



**Testimony  
Before the Indian Affairs Committee  
United States Senate**

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**Suicide Prevention Among Native American  
Youth**

*Statement of*

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Good morning Mr. Chairman and distinguished members of the Committee. My name is Vice Admiral Richard Carmona, and I am the Surgeon General of the U.S. Public Health Service.

I have had the honor of working with many of you, and I look forward to strengthening our partnerships to improve the health and well being of American Indian and Alaska Native communities, as well as all communities across our great nation.

I appreciate this opportunity to represent the U.S. Department of Health and Human Services (HHS) to discuss suicide and suicide prevention activities in Indian Country.

Suicide is one of the most tragic events that a family can endure. The heartache of families' grief cannot be underestimated or ignored. We must continue to ensure that we are a nation that takes the necessary steps to prevent suicide.

I believe — as I know you do — that the mental health of our nation is a critical component of our nation's public health.

Suicide costs us more than 30,000 lives each year. That's almost one person every 15 minutes. And once every 45 seconds someone engages in suicidal behavior. Even if the life is spared, the heartache and pain is so severe that the spirit may never fully heal.

On May 2, 2005, in Bismarck, North Dakota, Senator Byron Dorgan and Representative Earl Pomeroy heard testimony from my colleague Rear Admiral Charles Grim, Director of the Indian Health Service (IHS), Ulonda Shamwell of the Substance Abuse and Mental Health Services Administration (SAMHSA), and tribal and community representatives from across the country. They described in detail the significance of the suicide problem, as well as some of the efforts to address it. For the benefit of the full Committee, I will review some of the information shared at that hearing and provide supporting detail on some of the specific responses to the situation. I will also focus on specific leadership tasks for all of us to undertake — including federal, tribal, state, and community members — to successfully address the suicide problem and promote the health and well being of tribal communities.

### **Background**

The suicide rates in Indian Country are generally higher, and are characterized by younger people engaging in fatal and nonfatal suicidal behavior at much higher rates than the overall U.S. population.

- Based upon the most recent data from the Indian Health Service (*Trends in Indian Health, 2000-2001*, published in 2004), the suicide rates for American Indians and Alaska Natives are many times the national average for other population groups. For 5- to 14- year-olds, the suicide rate is 2.6 times higher than the national average. And there is an even

greater disparity in the later teenage years and into young adulthood. The suicide rate for American Indian / Alaska Native youth aged 15 to 24 is 3.3 times higher than the national average.

- In fact, young people aged 15-24 make up 40 percent of all suicides in Indian Country.
- Suicides are just the tip of the pyramid in examining suicidal behavior among American Indian youth. There are many more nonfatal injuries due to suicidal behavior than there are suicides. It is estimated that there are 13 nonfatal events for every fatality.

The patterns of completions suggest these young people act more impulsively than planned, are usually responding more to external stimuli (including significant family or interpersonal problems), have been using alcohol and/or other substances, and they tend not to have been previously seen in any behavioral health clinical setting.

In addition, suicide and suicidal behavior are becoming more prevalent in many of our smaller tribal communities.

We have some indications and areas to further explore in the small, but growing, literature on suicide among American Indians / Alaska Natives, but we have nothing close to the more robust literature and science that are available about

the general population. And what the available literature does tell us is that suicide in Indian Country is different from the overall population — including some of the ways I've just mentioned — and requires different approaches to prevention. In many of our tribal communities, suicide is not just an individual clinical condition, but also a community condition.

Suicide is not a single problem; rather it is a single response to multiple problems.

The reality is that we have not adequately explored either the problems or the necessary responses. We know that some of the underlying social, educational, and cultural issues related to suicide include poverty, lack of economic opportunity, limited educational alternatives, community breakdown, familial disruption, and stigma; and we need to better understand the role of social risk and protective factors. These social issues are every bit as important to understand and address as are clinical factors such as substance abuse and mental health. We know that these factors are all critical to promoting long-term health and minimizing potential suicidal behavior. We can guide and evaluate programs to reduce suicidal behavior by what we learn about social, educational, cultural, and clinical factors.

In sum, we know enough to know there are differences, and we can identify some of the more critical differences, but we do not yet have as complete an understanding as we should to guide suicide treatment or prevention.

This is particularly true in Indian Country. To address it appropriately requires public health and community interventions as much as clinical interventions. It also requires resources sufficient to understand and support the interventions. The Administration's FY 2006 budget request for IHS includes a total of \$59 million for mental health, an increase of \$4.3 million, or 8 percent, over FY 2005.

We also know enough to take active steps to respond, which leads me to the next critical question: What are we doing to prevent suicide in Indian Country?

My predecessor, Surgeon General David Satcher, shined a bright light on the too-often darkened pain of suicide. He said that we need to work to prevent suicide and suicidal tendencies before they manifest.

In 1999, he issued *The Surgeon General's Call to Action to Prevent Suicide*. It is the product of an effort that brought the best science together with the best experience on the subject of suicide prevention, and was organized around three central themes of Awareness, Intervention, and Methodology. In addition, Dr. Satcher was instrumental in developing the *National Strategy for Suicide Prevention*. It details 11 national goals and 68 specific objectives to reduce suicide in the United States.

The Strategy was and remains the national blueprint for action to prevent suicide. Promoting awareness, supporting treatment, enhancing research, and fostering

collaborations among public and private organizations as endorsed by the goals have been very successful. I am proud to report that for the general population, the long-term trend in the United States has been toward a decline in the suicide rate. I am troubled by the fact, however, that suicide in Indian Country is not declining.

Because of this fact, one of Dr. Grim's first acts as Interim Director of the IHS in 2002 was to convene a tribal consultation on behavioral health. Representing over 200 tribes and tribal organizations, the consultation provided recommendations for long-term goals to revitalize and promote behavioral health in Indian Country. In the past three years, every one of those goals has been addressed, with substantial progress noted in all of them. This has been a collaborative process between HHS, the Department of the Interior, and other federal agencies, tribes, states, and communities. Collaboration is the hallmark of this new behavioral health approach. But it marks only the beginning of a much longer process in which we are currently engaged to bring leadership, programs, and resources to what is, by any reasonable judgment, an ongoing crisis.

In the short term, a federal crisis response capability was developed to intervene quickly, collaboratively, and effectively in tribal communities. This federal response capability includes the IHS, the Office of Force Readiness and Deployment of the U.S. Public Health Service, SAMHSA, and the Department of the Interior. It provides emergency short-term and intermediate-term direct

services, training, and infrastructure support to communities in crisis. The teams have been deployed to tribal communities twice in the past two years and were highly effective in both cases. In fact, these deployments now serve as models for intervention, not only in Indian Country, but for any small or isolated community in need.

Various models of care have also been developed and are currently in use. For reservation-based programs, there are highly innovative approaches that show great efficacy and could be used as models for other tribal communities. For example, the Jicarilla Apache of Northern New Mexico, in the span of approximately 10 years, addressed one of the highest rates of suicidal activity in the United States by developing a community-based intervention strategy that remains a model for tribally run programs. The strategy brought together tribal leadership, community members, youth, clinicians, researchers from the University of New Mexico, and IHS personnel to design and implement the program. The program involves the entire community, from tribal government, to schools, to social service and law enforcement agencies. The result is that over the past decade, suicidal activity has fallen by approximately 60 percent among the Jicarilla Apache of Northern New Mexico — and has been maintained at that level.

Another success story, and a landmark best practice, goes back to the year 2000, when the Phoenix Indian Medical Center, the second-largest Indian Medical Center in the country, responded to patient waiting lists of sometimes up



to six months by performing a data-based analysis of patient needs, services, and flow, and then completely overhauling its behavioral health care delivery system. The Center instituted what it calls the “Open Access Model of Care.” What this means is that instead of making appointments and having to wait for weeks and sometimes months to see a mental health professional, a patient can walk in to the behavioral health department between 8 a.m. and 2 p.m. and see a licensed clinician that same day. In the 5 years it has been in operation, there has not been a suicide completion noted among active patients in the service. This is particularly impressive because the Center sees, on average, over 18,000 patients per year. Let me stop here and point out that this is a remarkable achievement for any organized health care anywhere.

Finally, from the largest to the smallest: In Alaska the Behavioral Health Aid program trains community member paraprofessionals to screen and intervene in the smallest villages in the vast territory of Alaska. Specific training in screening, crisis intervention, referral, and consultation techniques are combined with external supervision and culturally specific traditional sensibilities to create behavioral health first responders for communities too small and too isolated to be able to otherwise access behavioral health professionals. The program is in its infancy but shows substantial promise for long-term success and the possibility of replication across Indian Country.

The longer term is also being addressed by the Indian Health Service Director’s National Behavioral Health Initiative. As Dr. Grim described in his previous

testimony, this initiative brings together various federal agencies, including SAMHSA, the National Institute of Mental Health of the National Institutes of Health (NIH), IHS, the U.S. Public Health Service Commissioned Corps, American Indian / Alaska Native communities and programs, and other public and private organizations to provide strategic direction and concrete action.

Indian Country has adopted the planned approach of the *Surgeon General's Call to Action to Prevent Suicide* and is taking active steps to implement it. To that end, IHS, NIMH, SAMHSA, the U.S. Public Health Service Commissioned Corps, the Department of the Interior, and other federal agencies are working together with tribal governments and American Indian/Alaska Native communities to collaboratively extend the service and science base to the community level.

Within the past year, it already established surveillance, training, and prevention programming for American Indian/Alaska Native communities nationally, but its major work is only just beginning for long-term, sustainable system change. It will support clinical and community program development in Indian Country, as well as basic and program research. Work has been ongoing for the past two years to develop and implement approaches, as well as bring together representatives from across the United States, Canada, the Americas, and Circumpolar North to continue that work. The first international meeting of the National Behavioral Health Initiative will be held this fall. The charge is to provide strategic leadership and implement ongoing work groups to turn that leadership into concrete action.

The issue of suicide in Indian Country will take years, not months, to address, and just as suicide among American Indian/Alaska Native populations is a multifactorial phenomena, the response must also be multifaceted. We know that effective programs are dependent on clinical, educational, familial, community, interagency, and intergovernmental responsibilities being carried out. I commit my support to you and all those represented here today. I also commit the U.S. Public Health Service Commissioned Corps to continue providing leadership and personnel to support tribes and tribal programs to reduce suicide and suicidal behavior among all our tribal communities.

Led from the top by President Bush and Secretary Leavitt, we are working day and night to address the risks for suicide. The President signed the Garrett Lee Smith Memorial Act in October 2004. The \$11 million dollars made available under this Act will help enable states, Indian tribes, colleges, and universities to develop suicide prevention and intervention programs. SAMHSA is administering this grant program, and accepted applications through June 1 for a variety of youth suicide prevention efforts. In addition, the National Strategy for Suicide Prevention is a joint effort of SAMHSA, the Centers for Disease Control and Prevention, NIH, the Health Resources and Services Administration, and IHS.

For those looking for more information on what we are doing at HHS and ways that you can help prevent suicide, I recommend

[www.mentalhealth.org/suicideprevention](http://www.mentalhealth.org/suicideprevention)

Suicide is the most sobering of all death. We can and must do a better job of preventing it. The positives that result from discussions like this include the fact that by talking about suicide and suicidal behavior, we take it out of the darkness, and remove the mystery. It should always be okay to talk about being depressed or about having suicidal thoughts. Young people should be able to go to parents, teachers, and other caring adults for help with depression and even anger without feeling like they will be labeled “weak” or “bad” or “broken.” Adults should be able to talk with friends, family, co-workers, neighbors, and professionals who can help prevent suicidal thoughts from becoming suicidal actions.

Paramedics and emergency room doctors like me are the often-heralded lifesaving heroes. Each of them deserves praise, that is true. But so does everyone who has ever held out a hand, given a hug, or spoken words of encouragement when a person considering suicide needs it most.

As the Surgeon General, I want to thank you for all of the lives that you’ve saved. I was a trauma surgeon in Arizona before coming to Washington to be the Surgeon General. Too often, by the time I saw someone on the gurney who had attempted suicide, it was too late for me to help them.

That is why each of you is so important to this national cause. You don't have to be a trauma doctor to save a life. You can be a counselor, a teacher, an organizer, a loved one, a friend or — indeed — an elected leader.

Thank you for caring and for taking action.

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 can be a consequence. The programs I have described are some methods and means to restore that hope and engage youth and their communities to sustain and nurture it. They are not sufficient, in and of themselves, to significantly change many peoples' living conditions. However, if we can act together, across tribal governments, states, and communities, I believe there is hope that the tide can be turned and hope restored. I commit to work with you and anyone else in and out of government to bring services and resources to this important effort.

I appreciate the opportunity to discuss with you this health crisis in Indian Country. Thank you, and I look forward to our discussion.