

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

SUICIDE PREVENTION PROGRAMS

AND

THEIR APPLICATION IN INDIAN COUNTRY

May 17, 2006

STATEMENT OF THE INDIAN HEALTH SERVICE
OVERSIGHT HEARING ON
SUICIDE PREVENTION PROGRAMS AND THEIR APPLICATION IN
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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, National Behavioral Health Consultant. Today I am pleased to have this opportunity to testify on behalf of Secretary Leavitt on suicide prevention programs 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 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.

Secretary Leavitt has also been proactive in raising the awareness of Tribal issues within the Department by contributing to our capacity to speak with one voice, as One Department, on behalf of the Tribes, and through the process of Tribal consultation. As such, he 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 and seek opportunities for collaboration and coordination among HHS programs serving Native Americans.

We are here today to discuss suicide prevention programs and their application in Indian Country.

Background -

Suicide in Indian Country, is characterized by higher rates, for younger people, and affecting entire communities because suicide, like an infectious disease, quite often spreads rapidly among our families and peer groups in what are called suicide clusters.

- Using the latest information available, suicide rates for American Indians range from 1.5 to over 3 times the national average for other groups. (*Trends in Indian Health, 2000-2001*) [Note: IHS acknowledges that other data sets are available, including household survey data used by the SAMHSA.]
- It is the second leading cause of death (behind unintentional injuries and accidents) for Indian youth aged 15-24 and is 2.5 times higher than the national average. (*Trends in Indian Health, 2000-2001*)[Note: CDC 2003 data states the rate among all self identified American Indian/Alaska Natives as almost twice the national rate compared to the IHS rate which is calculated only for the IHS service population.]
- 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*)

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 behavioral health programs. The Indian Health Service is requesting a total of \$62 million for mental health in FY 2007, an increase of 5% percent over FY 2006.

Addressing Suicide Among American Indians

The most important thing to remember is 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. 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.

Since then, 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. The initiative addresses all eleven goals of the Department of Health and Human Services (HHS) National Strategy for Suicide Prevention (NSSP), which represents the combined work of advocates, clinicians, researchers and survivors around the nation. It lays out a framework for action to prevent suicide and guides development of an array of services and programs that must be developed. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. The NSSP Goals and Objectives for Action was published by the U.S. Department of Health and Human Services in May of 2001, with leadership from the Surgeon General.

- Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable
- Goal 2: Develop Broad-based Support for Suicide Prevention
- Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services
- Goal 4: Develop and Implement Suicide Prevention Programs
- Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm
- Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment
- Goal 7: Develop and Promote Effective Clinical and Professional Practices
- Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services
- Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media
- Goal 10: Promote and Support Research on Suicide and Suicide Prevention
- Goal 11: Improve and Expand Surveillance Systems

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:

As over sixty percent of the IHS mental health budget goes directly to Tribal programs, it is clear that Tribes, are 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 crisis services, training, and community mobilization tools for communities in need. It also serves to provide representative membership in some of the specific programs that have been developed. In September 2005, the Suicide Prevention Committee created the Indian Health Service Suicide Prevention Work Plan to reduce the impact of suicide and suicide-related behaviors utilizing a comprehensive, culturally sensitive and linguistically appropriate community-based approach.

IHS Headquarters 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.
- Establish a partnership between the IHS and the BIA, to increase access to health and mental health care for children attending BIA funded schools. In February, 2006, Mr. James E. Cason, Associate Deputy Secretary of the Department of the Interior, and I signed the *Memorandum of Agreement for Indian Children with Disabilities* (including children with mental and substance abuse problems) to encourage collaboration in the delivery of appropriate coordinated services, by sharing resources and personnel between our respective national and local offices, as well as with State and local education agencies and other entities.
- Strengthen partnerships between State and Federal agencies in the area of suicide prevention. IHS representatives are members of many State suicide prevention teams/coalitions throughout the country, ensuring that AI/ANs are provided access to State services. For example, in the Albuquerque Area IHS has partnered with the State of New Mexico to deliver ASIST training, which is listed on Substance Abuse and Mental Health Service Administration's (SAMHSA) national registry of evidence based practices, to Tribal communities.
- Participate in workgroups to improve suicide prevention and intervention activities. As a result of the Transformation of Mental Health Care and the National Suicide Prevention strategy, IHS has formed an alliance with SAMHSA, other HHS agencies, and non-governmental organizations, States and

Tribes to address and reduce suicide activity across the U.S. and in Indian Country.

- Provide active outreach to attempters, families and affected communities. For example, the IHS Aberdeen Area and the Standing Rock Tribe's Oniyape program have created an MOU to expedite outreach services to community members who are affected by suicide.
- Continue to train community members as QPR (Question, Persuade and Refer) Gatekeepers. The IHS Aberdeen Area and the Aberdeen Area Tribal Chairmen's Health Board have a Question, Persuade and Refer (QPR) initiative, to assure competency for non-mental health providers to identify and respond appropriately to suicidal behaviors.
- Involve American Indian and Alaska Native youth in suicide prevention efforts, primarily through school programs/curriculums and boys and girls clubs. For example, Tucson Area is encouraging the Tohono O'odham and Pasqua Yaqui youth to plan and implement suicide prevention trainings and conferences for youth. National Strategy for Suicide Prevention (NSPN) provided \$35,000 for suicide prevention trainings/activities to the Tucson Area. The Tucson Area Division of Behavioral Health collaborated with the Tohono O'odham and Pasqua Yaqui youth to address suicide awareness, prevention, and the ramifications of suicide in Native Communities. In addition, the IHS Health Promotion and Disease Prevention (HPDP) program is holding the Northwest Regional Youth Summit, which is promoting suicide prevention awareness, in Eugene, Oregon, on June 20-22, 2006.
- Utilize Tribal colleges to provide suicide prevention trainings and programs. For example: IHS staff have provided technical assistance to the Ft. Peck community to create a suicide prevention program where Tribal college students will be recruited as positive adult mentors for youth in response to increased suicide rates in that community. The Aberdeen Area has also collaborated with the United Tribes Technical College to provide clinicians, community paraprofessionals and laypersons with an online community suicide prevention workshop which is centered on public health mobilization models.
- Provide workshops and forums on suicide prevention. For example, the IHS National Suicide Prevention Network (NSPN) provided \$25,000 to each of the 4 areas with the highest rate of suicides (Aberdeen, Bemidji, Alaska and Tucson) to provide Area wide suicide prevention trainings to I/T/Us.
- Also, suicide prevention programming is being offered at the 4th annual IHS/SAMHSA National Behavioral Health Conference to be held in San Diego, June 6-8. It is the largest annual

gathering of behavioral health personnel in Indian Country and serves to disseminate the latest information on suicide prevention programs nationally. This year, youth attending Tribal colleges and universities (TCUs) are being specially sponsored to attend this conference.

- Promote innovative training and service programs to offer communities direct intervention capabilities they would otherwise not have. The Alaska Behavioral Health Aide Program, which is designed to offer services in very remote and isolated locales, has incorporated specific suicide prevention programming into their core training curriculum.
- Provide American Indian and Alaska Native communities with culturally appropriate information about best and promising practices and training for suicide prevention and intervention. The IHS National Suicide Prevention Network (NSPN) has developed a community suicide prevention website or "tool kit", which will be available on line next month.
- Health Promotion/Disease Prevention (HPDP) has developed a web-based clearinghouse to disseminate best practices, resources, training opportunities, and effective health promotion and disease prevention for I/T/Us and Tribal community organizations. Community health assessment tools and IHS Area health profiles are being developed to identify risk factors, including those for suicide, in order to create effective programming and interventions.

IHS is collaborating with the 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. While we have increasingly more accurate prevalence data, as in the IHS RPMS reporting system, and SAMHSA's National Survey on Drug Use and Health (NSDUH), and Drug and Alcohol Services Information System (DASIS), substantive programmatic and evaluative research is still very limited. Additionally, what research is available suggests suicide in our communities differs in substantial ways from other populations.

After three years of international planning and collaboration, the Indigenous Suicide Prevention Research and Programs in Canada and the U.S. Conference was held in Albuquerque, NM, February 7-9, 2006. It was the first time a conference was held to specifically address the research needs among First Nations, Inuit and American Indians and Alaska Natives regarding suicide and suicide prevention. The IHS collaborated with the National Institute of Mental Health (NIMH) and Health Canada to facilitate this international conference with representatives from the

National Congress of American Indians (NCAI), the Assembly of First Nations (AFN), the Inuit Tapariit Kanatami (ITK), U.S. Territories, Indigenous researchers, clinicians, program personnel, wisdom-keepers, and community members. Over 200 international participants met to share current programs and methodologies and develop a concrete research agenda and specific programs for Indigenous populations.

These research agendas, clinical programs, and community mobilization efforts are all driven and evaluated using data. IHS has spent \$4,000,000 over the last four years on system wide improvements to its Behavioral Health Management Information System (BH-MIS), including a comprehensive upgrade of its patient information and documentation systems, as well as programs and personnel to support clinics and Tribes using them. In fiscal year '05, the most recent upgrade to the Resource and Patient Management System (RPMS) behavioral health patient care system and the completely digital Suicide Reporting Form were deployed as an integrated part of the Behavioral Health Management Information System (BH-MIS) Resource and Patient Management System (RPMS) Package. 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 and create more effective programs. The system is now deployed and in operation in over 250 clinical sites across the country.

For the first time, far more accurate data are being gathered and shared from individual clinicians to communities, and with national policy makers and programs. The data on prevalence in this testimony, for example, came directly from the information gathered via the IHS Behavioral Health Management Information System (BH-MIS). No longer are we estimating or extrapolating, because we now have representative information for the country and communities affected.

Future activities involve continued upgrading of the Behavioral Health Management Information System (BH-MIS). The new Electronic Health Record will, for the first time, fully integrate behavioral health and medical patient documentation in a single electronic chart. Telehealth technology is also being developed using the Behavioral Health Management Information System (BH-MIS) to provide direct clinical services, as well as sharing patient care documents and electronic charts across wide geographic areas in realtime. This will be primarily to support distant psychiatric services to remote communities where such services are not available now. Aberdeen, Alaska, Albuquerque,

and Phoenix areas are already using these technologies as a cost effective method to delivering high quality, specialized psychiatric services over vast, remote areas.

Finally, the IHS has established a National Suicide Prevention Network, composed of at least one person from each IHS Area. During 2005, the NSPN project provided suicide prevention skills training to approximately 20 NSPN team members and 370 community members, who were mostly youth (ages 15-21), in Albuquerque, NM, Billings, MT, Ft. Yates, ND, and Red Lake, MN. In 2006, IHS allocated \$300,000 to carry the NSPN project forward. The NSPN project is providing (1) suicide prevention services/trainings to a minimum of 7 communities in crisis or in need of suicide prevention services; (2) at least one Area wide suicide prevention training for each of the 4 IHS Areas with the highest rates of suicide (Aberdeen, Alaska, Bemidji, and Tucson Areas); and (3) one or more suicide prevention trainings for NSPN team members to continue to build capacity. Some of the communities that are receiving assistance to date include:

1. Red Lake Tribe
2. Standing Rock Tribe
3. Crow Creek Sioux Tribe
4. Gros Ventre (pronounced Gro Von) and Assiniboine Tribes at Ft. Belknap,
5. Ft. Peck Assiniboine and Sioux Tribes,
6. Omaha, Winnebago, and Santee Tribes of NE,
7. To'hono Odham, Pasqua Yaqui, and the Supai Tribes of AZ,
8. Alaska Native Tribal Health Corporation.

So, taken all together, where are we?

I think we are still 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. 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 these young people 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 suicide prevention programs in Indian country. I will be happy to answer any questions that you may have.