

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

On

"THE PREVENTABLE EPIDEMIC: YOUTH AND THE
URGENT NEED FOR MENTAL HEALTH CARE RESOURCES
IN INDIAN COUNTRY"

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STATEMENT OF THE INDIAN HEALTH SERVICE
FOR THE OVERSIGHT HEARING
ON YOUTH AND THE URGENT NEED FOR MENTAL HEALTH CARE
RESOURCES IN INDIAN COUNTRY

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Mr. Chairman and Members of the Committee:

Good morning, I am Randy Grinnell, Deputy Director of the Indian Health Service (IHS). I am accompanied by Rose Weahkee, Ph.D., Director, Division of Behavioral Health. Today, I appreciate the opportunity to testify on youth and mental health care resources in Indian Country. Access to mental health care services is an important component of fostering well-being in American Indian and Alaska Native communities.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services because it is a health care system that was established to meet the federal trust responsibility to provide health care to American Indians and Alaska Natives. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban

operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The IHS has the responsibility for the delivery of health services to an estimated 1.9 million federally-recognized American Indians and Alaska Natives. 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 duty 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 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 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 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 also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for people, and the construction, replacement, and repair of healthcare facilities.

This week, the President signed the Patient Protection and Affordable Care Act, the health insurance reform bill passed by Congress. This new law permanently authorizes the IHCIA. In addition to the many improvements made to the Indian health system, the law authorizes a comprehensive youth suicide prevention effort as part of the behavioral health services. I want to acknowledge Chairman Dorgan's leadership on this issue, and the Committee's effort to improve access to health care for American Indians and Alaska Natives.

Background

Suicide is a complicated public health challenge with many contributing risk factors. In the case of American Indians and Alaska Natives, they face, on average, a greater number of these risk factors individually or the risk factors are more severe in nature for them. Every year, several communities in Indian Country experience crisis episodes during which suicides take on a particularly ominous and seemingly contagious form, often referred to as suicide clusters. In these communities, the suicidal act becomes a regular and transmittable form of expression of the despair and hopelessness experienced by some Indian youth. While most vividly and painfully expressed in these communities, suicide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including urban communities. Access to adequate care is critical for those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts.

IHS "*Trends in Indian Health, 2002-2003*" reports:

- The American Indian and Alaska Native suicide rate (17.9) for the three year period (2002-2004) in the

IHS service areas is 1.7 times that of the U.S. all races rate (10.8) for 2003.

- Suicide is the second leading cause of death (behind unintentional injuries) for Indian youth ages 15-24 residing in IHS service areas and is 3.5 times higher than the national average.
- Suicide is the 6th leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide.
- American Indian and Alaska Native young people ages 15-34 make up 64 percent of all suicides in Indian Country.

On a national level, many American Indian and Alaska Native communities are also affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.¹ Significant health disparities among American Indians and Alaska Natives exist across the spectrum of substance abuse problems. The most current IHS health data statistics indicate:

¹ Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives*. National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

- Alcohol-related age-adjusted mortality rate (43.7) for years 2002-2004 for AI/AN in the IHS service areas as compared to the US all races rate (7.0) for the year 2003.²
- Drug-related age-adjusted mortality rate (15.0) for years 2002-2004 for AI/AN in the IHS service areas as compared to the US all races rate (9.9) for the year 2003.³
- NOTE: Rates are per 100,000 population and are adjusted to compensate for misreporting of American Indian and Alaska Native race on the state death certificates.

According to a 2001 mental health supplement report of the U. S. Surgeon General, "Mental Health: Culture, Race, and Ethnicity", there are limited mental health services in Tribal and urban Indian communities.⁴ While the need for mental health care is great, services are lacking, and

² US Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p. 91.

³ US Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p. 196.

⁴ U.S. Department of Health and Human Services. (2001). *Mental Health: Cultural, race, and ethnicity supplement to mental health: Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

access to these services can be difficult and costly.⁵ The current system of services for treating mental health problems of American Indians and Alaska Natives is a complex and often fragmented system of tribal, federal, state, local, and community-based services. The availability and adequacy of mental health programs for American Indians and Alaska Natives varies considerably across communities.⁶ American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and in-patient facilities.⁷

Addressing Mental Health Care Resources in Indian Country

IHS and Substance Abuse and Mental Health Services Administration (SAMHSA) work closely together to formulate long term strategic approaches to address the issue of suicide and mental health care in Indian Country more effectively. For example, IHS and SAMHSA are actively involved on the Federal Partners for Suicide Prevention Workgroup. In 2001, the Office of the Surgeon General coordinated the efforts of numerous agencies, including IHS, SAMHSA, Centers for Disease Control and Prevention

⁵ Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives*. National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

⁶ Ibid.

⁷ Ibid.

(CDC), National Institute for Mental Health (NIMH), Health Resources and Services Administration (HRSA), and other public and private partners to develop the first, comprehensive, integrated, public health approach to reducing deaths by suicide and suicide attempts in the United States in the National Strategy for Suicide Prevention. This resulted in the formation of the ongoing Federal Partners for Suicide Prevention Workgroup.

Currently, in partnership with tribes, IHS is developing strategic plans to address suicide and behavioral health for the Indian health system. These strategic plans will foster collaborations among Tribes, Tribal organizations, Urban Indian organizations, and other key community resources. These collaborations will provide us with the tools we need to adapt the shared wisdom of these perspectives, consolidate our experience, target our efforts towards meeting the changing needs of our population, and develop the framework that will serve to pave the way over the coming years to address suicide and behavioral health in Indian Country.

The IHS is responsible for providing mental health services to the American Indian and Alaska Native population it

serves. The IHS Mental Health/Social Service (MH/SS) program is a community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Many of the IHS, Tribal, and Urban (I/T/U) mental health programs that provide services do not have enough staff to operate 24 hours/7 days a week. Therefore, when an emergency or crisis occurs, the clinic and service units will often contract out such services to non-IHS hospitals and crisis centers.

There are many reasons for a lack of access to care. Indian Country is predominantly rural and remote, and this brings with it the struggles of providing support in settings where appropriate local care may be limited. Rural practice is often isolating for its practitioners. The broad range of clinical conditions faced with limited local resources challenge even seasoned providers. Some providers are so overwhelmed by the continuous demand for services, particularly during suicide outbreaks, that even

well-seasoned and balanced providers become at-risk for burn-out.

For example, there are situations where the appropriate treatment is known, such as counseling therapy for a youth survivor of sexual abuse, but there are simply no appropriately trained therapists in the community. One of our IHS Area Behavioral Health Consultants told me recently that there was only one psychiatrist in her half of a large Western state attempting to serve both the Indian and non-Indian population. Despite years of effort, the IHS Area Office had been unsuccessful in recruiting a fulltime psychiatrist to serve the tribes in that region.

Over the years, we have attempted to apply a number of remedies to these problems including adopting special pay incentives in order to make reimbursement packages more competitive, making loan repayment and scholarship programming available for a wide range of behavioral health specialties including social work, psychology, and psychiatry, along with active recruitment, development of the Indians into Psychology program, and emergency deployment of the United States Public Health Service Commissioned Corps.

Methamphetamine and Suicide Prevention Initiative

The IHS received an appropriation in the amount of \$13.782 million in FY 2008, an increase of \$2.609 million in FY 2009, and \$16.391 million in FY 2010 for a national initiative to support the development of pilot projects for model practices for methamphetamine and suicide reduction programs in Indian Country.

The Methamphetamine and Suicide Prevention Initiative (MSPI) implemented by IHS and its tribal partners nationally, marks a significant milestone in suicide prevention efforts in Indian Country as well as tribal/federal partnerships for health that embraces the Administration's commitment to tribal engagement and partnership.

MSPI now supports 129 community developed prevention and intervention pilot programs across the country. Each program represents partnerships between tribal communities and programs and the IHS, to develop, implement, and disseminate promising prevention and treatment service programs nationally.

To create the overall MSPI approach, IHS engaged in close collaboration with Tribes and Tribal Leaders over the course of almost a year. During this time, we crafted a model, and the IHS accepted all of the Tribal Leaders' recommendations for approaches and funding allocations with only minor adjustments for disbursement methodologies. It was and remains a creation of close collaboration and partnership with Tribes.

It is a new program focusing on suicide and substance abuse in Indian Country. The program is completely community driven from conception through execution for each program in each community. Indian communities decide what they need and establish programs to meet those needs.

Indian Tele-health Based Behavioral Health Services

IHS recognizes the need to support access to services and to create a broader range of services tied into a larger network of support and care. As evidenced by the Alaska experience, where there are often no workable options other than tele-health based behavioral health services, we know such services work and are acceptable to many if not all of our clinic populations. As another example, a Southwest tribe has been providing child and youth-specific tele-

behavioral health services for the past two years and has achieved a show rate of >95% for scheduled appointments. This is an outstanding rate when other clinics with face to face provider availability only achieve a 65-70% show rate.

As a system of care, tele-health based behavioral health services are either actively being used or in planning stages for over 50 Indian health system sites (both tribal and federal). They include a range of programming, from a broad variety of mental health services, to specific and intermittently available services such as child psychiatry consultations. Services are being delivered in a range of settings including clinics, schools, and youth treatment centers. Only within the past five years has the telecommunications infrastructure, in some locations, become available and reliable enough to be used routinely for clinical care. The lack of infrastructure is a significant issue for many tribal communities.

MSPI dollars in the amount of \$863,000 are also being used to establish a National Tele-Behavioral Health Center of Excellence. An intra-agency agreement was signed in early August 2009 with our Albuquerque Area Office, which has agreed to take the lead on establishing a national center

to promote and develop tele-health based behavioral health services. They are working in partnership with a number of regional entities including the University of New Mexico and the University of Colorado. The University of New Mexico Center for Rural and Community Psychiatry is a leader in the use of tele-health technologies in rural settings. The University of Colorado Health Sciences Center and the VA Eastern Colorado Healthcare System are leaders in tele-health outreach to veterans including Indian veterans in the northern Plains, the State of New Mexico, and the Tribes and Pueblos of the region. Services are provided to a number of settings including school clinics, youth residential treatment centers, health centers, and others. They hope to leverage their ability to use federal service providers and provide technical and program support nationally to programs attempting to implement such services.

We have been tracking visits to behavioral health clinics using tele-health technology, and have preliminary indications that IHS programs are increasingly adopting and using these technologies. Tele-behavioral health services require adequate and reliable bandwidth if they are to be sustainably implemented. Increasing bandwidth utilization

strains the telecommunications infrastructure. IHS was fortunate enough to be the recipient of ARRA funding to improve our telecommunications infrastructure which will increase the reliability and availability of appropriate bandwidth across the Indian healthcare system. Approximately \$19 million of our Health Information Technology ARRA funding will be spent to provide new routers, switches, and basic telecommunications infrastructure to ensure current needs are met, as well as improve our ability to prioritize traffic over the network. ARRA funding is also supporting a mass procurement of state-of-the-art clinical videoconferencing equipment that will be distributed to Tribal, Urban, and Federal care sites depending on need later this fall. We are working to improve access to videoconferencing and bandwidth capacity to strengthen our telecommunications infrastructure. As one of our providers who is active in telemedicine told us recently, "My patients are very patient and are willing to tolerate surprisingly bad connections. But when my image freezes up with regularity I may as well be using the telephone." We are investing in the infrastructure expansion, support, and maintenance needed to keep pace with potential service demands and to plan for the long

term success of this and any new Indian tele-mental health effort.

We see many benefits to the use of telemedicine for the treatment of youth suicide. This technology promises to connect widely separated and often isolated programs of varying sizes together in a web of support. Whereas small clinics would need to develop separate contracts for services such as child and adult psychiatric support, pooling those needs in a larger pool provides potential access to a much larger array of services, and does so more cost-effectively and more conveniently for patients. Such a system could potentially move some clinics that are available every other Friday afternoon for 4 hours to systems where clinic time for assessments is available whenever the patient presents. This could translate into 24/7 access to emergency behavioral health service in any setting with adequate telecommunications service and rudimentary clinic staffing.

Such a system has other desirable consequences such as opportunities for mutual provider support. For example, currently when psychiatric providers take vacation, are on sick leave, or are training in places where they are the

sole providers, there are often either no direct services at that clinic for that time period, or a temporary doctor with limited understanding of the clinic is hired to provide services. Sufficient services could be provided via tele-health connections to reduce or eliminate discontinuities in patient care and do so at significantly less expense. Providers with particular specialty interests can share those skills and knowledge across a broad area even if they themselves are located in an isolated location. Burn out due to professional isolation is also decreased as videoconferencing readily supports clinical supervision and case management conferences. Universities providing distance-based learning opportunities have demonstrated for years that educational activities can also be facilitated by this technology. Families can participate in care even when at a distance from their youth, promoting improved contact and better resolution of home environmental concerns which is often the key issue in a youth transitioning successfully from a residential program to home. Recruitment becomes less problematic because providers can readily live and practice out of larger urban or suburban areas and are thus more likely to continue in service over time with sites. The resulting pool of providers accessible for hiring could

also increase because relocation to an isolated location may not be necessary. Such services would require behavioral health providers including psychiatrists, psychologists, clinical social workers, and therapists in addition to the tele-mental health technology.

Activities, including the National Tele-Behavioral Health Center of Excellence funded by the MSPI, will also help us understand how to effectively deliver such services, and in particular, will provide more focused experience in providing services to Indian youth. We believe tele-behavioral programs can become an integral part of the IHS behavioral health services, strengthen our clinical expertise in using tele-health services, and expand access to needed behavioral healthcare. We are working to augment the ability of the IHS Tele-Behavioral Health Center of Excellence to promote and support such services across the Indian health system.

IHS FY 2011 Budget Request for Mental Health Services

The FY 2011 budget request for Mental Health is \$77,076,000; an increase of \$4,290,000 over the FY 2010 enacted level. This increase represents: increases of \$748,000 for Federal and Tribal pay increases; increases of

\$748,000 for non-medical inflation of 1.5 percent; population growth increases of \$1.092 million, and increases of \$1,702,000 for staffing/operation costs for new/expanded facilities. We strive to support American Indian and Alaska Native communities eliminating behavioral health diseases and conditions by: 1) maximizing positive behavioral health and resiliency in individuals, families, and communities; 2) improving the overall health care of American Indians and Alaska Natives; 3) reducing the prevalence and incidence of behavioral health diseases; 4) supporting the efforts of American Indian and Alaska Native Communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention for individuals and their families; 5) supporting Tribal and Urban Indian behavioral health treatment and prevention efforts; 6) promoting the capacity for self-determination and self-governance, and; 7) supporting American Indian and Alaska Native communities and service providers by actively participating in professional, regulatory, educational, and community organizations at the National, State, Urban, and Tribal levels.

IHS FY 2011 Budget Request for Alcohol and Substance Abuse Services

The Alcohol and Substance Abuse Program (ASAP) exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in American Indian and Alaska Native communities. The FY 2011 budget request for Alcohol and Substance Abuse is \$205,770,000; an increase of \$11,361,000 over the FY 2010 enacted level. This increase represents: increases of \$1,840,000 for Federal and Tribal pay increases; increases of \$2,605,000 to fund the costs of providing health care and related services; population growth increases of \$2,916,000, and; increases of \$4,000,000 for a grant program to expand access to and thereby improve the quality of treatment for substance abuse treatment services by hiring additional qualified and trained behavioral health counselors and other addiction specialists to enhance substance abuse care in Federal, Tribal, and Urban facilities. The purpose of the IHS Alcohol and Substance Abuse Program is to raise the behavioral health status of American Indians and Alaska Natives to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. These programs provide alcohol and

substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The Alcohol and Substance Abuse Program exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in American Indian and Alaska Native communities.

SAMHSA's Role in Addressing Youth Suicides

American Indian and Alaskan Native tribes also look to SAMHSA for help in addressing youth suicides. Through its Garrett Lee Smith State and Tribal Grants, 20 American Indian and Alaskan Native tribes or tribal organizations have received grants ranging from \$400,000 to \$500,000 a year to prevent suicide. This represents 31% of all grants given out in the last four years under this program. In addition SAMHSA:

- Funds the Native Aspirations project which is a national project designed to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts. Through the Native Aspirations project, a total of 25 American Indian and Alaska Native communities determined to be

the most "at risk" develop or enhance a community-based prevention plan.

- Supports the Suicide Prevention Resource Center (SPRC) which is a national resource and technical assistance center that advances the field by working with states, territories, tribes, and grantees and by developing and disseminating suicide prevention resources.
- Funds the National Suicide Prevention Lifeline, a network of 141 crisis centers across the United States that receives calls from the national, toll-free suicide prevention hotline number, 800-273-TALK.

The National Suicide Prevention Lifeline's American Indian initiative has worked to promote access to suicide prevention hotline services in Indian Country by supporting communication and collaboration between tribes and local crisis centers as well as providing outreach materials customized for each tribe.

In summary, we look forward to opportunities to address the mental health care needs in Indian Country. We are committed to using available technologies including our growing national telecommunications infrastructure to help increase access to sorely needed behavioral health

services. For the Indian Health Service, our business is helping our communities and families achieve the highest level of wellness possible.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify. I will be happy to answer any questions that you may have.