DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

"EMPOWERING NATIVE YOUTH TO RECLAIM THEIR FUTURE"

AUGUST 9, 2011

STATEMENT OF THE INDIAN HEALTH SERVICE

FOR THE OVERSIGHT HEARING

EMPOWERING NATIVE YOUTH TO RECLAIM THEIR FUTURE

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Mr. Chairman and Members of the Committee:

Good Afternoon, I am Dr. Rose Weahkee, Director of the Indian Health Service (IHS) Division of Behavioral Health. I am pleased to have this opportunity to testify on the Indian health system's response to youth suicide in Indian Country.

The IHS plays a unique role in the U.S. Department of Health and Human Services to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives (AI/AN). The IHS provides comprehensive health service delivery to approximately 1.9 million Federally-recognized American Indians and Alaska Natives through a system of IHS, Tribal, and Urban facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population served. The agency aims to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our goal is to promote healthy AI/AN people, communities, and cultures, and to honor the inherent sovereign rights of Tribes.

The IHS is responsible for providing mental health services to the AI/AN population it serves. The IHS Mental Health/Social Service (MH/SS) program is a community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The most common MH/SS program model is an acute, crisis-oriented outpatient services staffed by one or more mental health professionals. Many of the IHS, Tribal, and urban mental health programs that provide services are not open 24/7. Therefore, when an emergency or crisis occurs, the clinic and service units will often contract out such services to non-IHS hospitals and crisis centers.

In the ongoing effort to meet the health and behavioral health challenges, there is a trend toward Tribal management and delivery of behavioral health services in AI/AN communities. Particularly in the last decade, Tribes have increasingly contracted or compacted via the Indian Self Determination and Education Assistance Act, Public Law 93-638, to provide those services themselves. Currently, 54% of the mental health and 84% of the alcohol and substance abuse programs are operated by Tribes. This evolution in behavioral health care delivery and management is changing the face of behavioral health services in Indian Country.

Where IHS was previously the principal behavioral health care delivery system for AI/ANs, there is now a less centralized and more diverse network of care provided by Federal, Tribal, and Urban Indian health programs. The “Indian health system” denotes

this larger network of programs and the evolving care delivery system across Indian Country. Meeting the needs of this system will require an evolution in IHS and Tribal collaboration as well, particularly as Tribal programs take more direct responsibility for services and IHS supports them in doing so.

Introduction

Suicide is a complicated public health challenge with many contributing risk factors. In the case of AI/ANs, they face, on average, a greater number of these risk factors individually or the risk factors are more severe in nature for them. In prior years, several communities in Indian Country experienced suicide contagion, often referred to as suicide clusters. In these communities, the suicidal act becomes a regular and transmittable form of expression of the despair and hopelessness experienced by some Indian youth.

The AI/AN suicide rate (17.9 per 100,000) for the three year period (2002-2004) in the IHS service areas is 1.7 times that of U.S. all races rate (10.8 per 100,000) for 2003. Suicide is the second leading cause of death behind unintentional injuries for Indian youth ages 15 - 24 residing in IHS service areas and is 3.5 times more frequently in those areas than the national average. Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide. AI/AN young people ages 15-34 comprise 64% of all suicides in Indian Country.[i] Suicide mortality rates have increased from 45.9 per 100,000 to 55.2 per 100,000 among AI/AN youth ages 15-24,

comparing data from 2003-2005 to those from 1999-2001. Overall, suicide mortality is 73% greater in AI/AN populations in IHS service areas compared to U.S. - All races.[ii]

On a national level, many AI/AN communities are also affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.[iii] AI/AN people suffer significantly and disproportionately from mental health disparities and lack access to culturally appropriate care. Each of these serious health issues has a profound impact on the health of individual, family, and community well being both on- and off-reservations.

According to a 2001 mental health supplemental report of the U. S. Surgeon General, "Mental Health: Culture, Race, and Ethnicity," there are limited mental health services in Tribal and urban Indian communities.[iv] While the need for mental health care is great, services are lacking, and access to these services can be difficult and costly.[v] The current system of services for treating mental health problems of AI/ANs is a complex and often fragmented system of Tribal, Federal, State, local, and community-based services. The availability and adequacy of mental health programs for AI/ANs varies considerably across communities.[vi] Navigating complex or fragmented combinations of Tribal, Federal, State, local, and community-based services can be confusing and discouraging, making it difficult to access care even if it is available. In addition, severe provider shortages are common.[vii]

There are many reasons for a lack of access to care and services. Indian Country is predominantly rural and remote, and this brings with it the struggles of recruiting and retaining providers. Rural practice is often isolating for its practitioners. The broad range of clinical conditions faced with limited local resources challenges even seasoned providers. Some providers are so overwhelmed by the continuous demand for services, particularly during suicide outbreaks, that even experienced and hard working providers become at-risk for burn-out.

In addition to clinical care, the importance of public health and community- and culture-based interventions is becoming more widely recognized.[viii] One factor that makes community- and culture-based interventions especially important is the role of historical trauma in the increased risk of suicide among AI/AN people. Historical trauma, exacerbated by re-traumatization of the community from the high rates of injury and death, continues to plague Indian communities.[ix] Historical trauma is also linked to increased suicide risk because anger, aggression, and violence felt in response to experiences of victimization can be turned against oneself.[x]

Addressing Suicide in Indian Country

Since 2008, IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. In particular, developing programs that are collaborative, community driven, and nationally supported, we believe, offer the most promising potential for long term success and sustainment. As an example of this, IHS

regularly relies on Tribal leadership and expertise to collaborate on a range of behavioral health problems and programs.

The IHS National Tribal Advisory Committee (NTAC) on Behavioral Health, which is made up of elected Tribal leaders from each IHS Area, provides recommendations and advice on the range of behavioral health issues in Indian Country. From making recommendations on significant funding allocations and service programs, to developing long term strategic plans for Tribal and Federal behavioral health programs for the future, the NTAC is the principal Tribal advisory group for all behavioral health services to IHS. They ensure collaboration among Tribal and Federal health programs, provide Tribal input into the development of programs and services, and also provide the inclusive and transparent development of processes and programs so important to all our communities and programs.

The IHS National Behavioral Health Work Group (BHWG) is the technical advisory group to IHS. Comprised of mental health professionals from across the country, the BHWG furthers the agency priorities to strengthen partnerships with Tribes, improve quality and access to care for patients, and provide direct collaboration and input for accountable, fair, and inclusive services across the Indian behavioral health system. They provide expert advice and recommendations for services, programs, and intervention models, as well as long term strategic planning and goal development. As the national technical advisory group to the agency, they also work very closely with the elected

Tribal leaders on the NTAC to provide collaborative links between the professional community and national Tribal leadership.

The IHS Suicide Prevention Committee (SPC) was established and tasked with identifying and defining the steps needed to significantly reduce and prevent suicide and suicide-related behaviors in AI/AN communities. It is the responsibility of the SPC to provide recommendations and guidance to the Indian health system regarding suicide prevention, intervention, and postvention in Indian Country.

IHS Methamphetamine and Suicide Prevention Initiative

The IHS Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally-coordinated demonstration pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. IHS, Tribes, Tribal programs, and other Federal agencies concurrently coordinate the development and implementation of the MSPI project, which now provides support to 127 IHS, Tribal, and urban Indian health programs nationally. The strategic goal is to support Tribal programs in their prevention, treatment, and infrastructure development as they increasingly are delivering their own services. The MSPI implemented by IHS and its Tribal partners nationally, marks a significant milestone in suicide prevention efforts in Indian Country as well as Tribal and Federal partnerships for health that embraces the Administration's commitment to Tribal engagement and partnership.

To create the overall MSPI approach, IHS engaged in close collaboration with Tribes and Tribal leaders over the course of almost a year. During this time, Tribal leaders developed a model and recommendations, which were accepted by IHS, for approaches and funding allocations. It was and remains a creation of close collaboration and partnership with Tribes. The program is community driven from conception through execution for each program in each community. Indian communities decide what they need and establish programs to meet those needs.

The MSPI data currently available indicate that a total of 289,066 persons have been served through both prevention and treatment activities. Prevention activities include, but are not limited to evidence-based practice training, knowledge dissemination, development of public service announcements and publications, coalition development, and crisis hotline enhancement. There were 42,895 youth participating in evidence-based and/or promising practice prevention or intervention programs. There were 674 persons trained in suicide crisis response teams.

American Indian/Alaska Native National Behavioral Health and Suicide Prevention Strategic Plans

On August, 1, 2011, in partnership with Tribes, IHS released the American Indian/Alaska Native National Behavioral Health and Suicide Prevention Strategic Plans. These strategic plans will foster collaborations among Tribes, Tribal organizations, urban Indian organizations, and other key community resources. These collaborations will provide tools needed to adapt the shared wisdom of these perspectives, consolidate our

experience, target our efforts towards meeting the changing needs of our population, and develop the framework that will serve to pave the way over the coming years to address suicide and behavioral health in Indian Country.

The American Indian/Alaska Native National Behavioral Health Strategic Plan is the culmination of over two years of close collaborative work, and contains three overarching strategic directions which are operationalized into 77 action steps, most of which are already in progress. It is the strategic framework for the continuing development of programs and services across the AI/AN behavioral health system, with an added emphasis on Tribal, Federal, and Urban program collaboration.

The American Indian/Alaska Native National Suicide Prevention Strategic Plan represents the combined efforts of Tribal, Federal, Urban, and other representatives across the country to develop strategic goals and objectives to address the ongoing suicide epidemic in so many of our communities. The suicide epidemic is the single most significant cause of concern across our communities and requires specific planning and program implementation, which this plan represents in eight strategic goals and 41 objectives.

The importance of including culture, cultural and traditional practices, and a variety of learning approaches is included in these strategic plans and should not be underestimated. AI/ANs see behavioral health as supporting their historic and continuing reliance on

elders, languages, community, culture, and traditional practices as protective factors that restore balance and serve as both prevention and treatment.

IHS Partnerships

Strategies to address mental health and suicide include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, urban Indian health programs, Federal, State, and local agencies, as well as public and private organizations. This effort seeks to establish effective long-term strategic approaches to address mental health and suicide prevention in Indian Country.

IHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) work closely together to formulate long term strategic approaches to address the issues of suicide and mental health care in Indian Country more effectively. For example, IHS and SAMHSA are actively involved on the Federal Partners for Suicide Prevention Workgroup. In 2001, the Office of the Surgeon General coordinated the efforts of numerous agencies, including IHS, SAMHSA, Centers for Disease Control and Prevention (CDC), National Institute for Mental Health (NIMH), Health Resources and Services Administration (HRSA), and other public and private partners to develop the first, comprehensive, integrated, public health approach to reducing deaths by suicide and suicide attempts in the United States in the National Strategy for Suicide Prevention. This resulted in the formation of the ongoing Federal Partners for Suicide Prevention Workgroup.

IHS, SAMHSA, Bureau of Indian Affairs (BIA), and Bureau of Indian Education (BIE) held ten regional suicide prevention listening sessions across Indian Country over the last twelve months to seek input on how the agencies can most effectively work in partnership with Tribes to prevent suicide. The Tribal listening sessions provided important information on suicide prevention needs, concerns, programs, and practices. This information was used to form the agenda for the Action Summit for Suicide Prevention held from August 1 – 4, 2011 in Scottsdale, AZ with over 1,000 in attendance. This collaborative work also paved the way for other Federal partners to join in the effort to prevent suicide among AI/ANs. For example, IHS and the Veterans Health Administration (VHA) Suicide Prevention Office have developed a joint plan to address suicide among Native veterans. VHA Suicide Prevention Coordinators participated in several of the listening sessions.

On September 10, 2010, Department of Health and Human Services Secretary Kathleen Sebelius and Department of Defense Secretary Robert M. Gates announced the creation of the National Action Alliance for Suicide Prevention. The Action Alliance is expected to provide an operating structure to prompt planning, implementation and accountability for updating and advancing the National Strategy for Suicide Prevention. On December 30, 2010, the National Action Alliance for Suicide Prevention announced three new task forces to address suicide prevention efforts within high-risk populations including American Indians/Alaska Natives. Jointly leading the American Indian/Alaska Native Task Force are Yvette Roubideaux, M.D., M.P.H., Director of the Indian Health Service; Larry Echo Hawk, J.D., Assistant Secretary of Indian Affairs, Department of the Interior;

and McClellan Hall, M.A., Executive Director, National Indian Youth Leadership Project.

Tribes also look to SAMHSA for help in addressing youth suicides. Through its Garrett Lee Smith State and Tribal Grants, Tribes and Tribal organizations have received grants ranging from $400,000 to $500,000 a year to prevent suicide. In addition, SAMHSA:

- Funds the Native Aspirations project which is a national project designed to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts. Through the Native Aspirations project, AI/AN communities determined to be the most "at risk" develop or enhance a community-based prevention plan.
- Supports the Suicide Prevention Resource Center which is a national resource and technical assistance center that advances the field by working with Tribes, States, territories, and grantees by developing and disseminating suicide prevention resources.
- Funds the National Suicide Prevention Lifeline, a network of crisis centers across the United States that receives calls from the national, toll-free suicide prevention hotline number, 800-273-TALK. The National Suicide Prevention Lifeline's American Indian initiative has promoted access to suicide prevention hotline services in Indian Country by supporting communication and collaboration between Tribes and local crisis centers as well as providing outreach materials customized for each Tribe.

Summary

In summary, we look forward to opportunities to address the suicide and mental health care needs in Indian Country. For the IHS, our business is helping our communities and families achieve the highest level of wellness possible. IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. We believe developing programs that are collaborative, community driven, and nationally supported offer the most promising potential for long term success and sustainment. Our partnership and consultation with Tribes ensure that we are working together in improving the health of AI/AN communities.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify. I will be happy to answer any questions that you may have.

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