide among Indigenous youth residing in New Mexico, I urge you to **advocate for the revision of New Mexico's Rural Health Care Tax Credit to include licensed social workers, therapists, and counselors.**

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