DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

YVETTE ROUBIDEAUX, MD, MPH

ACTING DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

"PROTECTING OUR CHILDREN'S MENTAL HEALTH: PREVENTING AND ADDRESSING CHILDHOOD TRAUMA IN INDIAN COUNTRY"

NOVEMBER 19, 2014

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good afternoon, I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). Today, I appreciate the opportunity to testify on preventing and addressing childhood trauma in Indian Country.

Background

As you know, the IHS plays a unique role in the U.S. Department of Health and Human Services (HHS) to meet the federal trust responsibility to provide health care to American Indian and Alaska Native (AI/AN) people. The IHS provides comprehensive health service delivery to 2.1 million American Indians and Alaska Natives through a system of IHS, Tribal, and urban Indian operated 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/AN people to the highest level, in partnership with the population we serve. The agency aims to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to promote healthy AI/AN people, communities, and cultures, and to honor 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 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, functions and activities to address the health needs of American Indians and Alaska Natives. The IHCIA includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for AI/AN people, and the construction, replacement, and repair of healthcare facilities, among other authorities.

The IHS, in partnership with Tribes and urban Indian health programs, provides essential medical and mental health services in over 600 hospitals, clinics, and health stations. These services include medical and surgical inpatient care, emergency care, ambulatory care, mental health and substance abuse treatment and prevention, and medical support services such as laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. Other services include public and community health programs such as diabetes; maternal and child health; communicable diseases such as influenza, HIV/AIDS, tuberculosis, and hepatitis; suicide prevention; substance abuse prevention; women's and elders' health; domestic violence prevention and treatment; and regional trauma/emergency medical delivery systems. The level of services provided in each community varies based on available resources. In addition, over half of the IHS budget is managed by Tribes under P.L. 93-638, the Indian Self Determination and Educational Assistance Act, and many of the public, community and behavioral health

programs are managed by Tribes even when the hospital or clinic is still under management by the IHS.

Childhood Trauma in AI/AN Children

According to the National Child Abuse and Neglect Data System, an estimated 686,000 children were exposed to incidents of child abuse and neglect in 2012. These data translate to a rate of 9.2 occurrences of child abuse and neglect for every 1,000 children per year.[1] While these data are not unique to AI/AN children, childhood trauma is disproportionately experienced by AI/AN children. The reasons are multifactorial and related to the high incidence of alcohol and drug abuse, mental health disorders, suicide, violence, and behaviorally-related chronic diseases among AI/AN people. Recurrent physical, emotional, and sexual abuse, as well as emotional and physical neglect leads to childhood trauma impacting the mental health and wellbeing of children. Other contributing factors of childhood trauma include household members who may have a substance abuse disorder, chronic depression, or other mental health diagnoses, family members who may be incarcerated, experience suicidal ideation, domestic violence in the household, and parental loss. Each of these serious behavioral health related issues have a profound impact on childhood trauma, the health of individuals, family, and community wellbeing.

Once again, another school shooting has shaken us to our core as one of the Nation's most serious tragedies. The heartbreak facing the Marysville, Washington, community and Tulalip Tribe offers another opportunity for a collective effort to reduce the chances of similar future

[1] U.S. Department of Health & Human Services. Administration for Children and Families. (2012). Child Maltreatment 2012. Available at http://www.acf.hss.gov/programs/cb/stats_research/index.htm#can

tragedies. There are no easy solutions and no single agency or single approach that will address the violence and many other problems impacting the mental health of our children and youth. The problem of childhood trauma is a multigenerational and societal problem. It is sweeping in scope and will take a coordinated, comprehensive, multi-dimensional public health response to change the course for our children and youth. Today, I appreciate the opportunity to discuss what the IHS is doing to address the many issues that relate to childhood trauma and to be part of the solution for these public health challenges. IHS is already, and wants to continue to be, a partner with other agencies, stakeholders and Tribes in these efforts to find solutions.

IHS Medical and Public Health Response to Childhood Trauma

The overall structure and types of services provided by IHS, Tribal and urban Indian health programs were described above. The funding IHS receives to provide primary care and behavioral health services is through the Hospitals and Health Clinics, Mental Health and Alcohol and Substance Abuse budgets, of which over 50 percent of funds are transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that design and manage the delivery of health programs in their communities. In addition, there are 34 urban Indian health programs serving approximately 600,000 AI/AN people, including children with varying levels of services.

In Fiscal Year (FY) 2013, IHS per capita spending estimates were $47 per person for mental health services and $117 per person for alcohol and substance abuse services. The average public and private expenditure among school-age American children from 2009-2011 was

$2,192 for mental health services[2]. While the IHS overall spending estimate on mental health services is not directly comparable for the amount spent per AI/AN child due to the nature of how services are accessed through our health system, it is a glimpse into the complexities faced by Tribes in providing comprehensive services for children and families. I would like to provide an overview of some of our major national programs and activities that are part of the IHS medical and public health response to childhood trauma.

National Policy

I spoke in my introduction about the dire statistics on child abuse and neglect and its huge impact on AI/AN children and youth. IHS works to positively influence the outcomes for children and youth who are victims of child maltreatment through development of policies, objectives, procedures, and responsibilities concerning the detection, management, prevention, and evaluation of child abuse and neglect. The IHS recently recognized the need for a more comprehensive, standalone policy, and the IHS is drafting a comprehensive national Child Maltreatment policy to ensure children who are abused or neglected receive comprehensive intervention and treatment services when they enter our health system, as well as outlines the health care responsibilities in providing a coordinated multidisciplinary response. This policy will help improve and enhance our overall response at IHS facilities.

Training

The IHS offers a comprehensive training program to meet the needs of our workforce as it relates to addressing childhood trauma. Specific for child abuse, IHS provides training related to the

[2] U.S. Department of Health & Human Services., (2014). Expenditures for Treatment of Mental Health Disorders among Children, Ages 5-17, 2009-2011: Estimates for U.S. Civilian Noninstitutionalized Population. Published by Agency for Healthcare Research and Quality. Available at: http://meps.ahrq.gov/mepsweb/data_files/publications/st440/stat440.shtml

identification, collection, and preservation of medical forensic evidence obtained during the treatment of child sexual abuse. Monthly webinars ensure the Indian health system receives the continuing education needed to maintain competencies in the treatment, prevention, and coordination of services for child maltreatment. For current and pressing behavioral health issues related to childhood trauma, the IHS provides virtual training seminars and consultation sessions on topics including child mental health, childhood trauma, suicide, historical trauma, Fetal Alcohol Spectrum Disorders, and school violence, among others.

Youth Regional Treatment Centers

To help youth battling substance abuse, IHS administers ten Youth Regional Treatment Centers (YRTCs) that provide inpatient treatment for substance abuse and co-occurring mental health disorders among AI/AN youth. The YRTCs provide a range of clinical services rooted in culturally relevant, holistic models of care including group, individual, and family psychotherapy, life skills development, medication management, aftercare relapse prevention, and post-treatment follow up services. YRTCs also provide education, culture-based prevention activities, and evidence- and practice-based models of treatment to assist youth overcome their challenges and become healthy, strong, and resilient community members.

Recently, the Jack Brown Center, an IHS funded YRTC that is located in Tahlequah, Oklahoma, completed construction on a new facility that will increase Jack Brown's capacity from 20 to 36 inpatient beds. Additionally, Congress authorized two YRTCs to be built in the IHS California Area. The Southern California facility is expected to open in FY 2015, and staffing costs were

included in the FY 2015 President's Budget. The FY 2015 Budget also included construction costs for the Northern California YRTC.

Community Health Representatives

The IHS Community Health Representative, or CHR, program is community-based program with a special focus on advocacy, health promotion, and disease prevention. In 2013, the CHR program partnered with Johns Hopkins University to implement Family Spirit, an evidence-based and culturally tailored in-home parent training and support program. Parents gain knowledge and skills to achieve optimum development for their preschool aged children across the domains of physical, cognitive, social-emotional, language learning, and self-help. The program is currently the largest, most rigorous, and only evidence-based home visiting program ever designed specifically for American Indian families. In 2013, IHS provided funding to further replicate the program in three American Indian communities.

Methamphetamine and Suicide Prevention Initiative

The IHS Methamphetamine and Suicide Prevention Initiative, or MSPI, is one of the most significant efforts at the core of the IHS' response to methamphetamine abuse and suicide in AI/AN communities. The MSPI's purpose is to promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. Of the 130 IHS, Tribal, and urban Indian health projects supported across the country through the MSPI, over 80 percent of projects provide prevention and treatment services to youth. For example, one Tribal project increased access to services by funding school based

mental health professionals at community schools. Youth now have immediate access to mental health providers in a familiar environment. These professionals are responsible for providing on-going mental health services to youth, as well as providing educational groups related to suicide, grief, and loss. School officials have witnessed the impact of the school-based health services and report youth are more likely to talk about suicide and reach out for help.

Throughout the 5 years of the MSPI, projects have significantly raised awareness through diverse and innovative programming. From 2009-2013, the MSPI resulted in more than 7,500 individuals entering treatment for methamphetamine abuse, over 15,000 tele-health substance abuse and mental health encounters, over 10,000 professionals and community members trained in suicide prevention and crisis response, and over 400,000 encounters with youth were provided as part of evidence-based and practice-based intervention and prevention services.

Community Awareness

To raise youth awareness on the issues of substance abuse and suicide, the IHS partnered with the Northwest Portland Area Indian Health Board to develop media campaigns. Using focus groups, youth developed the "I Strengthen My Nation" and "Community is the Healer" media campaigns, which empower Native youth to resist drugs and alcohol, motivates parents to talk openly to their children about drug and alcohol use, and raises awareness about the issue of suicide.

Domestic Violence Prevention Initiative

To prevent domestic and sexual violence, as well as family violence, the IHS administers the Domestic Violence Prevention Initiative, or DVPI. Through DVPI, 65 IHS, Tribal, and urban Indian health projects provide outreach, victim advocacy, intervention, policy development, and

community response teams. From 2010-2012, the DVPI resulted in over 28,000 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services; over 36,000 referrals for domestic violence services, culturally-based services, and clinical behavioral health services; with 487 forensic evidence collection kits submitted to federal, state, and Tribal law enforcement.

Drug and Alcohol Exposure during Pregnancy

To identify women who are using alcohol and drugs during pregnancy, IHS healthcare facilities conduct screening during routine women's health and prenatal encounters. In FY 2013, 65.7 percent of all AI/AN females ages 15 to 44 were screened for alcohol use. In one IHS service unit, approximately 54 percent of women tested positive for drug use while pregnant and 52 percent of the infants born tested positive for drugs. To combat this problem, IHS has drafted policies and coordinated efforts for a comprehensive and multidisciplinary response to provide services to mothers and families including prenatal services, treatment, and home visiting programs to promote healthy lifestyles.

Fetal Alcohol Spectrum Disorder

For the babies born with Fetal Alcohol Spectrum Disorders, or FASD, which is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy, IHS administers the Fetal Alcohol and Drug Unit (Unit), located within the University of Washington's Alcohol and Drug Abuse Institute. The Unit provides FASD information and strategies for prevention and intervention to AI/AN communities. Since 2012, over 300 high-risk, substance-abusing pregnant and parenting women and their families have

received evaluation, diagnosis, and referral services through the Unit. Additionally, the Unit has provided training and technical assistance to over 4,400 healthcare providers and AI/AN community members on FASD prevention and intervention topics.

IHS Partnerships

The IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. Strategies to address public safety and justice issues that impact childhood trauma include collaborations and partnerships between IHS, Substance Abuse and Mental Health Services Administration, Department of Justice (DOJ), and Department of Interior (DOI) through three Memoranda of Understanding, established by the Tribal Law and Order Act, Indian Health Care Improvement Act, and Individuals with Disabilities Education Act. These interagency coordination efforts work to ensure Federal agencies are comprehensively addressing the serious problems that have a significant impact on childhood trauma, such as alcohol, substance abuse, mental illness.

The IHS is working with other federal officials from DOJ and DOI as part of the Defending Childhood Initiative as a member of the American Indian/Alaska Native Children Exposed to Violence Federal workgroup. This partnership seeks to take immediate steps to improve the Federal response to AI/AN children exposed to violence. The role of IHS in this group is to ensure services are comprehensive and coordinated so that every child has access to medical and counseling appointments in a timely manner and on a routine basis.

The IHS partnership with the American Academy of Pediatrics' Committee on Native American Child Health (CONACH) works to develop policies and programs to improve the health of AI/AN children. CONACH members are committed to increasing awareness of the major health problems facing Native American children and monitoring legislation affecting AI/AN child health. CONACH conducts pediatric consultation visits to IHS and Tribal healthcare facilities, makes recommendations to improve services, and works to strengthen ties with Tribes throughout the United States.

Summary

In summary, IHS policies, training, programs, and partnerships promote a multifaceted range of activities for identification, treatment and prevention of childhood trauma. However, IHS cannot address this issue alone, and it is imperative to continue to build a wide safety net of Federal, non-Federal and Tribal resources for AI/AN children and families to help to further activities at the national, Tribal, state, and local levels. No one individual, community, or agency can do this alone. It will take all of us to prevent and reduce childhood trauma and we welcome your partnership and assistance with this important issue.

This concludes my remarks and I welcome any questions that you may have. Thank you.