Testimony
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SAMHSA's Efforts to Provide Mental Health and Substance Abuse Services to American Indians and Alaska Natives

Statement of

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Mr. Chairman and Members of the Committee, good morning. I am Kathryn Power, Director of the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA). I am pleased to offer testimony this morning on behalf of Charles G. Curie, Administrator of SAMHSA, an agency of the U.S. Department of Health and Human Services (HHS). Thank you for the opportunity today to describe how SAMHSA is working to provide effective mental health and substance abuse treatment services along with substance abuse prevention and mental health promotion services in Indian Country.

It is also a privilege to testify along with Dr. Charles Grim, Director of the Indian Health Service (IHS) this morning. SAMHSA and IHS have developed a strong partnership reflected in our current Intra-Agency Agreement to work efficiently and effectively together to help meet the public health needs of American Indians and Alaska Natives.

My testimony will focus on two issues of great concern to the public health of American Indian and Alaska Native youth. These two issues are suicide and violence. Sorrowfully there are real-life examples to illustrate the impact of suicide and violence in Indian Country.

Suicide Among American Indian and Alaska Native Youth

Recently, a suicide cluster occurred on the Standing Rock Reservation, in North Dakota and South Dakota. Eight young people took their own lives and dozens more

attempted to do so. Tragically, many other reservations have similar stories to tell. Suicide is now the second-leading cause of death (behind unintentional injury and accidents) for American Indian and Alaska Native youth aged 15-24. The suicide rate for this population is 250 percent higher than the national average. American Indians have the highest rate of suicide among all ethnic groups in the United States, with a rate of 14.8 per 100,000 as reported in 1998. Rates were highest in Tucson, Arizona and Alaska Areas — five to seven times higher than the overall U.S. rates. More than one-half of all persons who commit suicide in Indian communities have never been seen by mental health providers.

In studies that examine risk factors among people who have completed suicide, substance abuse occurs more frequently among youth and younger adults, compared to older adults. For particular groups at risk, such as American Indians and Alaska Natives, depression and substance abuse are the most common risk factors for completed suicide. Mental health and substance abuse disorders are also risk factors for violence.

Violence Among American Indian and Alaska Native Youth

According to the National Center for Injury and Prevention Control within the Centers for Disease Control and Prevention (CDC), injuries and violence account for 75% of all deaths among Native Americans ages 1 to 19. As I mentioned earlier, suicide is the

second-leading cause of death for Indian youth aged 15-24, followed by homicide, the third-leading cause of death for the same age group.

A recent example of violence in Indian Country is the tragedy at Red Lake. A 16-year-old junior at the Red Lake high school in Red Lake Minnesota took the lives of nine others and then his own. On March 21, 2005, the 16-year-old shot and killed his grandfather, his grandfather's partner, five students, a teacher, a security officer, and himself.

The statistical picture on the Red Lake reservation, home to about 5,000 Tribal members, is even bleaker than the national average. Red Lake Nation is an impoverished community. Thirty-nine percent of the population lives below the poverty line; 4 out of 5 students at Red Lake High school qualify for free or reduced fee lunch. A third of the teenagers on this reservation are not in school, not working, and not looking for work, compared with about 20 percent on all reservations. A survey last year by the Minnesota Departments of Health and Education found that young people on the Red Lake reservation are far more likely to think about suicide, be depressed, worry about drugs, and be violent with one another than children across the State. A state survey of ninth graders found that at Red Lake High, 43 percent of boys and 82 percent of girls had thoughts about suicide, with 20 percent of boys and 48 percent of girls saying that they had tried it at least once. This event has led to community trauma and turmoil. In response, SAMHSA has sent several staff on-site to coordinate services and technical assistance in collaboration with IHS and other HHS components, including

the Office of Intergovernmental Affairs within the Office of the Secretary, the PHS Commissioned Corps, the Administration for Children and Families (ACF) and its Administration for Native Americans, and the Office of Minority Health, as well as the State of Minnesota and the Tribe. The Child Trauma program within CMHS is available to assist, and counseling services have been set up and are being provided in this acute phase.

SAMHSA became a part of a major interagency effort to support the needs of the Red Lake Reservation. Planning in the initial phase established a coordinating and decision making process to assess the needs of and provide support for the communities involved. SAMHSA staff was immediately deployed to Red Lake to assist in the early phases of crisis care. This involved support of the health care team, educational programs, social services, Tribal council, and community at large. SAMHSA staff also provided technical assistance to the Tribe in an effort to help them access emergency funds, especially those funds available though the SAMHSA Emergency Response Grant (SERG) grant mechanism.

SAMHSA's Role in Better Serving American Indian and Alaska Native Populations

SAMHSA focuses attention, programs, and funding on improving the lives of people with or at risk for mental or substance use disorders. Consistent with President Bush's New Freedom Initiative, SAMHSA's vision is "a life in the community for everyone." The Agency is achieving that vision through its mission "building resilience and facilitating

recovery." SAMHSA's direction in policy, program and budget is guided by a matrix of priority programs and crosscutting principles that include the related issues of cultural competency and eliminating disparities.

To achieve the Agency's vision and mission for all Americans, SAMHSA-supported services are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. SAMHSA has put this understanding into action for the American Indian and Alaska Native communities it serves. It is important to note also that it is the SAMHSA Administrator's policy to level the playing field and to ensure that Tribal entities are eligible for all competitive grants for which States are eligible, unless there is a compelling reason to the contrary. In total, SAMHSA provides about $42 million to American Indians and Alaska Natives annually.

CMHS is transferring $200,000 to IHS to support programming and service contracts, technical assistance, and related services for suicide cluster response and suicide prevention among American Indians and Alaska Natives. One example is the development of a community suicide prevention "toolkit". This toolkit will include information on suicide prevention, education, screening, intervention, and community mobilization, which could be readily available to American Indian and Alaska Native communities via the Web and other digitally based media for "off the shelf" use.

To better assist Tribal organizations, SAMHSA funded a $1 million grant that was

awarded to the Oregon Health and Science University to establish the One Sky Center - an American Indian and Alaska Native National Resource Center. The One Sky Center provides technical assistance, training, information dissemination, and communication to increase substance abuse prevention and treatment knowledge and skills among service providers, policy makers, Tribal communities, funding organizations, and consumers. Today, the One Sky Center is a National Resource Center that, in addition to its many other services, maintains a comprehensive list of American Indian and Alaska Native programs that are currently funded by SAMHSA.

The Screening and Brief Intervention and Referral to Treatment (SBIRT) and Access to Recovery (ATR) programs are designed to intervene and provide treatment alternatives for individuals who require substance abuse treatment. These programs are available to Tribal organizations.

SAMHSA's commitment was especially noted in our efforts to encourage American Indian Tribes and Tribal organizations to apply for ATR funds. ATR is a Presidential initiative that provides funding to States and/or American Indian Tribes or Tribal organizations to expand substance abuse treatment capacity, to expand the array of providers, and to instill accountability into the substance abuse treatment system.

SAMHSA held 4 technical assistance briefings for States, and while many Tribes were free to attend these briefings, a fifth briefing was set up specifically for Tribes and Tribal organizations. As a result, 22 Tribes submitted applications, and a Tribal coalition, the

California Rural Indian Health Board, received one of 15 grants awarded in FY 04. The President is asking for an increase of $51 million for this program, which should allow for an additional 7 awards for which Tribes would be able to apply.

The SBIRT program has awarded a grant to the Cook Inlet Tribal Council near Anchorage, Alaska, to provide screening, brief intervention, and referral treatment for their population. SBIRT is designed to assist in reducing the suicide/violence in Indian Country by treating the underlying substance abuse that contributes to the problem. The FY 06 budget requests a $5.8 million increase in SBIRT funding.

Additionally, SAMHSA's Substance Abuse Treatment Targeted Capacity Expansion (TCE) grant program continues to expand treatment opportunities and capacity in local communities experiencing serious emerging drug problems. Tribes and Tribal organizations have received over $31 million in TCE funds, either in direct or indirect grant awards, during the past three years.

Regarding mental health services, SAMHSA also collaborates with IHS and the National Institute of Mental Health within the National Institutes of Health (NIH) on the Circles of Care grant program. The Circles of Care program supports the implementation of mental health service models designed by American Indian and Alaska Native Tribal and urban Indian communities that utilize a systems-of-care community-based approach to mental health and other supportive services for American Indian and Alaska Native children with serious emotional disturbances and their families.

SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Grant Program provides funding for direct services to improve systems of care for children and adolescents with serious emotional disturbance and their families. Seven Tribal organizations are among the current total of 63 grantees.

With regard to programs to address violence and suicide, in 1999, in response to school shootings in Kentucky, Arkansas, Oregon, and other states, Congress took action and launched the Safe Schools/Healthy Students Initiative (SSHS), under the collaborative leadership of the Departments of Education, Health and Human Services, and Justice. The SSHS awards three-year grants of $1 million to $3 million per year to school districts to do the following:

- Collaborate with local law enforcement and mental health agencies;
- Promote the healthy development of school-age children; and
- Promote mental health and prevent violence in youth by using evidence-based programs with demonstrated long-term positive effects.

When this initiative was created, two Tribal sites were funded in the initial cohort of 54 grantees and out of a pool of close to 500 applications. In particular, these two Tribal grantees emphasized the poverty of their communities. Repeatedly, researchers from different fields, "have firmly established that poverty and its contextual life circumstances are major determinants of violence. Violence is most prevalent among the poor, regardless of race."

For instance, our SSHS grantee in Pinon, Arizona, wrote in its application, “The Navajo Nation in northern Arizona is among the poorest and most desolate regions of the United States. The area has only one paved road for travel, 92% of the children receive free/reduced price lunches, and 60-90% of residents live without basic services, such as plumbing, running water, kitchens, sewers, and telephones, compared to less than 1% of the U.S. population at large.” It is within the context of these problems that this grantee endeavored to bring about change, and by and large, it was successful in turning a school community away from violence and toward resilience and a productive and meaningful life.

In January, SAMHSA launched the National Suicide Prevention Lifeline, 1-800-273-TALK. The national hotline is part of the National Suicide Prevention Initiative. This collaborative effort, led by SAMHSA, incorporates the best practices and research findings in suicide prevention and intervention with the goal of reducing the incidence of suicide nationwide. Along with the national hotline, a new website is being launched at www.suicidepreventionlifeline.org.

Additionally, SAMHSA, under the authority of the Garrett Lee Smith Memorial Act (Pub. L. 108-355), announced the availability of FY 05 funds for state-sponsored youth suicide prevention and early intervention programs. (Requests for Application No. SM-05-014, SM-05-015, and SM-05-017)

SAMHSA takes seriously the current challenges in Indian Country, which include few trained service providers, major transportation barriers, and multi-generational poverty. SAMHSA is being proactive in addressing these challenges that rob communities of their most valuable resource: their children and their future. The vital treatment and prevention efforts that I have discussed today are designed to address these problems and are improving services for American Indian and Alaska Native children, youth, and their families.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.