DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

Yvette Roubideaux, M.D., M.P.H., DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

S. 1635, 7th GENERATION PROMISE: INDIAN YOUTH SUICIDE

PREVENTION ACT OF 2009

September 10, 2009

STATEMENT OF THE INDIAN HEALTH SERVICE
OVERSIGHT HEARING ON S. 1635,
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Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). Today, I appreciate the opportunity to testify on S. 1635, 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The IHS has the responsibility for the delivery of health services to an estimated 1.9 million federally-recognized American Indians and Alaska Natives. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold

the Federal government’s obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government’s responsibility for meeting the health needs of American Indians and Alaska Natives: The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437, as amended. The Snyder Act authorized appropriations for "the relief of distress and conservation of health" of American Indians and Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the provision of programs, services, and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for people, and the construction, replacement, and repair of healthcare facilities.

Background

Many American Indian and Alaska Native communities are affected by high rates of suicide. A wide range of general

risk factors contribute to suicide. In the case of American Indian and Alaska Native young people, they face, on average, a greater number of these risk factors individually or the risk factors are more severe in nature for them. Research suggests that there are factors that protect Native youth and young adults against suicidal behavior. These factors are their sense of belonging to their culture, strong tribal spiritual orientation, and cultural continuity.

The soon to be published IHS *"Trends in Indian Health, 2002-2003"* reports:

- The American Indian and Alaska Native suicide rate (17.9) for the three year period (2002-2004) in the IHS service areas is 1.7 times that of the U.S. all races rate (10.8) 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 higher than the national average.
- Suicide is the 6th leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide.
- American Indian and Alaska Native young people ages 15-34 make up 64 percent of all suicides in Indian country.

On a national level, many American Indian and Alaska Native communities are affected by very high levels of suicide, poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.[1] According to the Institute of Medicine, an estimated 90 percent of individuals who die by suicide have a mental illness, a substance abuse disorder, or both.[2] According to a 2001 mental health supplement report of the Surgeon General, "Mental Health: Culture, Race, and Ethnicity", there are limited mental health services in Tribal and urban Indian communities.[3] While the need for mental health care is great, services are lacking, and access to these services can be difficult and costly.[4]

Addressing Suicide among American Indians

The current system of services for treating mental health problems of American Indians and Alaska Natives 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 American Indians and Alaska Natives varies considerably

[1] Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives*. National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.
[2] Institute of Medicine (2002). *Reducing suicide: A national imperative.* Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., Bunney, W. E. (Eds.) Washington, DC: National Academies Press.
[3] U.S. Department of Health and Human Services. (2001). *Mental Health: Cultural, race, and ethnicity supplement to mental health: Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[4] Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives*. National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

across communities.[5] American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and in-patient facilities.[6]

IHS and SAMHSA work closely together to formulate long term strategic approaches to address the issue of suicide 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, CDC, NIMH, 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.

The Indian Health Service (IHS) is responsible for providing mental health services to the American Indian and Alaska Native 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 service staffed by one or more mental health

[5] Ibid.

professionals. Many of the IHS, Tribal, and Urban (I/T/U) mental health programs that provide services do not have enough staff to operate 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.

Suicide is a complicated public health challenge with many contributing factors, and barriers to care in American Indian and Alaska Native communities. Indian Country has communities every year where suicide takes on a particularly ominous and seemingly contagious form, 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. While most vividly and painfully expressed in these communities, suicide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including urban communities. The pain only deepens when those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts, are unable to access adequate care.

There are many reasons for a lack of access to care. Indian Country is predominantly rural and remote, and this brings with it the struggles of providing support in settings where appropriate local care may be limited. Rural

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[6] Ibid.

practice is often isolating for its practitioners. The broad range of clinical conditions faced with limited local resources challenge even seasoned providers. Some providers are so overwhelmed by the continuous demand for services, particularly during suicide outbreaks, that even well-seasoned and balanced providers risk burn-out.

For example, there are situations where the appropriate treatment is known, such as counseling therapy for a youth survivor of sexual abuse, but there are simply no appropriately trained therapists in the community. One of our IHS Area Behavioral Health Consultants told me recently that there was only one psychiatrist in her half of a large Western state attempting to serve both the Indian and non-Indian population. Despite years of effort, the IHS Area Office had been unsuccessful in recruiting a fulltime psychiatrist to serve the tribes in that region.

Over the years, we have attempted to apply a number of remedies to these problems including adopting special pay incentives in order to make reimbursement packages more competitive, making loan repayment and scholarship programming available for a wide range of behavioral health specialties including social work, psychology, and psychiatry, along with active recruitment, development of the Indians into Psychology program, and emergency deployment of the Commissioned Corps.

Indian Tele-health Based Behavioral Health Services

IHS recognizes the need to support access to services and to create a broader range of services tied into a larger network of support and care. As evidenced by the Alaska experience, where there are often no workable options other than tele-health based behavioral health services, we know such services work and are acceptable to many if not all of our clinic populations. As another example, a Southwest tribe has been providing child and youth-specific tele-behavioral services for the past two years and has achieved a show rate of >95% for scheduled appointments. This is an outstanding rate when other clinics with face to face provider availability only achieve a 65-70% show rate.

As a system of care, tele-health based behavioral health services are either actively being used or in planning stages for over 50 Indian health system sites (both tribal and federal). They include a range of programming, from a broad variety of mental health services, to specific and intermittently available services such as child psychiatry consultations. Services are being delivered in a range of settings including clinics, schools, and youth treatment centers. Only within the past five years has the telecommunications infrastructure, in some locations, become available and reliable enough to be used routinely for clinical care. The lack of infrastructure is a significant issue for most tribal communities.

The Methamphetamine and Suicide Prevention Initiative (MSPI) is another coordinated program designed to provide

prevention and intervention resources for Indian Country. This initiative promotes the development of evidence-based and promising practices using culturally appropriate prevention and treatment to address methamphetamine abuse and suicidal behaviors in a community-driven context. IHS is using the MSPI funding to promote adoption of technologies on a larger, system wide basis. For example, in the California and Oklahoma Areas, programs will benefit from MSPI grants supporting increased access through tele-health service delivery.

MSPI dollars in the amount of $863,000 are also being used to establish a National Tele-Behavioral Health Center of Excellence. An intra-agency agreement was signed in early August with our Albuquerque Area Office, which has agreed to take the lead on establishing a national center to promote and develop tele-health based behavioral health services. They are working in partnership with a number of regional entities including the University of New Mexico and the University of Colorado. The University of New Mexico Center for Rural and Community Psychiatry is a leader in the use of tele-health technologies in rural settings. The University of Colorado Health Sciences Center and the VA Eastern Colorado Healthcare System are leaders in tele-health outreach to veterans including Indian veterans in the northern Plains, the State of New Mexico, and the Tribes and Pueblos of the region. Services are provided to a number of settings including school clinics, youth residential treatment centers, health centers, and

others. They hope to leverage their ability to use federal service providers and provide technical and program support nationally to programs attempting to implement such services.

We have been tracking visits to behavioral health clinics using tele-health technology, and have preliminary indications that IHS programs are increasingly adopting and using these technologies. Tele-behavioral health services require adequate and reliable bandwidth if they are to be sustainably implemented. Increasing bandwidth utilization strains the telecommunications infrastructure. IHS was fortunate to be recipients of ARRA funding to improve our telecommunications infrastructure to increase the reliability and availability of appropriate bandwidth across the Indian healthcare system. Approximately $19 million of our Health Information Technology ARRA funding will be spent to provide new routers, switches, and basic telecom infrastructure to ensure current needs are met, as well as improve our ability to prioritize traffic over the network. ARRA funding is also supporting a mass procurement of state-of-the-art clinical videoconferencing equipment that will be distributed to Tribal, Urban, and Federal care sites depending on need later this fall. We are working to improve access to videoconferencing and bandwidth capacity to strengthen our telecommunications infrastructure. As one of my providers who is active in telemedicine told me, "My patients are very patient and are willing to tolerate surprisingly bad connections. But when my image freezes up

with regularity I may as well be using the telephone.” We are investing in the infrastructure expansion, support, and maintenance needed to keep pace with potential service demands and to plan for the long term success of this and any new Indian tele-mental effort.

We see many benefits to the use of telemedicine for the treatment of youth suicide. This technology promises to connect widely separated and often isolated programs of varying sizes together in a web of support. Whereas small clinics would need to develop separate contracts for services such as child and adult psychiatric support, pooling those needs in a larger pool provides potential access to a much larger array of services, and does so more cost-effectively and more conveniently for patients. Such a system could potentially move some clinics that are available every other Friday afternoon for 4 hours to systems where clinic time for assessments is available whenever the patient presents. This could translate into 24/7 access to emergency behavioral health service in any setting with adequate telecommunications service and rudimentary clinic staffing.

Such a system has other desirable consequences such as opportunities for mutual provider support. For example, currently when psychiatric providers take vacation, are on sick leave, or are training in places where they are the sole providers, there are often either no direct services at that clinic for that time period, or a temporary doctor

with limited understanding of the clinic is hired to provide services. Sufficient services could be provided via tele-health connections to reduce or eliminate discontinuities in patient care and do so at significantly less expense. Providers with particular specialty interests can share those skills and knowledge across a broad area even if they themselves are located in an isolated location. Burn out due to professional isolation is also decreased as videoconferencing readily supports clinical supervision and case management conferences. Universities providing distance-based learning opportunities have demonstrated for years that educational activities can also be facilitated by this technology. Families can participate in care even when at a distance from their youth, promoting improved contact and better resolution of home environmental concerns which is often the key issue in a youth transitioning successfully from a residential program to home. Recruitment becomes less problematic because providers can readily live and practice out of larger urban or suburban areas and are thus more likely to continue in service over time with sites. The resulting pool of providers accessible for hiring could also increase because relocation to an isolated location may not be necessary.

It is important to note that the proposed services would require behavioral health providers including psychiatrists, psychologists, clinical social workers, and therapists in addition to the telemental health technology.

The behavioral health services discussed in my testimony today are available or will be available to some degree already at 50 federal and tribal sites, or are otherwise unavailable or irregularly available in the Indian health care system.

As described in my testimony today, IHS supports and indeed is already funding many of the activities included in the demonstration grant program outlined in, S. 1635, the 7th Generation Promise. These activities, including the National Tele-Behavioral Health Center of Excellence funded by the MSPI, will also help us understand how to effectively deliver such services, and in particular, will provide more focused experience in providing services to Indian youth. We believe tele-behavioral programs can become an integral part of the IHS behavioral health services, strengthen our clinical expertise in using tele-health services and expand access to needed behavioral healthcare. We are working to augment the ability of the IHS Tele-behavioral Health Center of Excellence to promote and support such services across the Indian health system. The additional services proposed in this legislation could help facilitate our ability to provide needed services.

In summary, we look forward to opportunities to address the critical problem of youth suicide in Indian Country. We are committed to using available technologies including our growing national telecommunications infrastructure to help increase access to sorely needed behavioral health

services. For Indian Health Service, our business is helping our communities and families achieve the highest level of wellness possible.

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.