DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

TEEN SUICIDE AMONG AMERICAN INDIAN YOUTH

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STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON
TEEN SUICIDE AMONG AMERICAN INDIAN YOUTH

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Mr. Chairman and Members of the Committees:

Good morning, I am Dr. Charles Grim, Director of the Indian Health Service (IHS). I am accompanied by Dr. Jon Perez, Director, Division of Behavioral Health. Today I am pleased to have this opportunity to testify on behalf of Secretary Leavitt on teen suicide among American Indian Youth.

The IHS has the responsibility for the delivery of health services to an estimated 1.8 million Federally-recognized American Indians and Alaska Natives 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 foundation 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 provided 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 health care facilities.

We are here today to discuss the teen suicide among American Indian youth.

Background –

Suicide in Indian Country, in contrast to most of the rest of the United States population, is characterized by higher rates, from younger people, and very often affecting entire communities as a result of suicide clustering.

- Using the latest information available, suicide rates for Native Americans range from 1.5 to over 3 times the national average for other groups. (*Trends in Indian Health, 2000-2001)*
- It is the second leading cause of death (behind unintentional injuries) for Indian youth aged 15-24 and is 2.5 times higher than the national average. (*Trends in Indian Health, 2000-2001)*
- It is the 5th leading cause of death overall for males and ranks ahead of homicide. (*Trends in Indian Health, 2000-2001)*
- Young people aged 15-34 make up 64 percent of all suicides. (*Trends in Indian Health, 2000-2001)*
- While suicide rates for all other racial groups declined from 1990 through 1998, they continued to increase for Native Americans.
- In a 1999 study of 11,666 7-12th grade Native American youth, 22 percent of the girls and 12 percent of the boys reported attempting suicide at some point in their young lives.

External demands upon individuals, families, and communities are many and powerful. Long histories of subjugation and continued resulting challenges of

maintaining cultures, managing poor economies, and subsisting with lack of opportunities mean most of these demands are negative and destructive. The most common IHS mental health program model provides acute crisis-oriented outpatient services. Inpatient services are purchased from non-IHS hospitals or provided by State or County mental hospitals. Triaged care is the rule, not the exception, in virtually all of our programs. The Indian Health Service is requesting a total of $59 million for mental health in FY 2006, an increase of 8 percent over FY 2005.

The Red Lake School shootings gave me close, firsthand experience with the devastation brought about by these effects. I also saw the community coming together and drawing strength from the support of mental health professionals and tribal spiritual leaders. In fact, programs begun within the last two years to promote suicide prevention and to respond to a community in crisis guided much of the response. While there is much to do, there is a sense of hope and a spirit of collaboration among the community and tribal leaders, the State and Federal programs. There is cause for hope, even in the face of such tragedy. It is the same when we look at suicide directly.

Addressing Teen Suicide Among American Indian Youth

Suicide is not a single problem; rather it is a single response to multiple problems. Neither is it a strictly clinical or individual problem, but one that affects and is affected by entire communities. Quoting from the Institute of Medicine's landmark 2002 publication, *Reducing Suicide,* "Suicide may have a basis in depression or substance abuse, but it simultaneously may relate to social factors like community breakdown, loss of key social relations, economic depression, or political violence."

This is particularly true in Indian Country. To address it appropriately requires public health and community interventions as much as direct, clinical ones. Also, and not inconsequentially, it requires resources sufficient to support them. In late September of 2003, I announced the IHS National Suicide Prevention Initiative, designed to

directly support I/T/U's in three major areas associated with suicide in our communities:

- First, to mobilize Tribes and tribal programs to address suicide in a systematic, evidence based manner.
- Second, to expand and enrich research and program bases.
- And, third, to support and promote programmatic collaborations on suicide prevention.

Over the last year and a half, substantial progress has been made in developing plans and programs, but it is only the beginning of what must be a long term, concerted and coordinated effort among Federal, tribal, State, and local community agencies to address the crisis. The initiative addresses all eleven goals of the National Strategy for Suicide Prevention. It also extends and enhances work between tribal communities, local, State, and Federal agencies, and now even includes the greater tribal and indigenous populations of North America through our ongoing partnerships with Health Canada, First Nations, and Inuit.

Let me briefly summarize some of the efforts we have undertaken in each of the three major initiative areas:

Fifty percent of the IHS mental health budget goes directly to tribal programs, it is clear, then, that Tribes, not IHS, are now primarily providing services to their communities. IHS now seeks to support those direct services with programs and program collaborations to bring resources and methodologies to the communities themselves. The IHS National Suicide Prevention Committee was impaneled in February, 2004, to help guide the overall IHS/tribal effort. Composed of primarily tribal behavioral health professionals from across the country, it serves not only to assist in providing direction for efforts, but also to provide representative membership in some of the specific programs that have been developed.

IHS is currently working with IHS Areas, tribal communities, and States to:

- Establish area-wide suicide surveillance and prevention systems in collaboration with the Bureau of Indian Affairs (BIA) and States to collect information from law enforcement and medical examiner databases. This supplements the IHS Behavioral Health Management Information System which gathers information from tribal and IHS health care facilities.
- Strengthen partnerships between State and Federal agencies in the area of suicide prevention. IHS representatives are members of State suicide prevention teams/coalitions in many States throughout the country, ensuring that AI/ANs are provided access to State services,
- Participate in workgroups to improve suicide prevention and intervention activities.
- Provide active outreach to attempters, families and community.
- Train lay-persons from the community as QPR (Question, Persuade and Refer) Gatekeepers.
- Involve American Indian and Alaska Native youth in suicide prevention efforts, primarily through school programs/curriculums and boys and girls clubs
- Provide workshops and forums on suicide prevention. One IHS Area (Aberdeen) has a Question, Persuade and Refer (QPR) initiative, to assure competency for non-mental health providers to identify and respond appropriately to suicidal behaviors.
- Promote innovative training and service programs, as in the Alaska Behavioral Health Aide Program, to offer communities direct intervention capabilities they would otherwise not have.

Research into suicide in Indian Country is limited, and what research is available suggests suicide in our communities differs in substantial ways from other racial and ethnic groups, suggesting younger and more impulsive suicide attempt profiles than other populations. To that end, IHS is collaborating with National Institute of Mental Health, Health Canada, and the Canadian Institute for Health Research, on a multiyear effort to better understand suicide in Indian Country, and to develop evidence based interventions for prevention. Staff from these agencies has

been working for over a year to develop this initiative and its first international meeting will be held this September in Albuquerque, NM. The purpose is to bring together researchers, clinicians, program personnel, wisdom-keepers, and governmental representatives from North America to begin a 5 year, interagency and, indeed, international effort to develop a concrete research agenda and develop specific programs for Indigenous populations.

These research agenda and programs will be driven by data. IHS has spent $3,000,000 over the last three years on system wide improvements to its behavioral health management information system, including a comprehensive upgrade of its patient information and documentation systems. It goes far beyond data systems and represents a new way of looking at programs, services, documentation, and evaluation utilizing digital technology as a major tool to integrate them. The latest version of the software package, the Behavioral Health Management Information System Graphical User Interface (BH-MIS GUI), was deployed in January. It has been extremely successful in providing much needed data not only to national programs, but also communities themselves. Now patients can be screened for potential suicide risk, suicide clustering can be discerned quickly in communities and Areas, and clinicians have comprehensive treatment planning and documentation tools to support their clinical interventions. For the first time, far more accurate data are being gathered and shared from the individual clinician to national policy makers. The data on prevalence in this testimony, for example, came directly from the information gathered via the IHS MIS system.

Finally, Substance Abuse and Mental Health Services Administration and IHS have created a national suicide prevention intervention team for Indian Country. Composed of one person from each IHS Area, these personnel are currently being trained in community suicide prevention and mobilization. Once trained, they will be able to, in turn, train personnel in tribal communities to provide suicide prevention programming, including materials, techniques, and protocols. Training should be completed by summer and the team members will be ready to begin supporting

communities at that time. This will also be a multiyear collaboration which we hope to expand as resources allow.

So, taken all together, where are we?

I think we are engaged in a battle for hope. For those young people who see only poverty, social and physical isolation, lack of opportunity, or familial dissolution, hope can be lost and self destructive behavior becomes a natural consequence. The initiative and programs I have described are some methods and means to restore that hope and engage youth and their communities to sustain and nurture it. But they 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 there is hope that the tide can be turned and hope restored. 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 teen suicide among American Indian youth. I will be happy to answer any questions that you may have.