

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

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INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON YOUTH SUICIDE IN INDIAN COUNTRY

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STATEMENT OF THE INDIAN HEALTH SERVICE OVERSIGHT HEARING  
ON YOUTH SUICIDE IN INDIAN COUNTRY

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Mr. Chairman and Members of the Committee:

Good morning, I am Robert McSwain, Director of the Indian Health Service (IHS). I am accompanied by Richard Olson, MD., Acting Director, Office of Clinical and Preventive Services, and Rose Weahkee, PhD., Public Health Advisor, Division of Behavioral Health. Today, I appreciate the opportunity to testify on youth suicide in Indian Country.

The IHS has the responsibility for the delivery of health services to an estimated 1.9 million Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, Tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial decisions, and statutes. 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/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 regular appropriations for "the relief of distress and conservation of health" of American Indians/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 included 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.

The Department of Health and Human Services (HHS) has been proactive in raising the awareness of Tribal issues through the process of Tribal consultation. As such, HHS recognizes the authority provided in the Native American Programs Act of 1974, and utilizes the Intradepartmental Council for Native American Affairs to address cross cutting issues such as suicide and to seek opportunities for collaboration and coordination among HHS programs serving Native Americans.

We are here today to discuss youth suicide in Indian Country.

### **Background**

Suicides and suicide-related behaviors exact a profound toll on American Indian and Alaska Native communities. Suicides reverberate through close-knit communities and continue to affect survivors many years after the actual incident.

- Using the latest information available, 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 U.S. all races rate (10.8) for 2003. (This information will be published in the upcoming "Trends in Indian Health, 2002-2003").
- 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. (This information will be published in the upcoming "Trends in Indian Health, 2002-2003").
- Suicide is the 6<sup>th</sup> leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide. (This information will be published in the upcoming "Trends in Indian Health, 2002-2003").

- American Indian and Alaska Native young people ages 15-34 make up 64 percent of all suicides in Indian country. (This information will be published in the upcoming "Trends in Indian Health, 2002-2003").

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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> While the need for mental health care is great; services are lacking, and access can be difficult and costly.<sup>4</sup>

The system of services for treating mental health problems is a complex and often fragmented system of tribal, federal, state, local, and community-based services. The availability and adequacy of mental health programs varies considerably across communities.<sup>5</sup> American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and in-patient facilities.<sup>6</sup>

The Indian Health Service is most directly responsible for providing mental health services to American Indians and Alaska Natives. The purpose of the IHS Mental Health/Social Service (MH/SS) program is to support the

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<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> 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..

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

unique balance, resiliency, and strength of our American Indian and Alaska Native (AI/AN) cultures. The 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 MH/SS program provides general executive direction and recruitment of MH/SS program staff to 12 Area Offices (regional) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to 163 Service Units. These Service Units consist of IHS, Tribal, and urban Indian programs whose MH/SS staff are responsible for the delivery of comprehensive mental health care to over 1.9 million American Indians and Alaska Natives.

The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Many of the IHS, Tribal and Urban (I/T/U) mental health programs that provide services in times of crises do not have enough staff to operate 24/7. Therefore, when an emergency occurs, the clinic and service units will often contract out such services to non-IHS hospitals and crisis centers. Inpatient services are often purchased from non-IHS hospitals or provided by State or County mental health facilities. Medical and clinical social work in the MH/SS program model are usually provided by one or more social workers who assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling.

The MH/SS program model also includes tele-behavioral health technology. Tele-behavioral health technology is increasingly adopted throughout the Indian health system to improve access to behavioral health services. Currently, over 30 IHS and Tribal facilities in 8 IHS Areas are augmenting on-site behavioral health services with tele-behavioral health services. This type of system capacity building supports not only distance psychiatric services to remote communities where such services are not available now but can also be used to share resources more efficiently in urban and semi-urban areas. A National Telebehavioral Health Center of Excellence is in the

planning stages and should provide increased access to televideoconferencing based behavioral health services such as telepsychiatry.

Over the last 15 years, most of the behavioral health programs have transitioned from IHS to local community control via Tribal contracting and compacting. Over half of the Tribes have administrative control over the delivery of the majority of mental health and substance abuse programs through tribal contracts and compacts. Such local programs are community based and have direct knowledge of their population and what interventions can be effectively implemented. It is clear then that Tribes, not IHS, are now primarily providing services to their communities. IHS now seeks to support those services with programs and program collaborations to bring resources to the communities themselves.

### **Addressing Suicide among American Indians**

Suicide is a complicated public health challenge with a myriad of contributors in American Indian/Alaska Native communities. Only the pursuit of a multi-targeted, coordinated, and persistent effort that is acutely aware of the cultural context of suicide and blends the best of traditional AI/AN healing wisdom and western public health tools is likely to succeed on a national basis. The losses caused by suicide affect us all and so the solutions must come from all of us working together.

IHS has five targeted approaches for suicide prevention and intervention:

- Assist I/T/Us in addressing suicide utilizing community level cultural approaches.
- Identify and share information on best and promising practices.
- Improve access to behavioral health services.
- Strengthen and enhance IHS' epidemiological capabilities.
- Promote collaboration between Tribal and urban Indian communities with Federal, State, national, and local community agencies.

To address youth suicide in Indian Country appropriately requires public health and community interventions as much as direct, clinical ones. Since 2003, the IHS National Suicide Prevention Initiative has provided a critical framework for addressing the tragedy of suicide in American Indian and Alaska Native communities. The IHS National Suicide Prevention Initiative builds on the foundation of the HHS "National Strategy for Suicide Prevention" and the 11 goals and 68 objectives for the Nation to reduce suicidal behavior and its consequences, while ensuring we honor and respect our people's traditions and practices.

Traditional knowledge, along with the role of Elders and spiritual leaders, needs to be respected and validated for the important role they play in healing and wellness. Understanding and decreasing suicide in our communities will require the best holistically and culturally sensitive, collaborative efforts our communities and the agencies that serve them can bring together. With these principles in mind, we hope to provide a holistic, cultural foundation to suicide prevention, building on the strong resilience of AI/AN communities. We will strive to bridge concepts between AI/AN communities, government agencies, and non-profit organizations in order to effectively prevent suicide.

The Suicide Prevention Initiative is complemented by the IHS Behavioral Health Initiative, both of which seek to address suicide prevention through a holistic, community-centered approach. Two other focus areas that are closely linked to the Behavioral Health Initiative are the Chronic Disease Management and Health Promotion and Disease Prevention Initiatives. All of these initiatives are pertinent to suicide prevention efforts and seek to address the underlying causes of poor physical and mental health, rather than just treating the symptoms. They also stress the empowerment and full engagement of individuals, families, and communities in health care.

Indian Health Service supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the "Medical Home". This offers new opportunities for interventions that

identify high risk individuals before their actions or behavior becomes more clinically significant. One primary care based behavioral health intervention is the Alcohol Screening Brief Intervention for patients presenting after physical trauma, which our agency is broadly promoting as an integral part of a primary care based behavioral health program. Studies suggest that this and similar interventions can dramatically reduce further traumatic injury as well as alcohol and other substance abuse more generally. The agency, through our Chronic Disease Collaborative and Innovations in Primary Care project, is also supporting efforts to integrate behavioral health providers directly into primary care settings as has been done successfully in Alaska and in other progressive primary care sites across the country. This presents a dramatic change from the usual model of distinct and separate medical and behavioral health service delivery and we intend to support this practice shift over the coming years through developing further learning communities, sharing implementation best practices as they develop, and re-aligning and supporting the development of primary care-based behavioral health resources.

We have made substantial efforts over the last several years to improve our behavioral health data collection in the Resource and Patient Management System (RPMS). Behavioral health information can now be integrated with primary care and other clinical information supporting coordinated care and improved health outcomes. As increasing numbers of clinics adopt the integrated model, data will become available that may help identify opportunities for intervention in medical, behavioral health, and community settings. IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion which is available to all providers in the RPMS health information system. The Suicide Reporting Database is beginning to provide a more detailed picture of who is committing or attempting suicide and identifies salient factors contributing to the events. Accurate and timely data captured at the point of care provides important clinical and epidemiological information that can be used to inform intervention and prevention efforts. IHS is currently developing an IHS-wide Behavioral Health "data mart" to



provide IHS leadership with up-to-date information on suicidal events including suicide completions. The application will include a number of available reports and will provide the ability to identify "cluster" events to assist in the mobilization and deployment of available resources. Finally, IHS GPRA measures now include screening for depression in primary care settings as best practice in order to assist in identifying patients at risk for developing suicidal ideation. Tools have been selected to assess depression, monitor response, track such response over time, and are incorporated into the IHS Electronic Health Record. IHS has consistently met or exceeded target goals for this GPRA depression screening measure. This level of monitoring is key to identifying at risk populations by providers and ensuring they receive timely and adequate care.

The IHS Emergency Services Program is supporting AI/AN communities by utilizing the IHS Emergency Response to Suicide Model to assess communities with high incidence of suicide, coordinate a response to the affected community, and augment existing staff, with the goal of mitigating the emergency and stabilizing the community. For example, in FY 2008, the IHS Emergency Services staff managed on behalf of HHS the deployment of Public Health Service mental health clinicians through the Office of Force Readiness and Deployment (OFRD) to a Tribal community from January - May 2008 to respond to a suicide "cluster" in that community. Federal and community efforts are still ongoing in that community. The deployment was directly requested by that Tribal government, and HHS' response was coordinated through the Office of Intergovernmental Affairs.

Substantial progress has been made in developing plans and delivering programs, but it is still only the beginning of a long term, concerted and coordinated effort among Federal, Tribal, State, and local community agencies to address the crisis. We have recognized that developing resources, data systems, and promising programs, as well as sharing information across the system, requires national coordination and leadership. In response to the problem, the IHS, with Federal partners, Tribal, and Urban Indian communities across the country, will expand ongoing partnerships and formulate long term strategic approaches

to intervene in the suicide crisis and provide suicide prevention and early intervention activities.

Last year, I established the National Tribal Advisory Committee (NTAC) on Behavioral Health made up of Tribal Leaders from each IHS Area. The Committee serves as an advisory body to the Indian Health Service, providing expertise, guidance, and recommendations on behavioral health issues affecting the delivery of health care for AI/ANs. In addition, the National Behavioral Health Workgroup was established which is comprised of Tribal and Urban behavioral health service providers. The workgroup provides information to the National Tribal Advisory Committee on Behavioral Health on issues in Indian Country.

To help guide the overall Indian health system effort, the National Suicide Prevention Committee, comprised of suicide prevention experts, was established. The Committee was tasked with identifying and defining the steps needed to build on the previous suicide prevention efforts to significantly reduce the impact of suicide and suicide-related behaviors on AI/AN communities. Members of the Suicide Prevention Committee are interdisciplinary and represent a broad geographic distribution within and outside the Indian health system.

It is the responsibility of the IHS Suicide Prevention Committee to provide recommendations and guidance to the Indian Health Service regarding suicide prevention and intervention in Indian Country. This past year, the SPC developed an Indian Health System National Suicide Prevention Strategic Plan. The National Suicide Prevention Strategic Plan is a first step in describing and promoting the accumulated practice-based wisdom in AI/AN communities. At its best, the plan will be a living and constantly changing reflection of the collaborative and focused efforts of the many people throughout American Indian/Alaska Native communities who are working to reduce the scourge of suicide.

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

practices using culturally appropriate prevention and treatment to address methamphetamine abuse and suicidal behaviors in a community-driven context.

The goal is to intervene effectively to prevent, reduce or delay the use and/or spread of methamphetamine abuse by increasing access to methamphetamine and suicide prevention services through culturally relevant services. The \$14 million initiative focuses on supporting promising or model practices for methamphetamine and suicide reduction programs in Indian Country.

So, taken all together, where are we?

We acknowledge that the complexity of suicide and its close cousins, violent and accidental death and injury, remains challenging. At the same time, we believe suicide and suicidal behaviors are preventable through the engagement of the affected communities and the application of research-supported public health approaches. Several Tribal and urban Indian communities have already taken up this challenge and have been implementing a number of innovative and culturally sensitive prevention initiatives. For example, Tribal and urban Indian communities are implementing the Native H.O.P.E. curriculum, the American Indian Life Skills Development, the Sources of Strength model, ASIST (Applied Suicide Intervention Skills Training), QPR (Question, Persuade, Refer), and other promising approaches in several communities across Indian Country. Increasing access to services, improving responsiveness of services, developing school and community level wisdom about how to manage distressed community members, educating and increasing awareness, and connecting young people to their culture are all successful approaches in Indian Country that are beginning to show us the way. However, for many other individuals and groups, it remains challenging to determine the best approach to prevent suicide in their own communities.

The initiatives and programs that I have described here are some of the methods and means to engage individuals and their communities. These efforts are not sufficient in and of themselves to significantly change many peoples' living conditions. However, if we can act together, among

agencies, branches of government, Tribes, States, and communities, I believe that the tide can be turned and hope restored to those who have lost hope. To that end, I commit to work with you and anyone else in and out of government to bring services and resources to that effort.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss youth suicide in Indian Country. I will be happy to answer any questions that you may have.