Indian Health Service
and
Substance Abuse and Mental Health Services Administration
National Conference

"Expanding Partnerships to Meet Substance Abuse Prevention & Treatment Challenges in AI/AN Communities"
June 8-10, 2004
San Diego, California

Opening Remarks
"Behavioral Health Strategies in IHS"
by
Charles W. Grim, D.D.S., M.H.S.A.

Assistant Surgeon General
Director, Indian Health Service
June 8, 2004

Good Morning. It is a pleasure to be here today at the fourth annual national meeting of the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Time, commitment, dedication and collaboration are some of the main functions that have contributed to today's event becoming a reality. In 1999 collaboration began with a vision. In 2000 our first collaborative effort was between the Center for Substance Abuse Treatment and the Indian Health Service, where over 70 people attended the "Provision of Treatment in Rural and Frontier Regions: Special Focus on Delivery of Services to Native Populations", involving 14 states. The second opportunity occurred in Chandler, Arizona where over 130 participants attended a conference titled "Services to Native Populations in Rural and Frontier Regions". It was decided at that conference that IHS should take the leadership role for the future conference. As a result of that recommendation, IHS expanded the conference to 35 reservation states, and SAMHSA included 35 state treatment directors and 35 state prevention directors. This marked a significant and critical benchmark in the expansion of collaboration. The planning committee went from a few to over 24 members representing Tribal Leaders, Urban Programs, American Indian organizations, State Directors from both Prevention and Treatment, and SAMHSA and IHS professional staff and directors. That conference resulted in 278 participants. Cooperation, collaboration and commitment have brought us here today. There are over 400 participants at this week's event. I commend the planning committee for IHS and SAMHSA and the IHS Behavioral Health planning committee for making this conference possible today.

I will share with you today some general information about our current and planned activities in the area of health promotion and disease prevention and some specific information on behavioral health programs in the IHS.

The goal of the Indian Health Service is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians and Alaska Natives. In the provision of health services, the IHS employs a holistic approach to medical treatment, addressing not only the physiological needs of the patient, but also their social, spiritual, and mental health.

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Current health problems among American Indians are strongly associated with factors that contribute to a social environment that challenges Indian people in making healthy lifestyle and behavioral choices. These factors include adverse consequences from poverty, inadequate education, high rates of unemployment, rural isolation, racial discrimination, eroding of traditional cultural and family support systems, and dislocation from their cultural heritage and tribal support system when living in urban, non-Indian communities. Unhealthy choices such as substance abuse, harmful sexual activity, and desperate acts of suicide, homicide, and risk-taking behaviors, can result in high rates of personal injuries and contribute to the beginnings of chronic diseases.

One factor in maintaining the capacity to make healthy choices is the mental health of the individual. Mental illness is one of the top disease burdens worldwide. Among American Indians and Alaska Natives, the need is especially acute. The prevalence of serious mental illness among adult American Indians and Alaska Natives is over 1½ times the rate for the overall U.S. population. The suicide rate for Indian people is the highest of all major ethnic groups and twice that of the general population. And the rate in individual communities can reach devastating highs. For example the suicide rate in Alaska communities is almost 4 times that for the general population, and among Alaska Native males 15-24 years old, it is 14 times the national average.

Mental illness affects many aspects of overall health status. Many studies have shown a high correlation between mental illness and substance abuse, and a clear link between mental illness and cultural alienation or displacement. An interrelationship of factors such as injury, poverty, low educational status, drug abuse, cultural alienation and depression justify the need for a comprehensive, multi-disciplinary approach to respond to lifestyle issues that contribute to chronic disease and poor health status.

The importance of community input, ownership, and control of health promotion programs in the IHS, Tribal and Urban health system cannot be overemphasized. Studies on primary prevention show that the most important predictor of the effectiveness of a prevention intervention is the degree of community ownership and control. Studies have also shown that establishing culturally relevant health programs at the community level is more effective than having a generic program imposed on a community.

To this end, the IHS has developed, and continues to support, partnership programs for training community leaders and community members in wellness planning and motivation skills, so they can develop their own plans based on local priorities, needs, and resources.

Over the last several years, IHS has shifted its strategic focus in the area of behavioral health. Currently over 97% of the Alcohol and Substance Abuse budget and 80% of the overall Mental Health and Social Services budget now go directly to Tribes operating programs under Indian Self-Determination Act awards. This trend of tribes taking responsibility for their own programs has resulted in IHS redirecting our priorities in the area of behavioral health from providing direct services to supporting tribes delivering those services.

An IHS shift in strategic focus began in fiscal year 2004, after tribal consultation, and a detailed analysis of the continued trend toward tribal contracting and compacting, funding patterns, statutory responsibilities, and national service delivery across the treatment and prevention spectrum. A five year strategic plan was developed and the resulting focus areas reflect these changes.

I will highlight a few of the key focus areas of the strategic plan: Leadership development is a key success factor in the advocacy of behavioral health issues in Indian communities. Communities must first identify local leaders and utilize them as educators and as representatives on local, regional and national committees. Leadership must include those qualities and characteristics that support the cultural values of their respective communities and provides positive role models for substance abuse healing and recovery.

Partnerships and collaborations are also key focus areas. Channeling more resources and health program efforts into behavioral health services and programs is an obvious need. But what is also desperately needed in Indian Country is a multi-faceted, partnership approach that brings together many federal and private resources to deal with the underlying issues of poverty, educational opportunity, cultural preservation, discrimination, and unemployment that challenge the mental health of Indian people.

One example of an important collaboration is the Memorandum of Understanding (MOU) between the United States and Canada, signed in May 2002, to further collaborative efforts between our two countries specifically centered on Native health. Suicide prevention has been chosen as one of the primary areas for direct collaborative efforts under this MOU.

A second example is the Indian Health Service's Children and Youth Initiative, which, in partnership with the Administration for Native Americans, will fund 22 children and youth grant projects over the next 3 years.

A third focus area is Data Development and the Electronic Health Record. The deployment of the IHS Electronic Health Record is one of the major information technology priorities for 2005. The Electronic Health Record of the Resource and Patient Management System (RPMS) builds on the IHS's 20-year record of maintaining

a database of patient-centered clinical information in the interest of improved quality of care and public health. It is the product of a partnership with the Veterans Administration and collaboration with them on the development of their Computerized Patient Record System. Our Electronic Health Record will help us address a number of critical issues, such as improved patient safety through direct provider order entry; risk reduction through improved and more legible documentation; protection of private health information through electronic security; improved quality of care through clinical decision support; and improved cost recovery through better documentation of services provided. By the end of this year there will be 20 sites using it, and by 2008 all of our health facilities will use the Electronic Health Record.

The RPMS has received high marks from the Department and the Office of Management and Budget's Program Assessment and Rating Tool analysis for its value in supporting the mission of the IHS, and the Electronic Health Record makes the RPMS database more accessible and useful to providers, nurses, and other users, allowing them both to retrieve and enter clinical information at the point of care.

The Tribes have identified data collection as their first strategic goal in developing the necessary infrastructure to address mental health issues. In order to know best where to direct scarce resources and in order for the IHS to be able to represent their needs, comprehensive and reliable mental health data on American Indians and Alaska Natives must be available. To this end, beginning in 2002, the IHS has dedicated $1 million a year for 5 years to directly address the need for behavioral health software development and infrastructure development. So far, an integrated system of behavioral health data collection software packages is being deployed this year with improvements scheduled for deployment through 2005. These systems are comprehensive patient management software packages. At the clinic and community level, the software will provide for digitized patient documentation, trending capabilities for clinical service decision-making, and the production of third-party revenue to help sustain and enhance health services. At the federal level, the software will provide much more accurate and reliable data about the behavioral health problems and treatments in American Indian and Alaska Native communities. The IHS and HHS can use these data to help Tribes seek increased resources from Federal and private sources, and to better represent Indian Country at all levels of government.

The goal of these and other IT investments is to improve health delivery, patient safety, and reduction of medical errors.

Educational levels are another factor in the overall status of mental and physical health. Unfortunately, in the last decade, only 66 percent of Native American students graduated from high school, compared to 75 percent for the general population. Studies have shown that minority students do best in educational environments that support and recognize their cultural identities. Decreasing drop-out rates by providing culturally competent educational programs and providing scholarship opportunities for higher education are helping Indian youth grow into successful and mentally healthy adults. Educational levels are closely tied to poverty levels, which are closely tied to mental health status, which impacts on overall health status. This obvious interrelationship of factors contributing to poor health status makes it imperative to address the entire continuum of socio-economic factors impacting on health.

Recognizing the tragic effects of suicide in American Indian and Alaska Native communities, the IHS has established an initiative to specifically address the issue of suicide prevention. The IHS is supported in this effort by the Department of Health and Human Services' development of a National Strategy for Suicide Prevention, which is founded on 11 goals and objectives for the nation to reduce suicide and its devastating consequences to families and communities. The IHS initiative will build on this foundation, while ensuring that we honor and respect the traditions and cultural practices of the American Indian and Alaska Native people and communities served by the agency. To support the suicide prevention initiative, the IHS is finalizing the implementation of a suicide information management system that will contain more and better data about suicide among Indian people. This information can be used to help focus our current suicide prevention efforts, identify trends earlier, and to determine future funding and program needs.

Finally, in the area of treatment, the IHS currently has 12 Youth Regional Treatment Centers that address substance abuse issues through culturally appropriate treatment approaches for Indian youth between the ages of 12-18. They also incorporate an education component, and families or caregivers are an essential part of the treatment process.

In summary, to end the devastating cycle of despair among Indian people, the Indian health system must continue to work in unison with other Federal agencies and private foundations, universities, and organizations to bring all possible resources to bear on Indian health issues. Health status is not determined just by the availability of health services. It is the result of an interwoven tapestry of factors such as socioeconomic status, educational status, community and spiritual wellness, cultural and family support systems, and employment opportunities, to name a

few. The IHS, Tribes, and urban Indian health organizations have begun to weave a network of support systems and partnerships that will help to address all these contributory factors to the health and well-being of American Indians and Alaska Natives. Through partnerships with American Indian and Alaska Native people, opportunities and options to make healthy lifestyle and behavior choices will be increased.

Thank you for the opportunity to speak with you today, and for your participation in this important conference.

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