DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

OVERSIGHT HEARING ON

DEMANDING RESULTS TO END NATIVE YOUTH SUICIDE

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Chairman and Members of the Committee:
Good afternoon, I am Robert G. McSwain, Acting Director of the Indian Health Service (IHS). Today, I appreciate the opportunity to testify on "Demanding Results to End Native Youth Suicide."

Thank you for the invitation to talk about this very serious issue of Native youth suicide. It is with a heavy heart that we discuss an issue that continues to plague American Indian and Alaska Native (AI/AN) communities. Most recently, the Oglala Sioux Tribe has faced the same tragedy of a suicide cluster that too many other AI/AN communities have experienced. Our thoughts go out to the Oglala Sioux Tribe and the families and friends who are grieving the loss of their young people. Today, I will highlight our key programs, initiatives, and investments to end Native youth suicide and we look forward to continuing to work with the Committee to address this devastating problem.

As you know, the Indian Health Service (IHS) 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 2.2 million American Indians and Alaska Natives who belong to 566 Federally-recognized Tribes. 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. The agency goal is to assure that comprehensive, culturally appropriate personal and public health services are available and accessible to the AI/AN population. Our duty is to uphold the Federal Government's obligation to promote healthy AI/AN 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, 25 U.S.C § 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §§ 1601-1683. 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.

Introduction

We share your deep concern about the tragedy of suicide among Native youth. Suicide is a complicated public health challenge with many contributing factors in AI/AN communities. Although suicide contagion is not unique to AI/AN populations, too frequently, AI/AN communities experience suicide that takes on a particularly worrying 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 Native youth. While most vividly and painfully expressed in close knit AI/AN communities, suicide and suicidal behavior and their consequences send shockwaves through the community. We at IHS – and at HHS more broadly – try to prevent these suicide clusters from beginning and to halt them once they begin occurring.

However, all too many AI/AN communities are affected by high rates of suicide. The recently published IHS *"Trends in Indian Health, 2014"* reports:

- The age adjusted suicide rate (18.5 per 100,000 population) for the three year period (2007-2009) in the IHS service areas was 1.6 times that of the U.S. all races rate (11.6) for 2008.
- Suicide is the second leading cause of death (behind unintentional injuries) for Indian youth ages 15-24 residing in IHS service areas and the suicide death rate for this cohort is four times higher than the national average.
- Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide.

- AI/AN young people ages 15-34 make up 64 percent of all suicides in Indian country.

Responding to Suicide Crises

Tribal leaders will often request IHS to provide additional support and funding to help prevent any further suicides during a cluster. Since no two suicide clusters are the same, the IHS response is tailored to the needs of the community in crisis. In general, our Area Office typically takes the first steps to organize and implement a response to a suicide crisis. In particular, the IHS Area Office reaches out to tribal leadership to ensure IHS and key Federal partners, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), are aware of the Tribe's level of need and the specific requests for a response. We take steps to work hand-in-hand with the tribe, in organizing our response. IHS and SAMHSA coordinate to ensure Federal resources are readily available.

SAMHSA's resources may include existing grants awarded to the tribe under the new Tribal Behavioral Health Grant (TBHG) program that is focused on preventing suicidal behavior and substance abuse and promoting mental health in AI/AN youth or the Garrett Lee Smith State/Tribal Youth Suicide Prevention program that supports youth suicide prevention and early intervention strategies and collaborations among youth-serving institutions and systems (i.e., schools, juvenile justice, foster care, substance abuse, mental health, and other child and youth supporting organizations). Other SAMHSA resources include specialized technical assistance centers such as the Suicide Prevention Resource Center, National Native Children's Trauma Center, and National AI/AN Addiction Technology Transfer Center.

If the Tribe requests a deployment of healthcare providers, IHS takes the lead with the Division of Commissioned Corps Personnel and Readiness (DCCPR) to assess and plan for the deployment. A deployment team can be on the ground in a matter of days. These short term deployment teams are intended to deal with the immediate crisis until mid- and long-term solutions can be set in place.

Zero Suicide

In 2015, IHS will launch the Zero Suicide Initiative, a key concept of the 2012 National Strategy for Suicide Prevention. In our current system, suicide care has traditionally been provided by individual local champions and clinical providers. IHS is moving toward a more programmatic system-wide approach by implementing Zero Suicide. IHS' commitment to create a leadership-driven, safety-oriented culture committed to reducing suicide among people under our care will drive the improved patient outcomes we need to see as a result of a collective Agency effort. Moving forward, IHS is making the commitment to set big goals and improve our approach to inform system changes to provide better care for AI/AN individuals at risk for suicide.

Zero Suicide represents a bold goal for IHS. It is the foundational belief that suicide deaths for individuals under our care within our health and behavioral health systems are preventable. IHS is committed to creating a leadership-driven, safety-oriented culture focused on reducing suicide. The approach represents a commitment from IHS to set in place an organizational structure where suicidal individuals and individuals at-risk will receive coordinated care from a competent workforce. The fundamentals of Zero Suicide implementation include: leadership's commitment to reduce suicide deaths; training a competent, confident, caring workforce; identifying and assessing patients for suicide risk; engaging patients at risk for suicide in a care plan; treating suicidal thoughts and behaviors directly; following patients through every transition in care; and applying data-driven quality improvement. To accomplish our commitment, IHS has begun a virtual training series through the Tele-Behavioral Health Center of Excellence (TBHCE). IHS is also partnering with SAMHSA and the Suicide Prevention Resource Center to bring a tailored Zero Suicide Training Academy for IHS and Tribal healthcare facilities in 2015. In addition, as discussed below, the Fiscal Year (FY) 2016 Budget requests an additional $25 million to hire additional behavioral health providers through the Methamphetamine and Suicide Prevention Initiative (MSPI).

Methamphetamine and Suicide Prevention Initiative

The MSPI is an IHS nationally-coordinated demonstration project, focusing on providing much-needed methamphetamine and suicide prevention and intervention resources for AI/AN communities. It is a key resource for IHS as we work to prevent youth suicides. It promotes the

use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches from a community-driven context.

The MSPI supports 130 programs across the country. The goals of the MSPI are to:

- Prevent, reduce, or delay the use and/or spread of methamphetamine use;
- Build on the foundation of prior methamphetamine and suicide prevention and treatment efforts, in order to support the IHS, Tribes, and Urban Indian health organizations in developing and implementing culturally appropriate methamphetamine and suicide prevention and early intervention strategies;
- Increase access to methamphetamine and suicide prevention services;
- Improve services for behavioral health issues associated with methamphetamine use and suicide prevention;
- Promote the development of new and promising services that are culturally and community relevant; and
- Demonstrate efficacy and impact.

MSPI projects provide multiple services related to suicide and methamphetamine use. The most common focus of funded projects is suicide prevention (94%), methamphetamine prevention (69%), and suicide treatment and intervention (55%). The MSPI projects are in the sixth and final year of the demonstration program. From 2009-2014, the MSPI resulted in over 9,400 individuals entering treatment for methamphetamine use; more than 12,000 encounters via tele-health for substance abuse and mental health disorders; over 13,150 professionals and community members trained in suicide crisis response; and more than 528,000 encounters with youth provided as part of evidence-based and practice-based prevention activities.

MSPI projects offer a multitude of evidence-based practices and treatments. The most common types of evidence-based practices utilized among MSPI programs to prevent suicide are Question, Persuade, Refer (QPR); Applied Suicide Intervention Skills Training (ASIST); Safe Tell, Ask, Listen, Keepsafe (safeTALK); Mental Health First Aid; and Gathering of Native Americans. Evidence-based treatments to prevent suicide re-attempts utilized among MSPI programs include Motivational Interviewing, Cognitive Behavior Therapy (CBT), and Dialectical Behavior Therapy, to name a few. For instance, the White Earth MSPI project, called

Native Alive, stations mental health professionals at reservations schools and maintains a support hotline staffed by health professionals trained in ASIST.

MSPI projects often incorporate cultural elements into their programs and activities such as by teaching traditional beliefs, smudging, ceremonies, or sweat lodges in collaboration with traditional healers. The Absentee Shawnee MSPI project, Following in Our Footsteps, utilizes cultural activities such as Native American storytelling, arts and crafts, dancing, sweat lodge ceremonies, and positive youth activities to promote healthy life choices and positive decision-making skills.

Building on the associations between social connections and lower suicide risk, MSPI projects enlist partners to build community-based suicide prevention. Partnerships with local schools are key in the MSPI for school-based interventions to develop skills to protect against suicidal thoughts and behaviors, raise awareness, encourage help-seeking, and teach positive life and coping skills. Examples of such activities at work in MSPI communities include American Indian Life Skills, Native Hope, and Project Venture. Youth may not want or may not always be able to ask appropriate adults for help and may reach out to their peers for assistance. MSPI projects offer training to youth to build their intervention skills for such situations. The MSPI funds allow projects to expand community-based mental health care into youth-based settings, increasing access to care for mental health and substance use disorders for our Native youth. The funding for MSPI funding is not enough to go to every Tribe. Therefore, IHS awards the funds on a competitive basis. In FY 2015, IHS will open a new funding announcement for a project period to run from September 30, 2015 to September 29, 2020, contingent on appropriations.

Domestic Violence Prevention Initiative

Since the Institutes of Medicine (2002) report[1] on suicide research, there has been much learned about the role of child abuse in later suicide risk. According to the Center on the Developing Child at Harvard University, a toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity, such as physical or emotional abuse, chronic neglect,

[1] See: http://www.iom.edu/Reports/2002/Reducing-Suicide-A-National-Imperative.aspx

caregiver substance use and mental health disorders, exposure to violence, and/or the accumulated burdens of family economic hardship. These adverse childhood experiences can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.

IHS' primary response to children exposed to violence is through the Domestic Violence Prevention Initiative (DVPI). The IHS began the DVPI in 2010 with the purpose of better addressing domestic violence (DV) and sexual assault (SA), including the pediatric and adolescent population, within AI/AN communities. The program has awarded funding to a total of 65 projects that include IHS/Tribal/Urban operated programs. This initiative promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to DV and SA from a community-driven context. Types of evidence-based treatment practices provided by DVPI projects include CBT, Trauma Focused CBT, Beyond Trauma: Traumatic Incident Reduction, and Strengthening Families, a program to improve parenting and family relationships. Practice-based practices utilized by DVPI projects include elders teaching traditions, talking circles, or smudging ceremonies. For instance, Santa Clara Pueblo provides more community education activities; in-school services for young witnesses of family violence; violence prevention education in schools; and counseling for young victims of DV.

The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, and community and school education programs. The funding is also used for the purchase of forensic equipment, medical personnel training, and the coordination of Sexual Assault Examiner (SAE) and Sexual Assault Response Team activities. From 2010-2014, the DVPI resulted in over 50,500 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services. More than 38,000 referrals were made for domestic violence services, culturally-based services, and clinical behavioral health services. In addition, a total of 600 forensic evidence collection kits from eight SAE programs were submitted to Federal, state, and tribal law enforcement. In the last year, DVPI projects referred over 2,000 children and youth to behavioral health, cultural services, DV or SA services, shelter services, specialized medical care, or to victim advocates.

Prioritizing Behavioral Health Services for Native Youth

The Administration's 2016 Budget proposes key investments to launch Generation Indigenous (Gen-I), an initiative addressing barriers to success for Native American youth. This integrative, comprehensive, and culturally appropriate approach across the Federal Government will help improve lives and opportunities for Native American youth. The HHS Budget Request includes a new Tribal Behavioral Health Initiative for Native Youth with a total of $50 million in funding for IHS and the SAMHSA. Within IHS, the request includes $25 million to expand the successful MSPI to increase the number of child and adolescent behavioral health professionals who will provide direct services and implement youth-based programming at IHS, tribal, and urban Indian health programs, school-based health centers, or youth-based programs. SAMHSA will expand the Tribal Behavioral Health Grant program to support mental health promotion and substance use prevention activities for high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment. These activities will both fill gaps in services and fulfill requests from tribal leaders to support Native youth.

IHS' Gen-I activities include youth engagement through the development of youth steering committees at the local level to inform IHS on planning, implementation, and evaluation of its youth health programs and services. The information from the local youth steering committees will feed into regional and national recommendations to operationalize the input received from Native youth. Secondly, IHS will provide opportunities through its Pathways Internship Program. Pathways is a streamlined program designed to attract students enrolled in a wide variety of educational institutions (high school, home-school programs, vocational and technical, undergraduate and graduate) with paid opportunities to work in agencies and explore Federal careers while still in school. This program exposes students to jobs in the Federal civil service by providing meaningful "developmental work" at the beginning of their career, before their "career paths" are fully established. The flexible nature of the program is to accommodate the need to hire students to complete temporary work or projects, perform labor intensive tasks not requiring subject matter expertise, or to work traditional "summer jobs." The program provides agencies with the opportunity to hire interns who successfully complete the program and

academic requirements into any competitive service position for which the Intern is qualified. The IHS Gen-I Pathways Internship Program offers Native youth an opportunity to apply for paid summer positions at IHS Service Units in their local community. The initiative kicked off in May 2015, and we have posted job advertisements at all the IHS Areas and have over 80 summer internship positions allocated IHS-wide.

IHS will also provide more funding opportunities geared toward Native youth for early intervention and positive youth development through its three largest initiatives. In the Special Diabetes Program for Indians, grantees will have the option to elect to use FY 2016 funding to implement the Family Spirit Program, an early intervention home visiting program. Family Spirit is an evidence-based and culturally tailored in-home parent training and support program. Parents gain knowledge and skills to achieve optimum development for their preschool aged children across the domains of physical, cognitive, social-emotional, language learning, and self-help. The program is currently the largest, most rigorous, and only evidence-based home visiting program ever designed specifically for American Indian families. Family Spirit now has randomized controlled trial evidence demonstrating that it reduces risk factors associated with a number of adverse outcomes, including obesity and substance use.

The MSPI program will also provide FY 2015 funding for local programs to support their Gen-I activities through evidence-based and practice-based programming. Examples of such activities include implementation of American Indian Life Skills, Model Adolescent Suicide Prevention Program, Project Venture, Native HOPE (Helping Our People Endure), ASIST (Applied Suicide Intervention Skills Training), and cultural activities like Native American storytelling, traditional teachings, ceremonies, and other local relevant practices.

Behavioral Health Integration with Primary Care

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. The future of AI/AN health depends largely upon how effectively behavioral health is addressed by

individuals, families, and communities and how well it is integrated into community health systems. We know that successful and sustained behavioral change will require cultural reconnection, community participation, increased resources, leadership capacity, and the ability of systems to be responsive to emerging issues and changing needs. In 2014, IHS began a small pilot project of six sites, the Behavioral Health Integration Initiative (BH2I). The goal of the funding was for sites to develop rapid cycle improvements of behavioral health integration with primary care using the Improving Patient Care (IPC) model. BH2I will continue into FY 2016. IHS will host a National Behavioral Health Integration with Primary Care Conference in Phoenix, Arizona to disseminate integration best practices and lessons learned from BH2I.

The IPC Program is an outpatient primary care quality improvement program designed to assist IHS/Tribal/Urban Indian clinics with improving their care delivery and achieving Patient Centered Medical Home (PCMH) recognition. The PCMH is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults. The PCMH is best described as a model that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. The medical home is focused on the needs of patients, and when appropriate, their families and caregivers. A significant element of the PCMH is integration of behavioral health services into primary care patient visits. This can include screening for behavioral health conditions, addressing beliefs about diseases and treatments, identifying disorders and initiating treatment, and collaboration with behavioral health professionals as part of the integrated primary care team.

Training and Tele-Behavioral Health Services

IHS recognizes the need to support access to services and to create a broader range of services linked into a larger network of support and care. IHS piloted the use of tele-behavioral health to increase access to specialty behavioral health services in the MSPI demonstration pilot phase. MSPI projects provided over 6,000 tele-behavioral health encounters in the fifth year alone.

The TBHCE was developed in 2009 to promote and develop tele-behavioral health services. Working in partnership with the University of New Mexico, the TBHCE provides services in a number of settings including school clinics, youth residential treatment centers, and health

centers. The TBHCE has leveraged their ability to use federal service providers and provides technical and program support nationally for programs attempting to implement tele-health services. IHS programs are increasingly adopting and using these technologies with more than 8,000 encounters provided via tele-behavioral health in FY 2014.

IHS benefits from the use of telemedicine for the prevention and treatment of youth suicide by connecting widely separated and often isolated programs of varying sizes together into a network of support. For example, small clinics would need to develop separate contracts for services such as child and adult psychiatric support, but the TBHCE is able to provide more cost-effective specialty care conveniently located within the clinic patients utilize for services. Such a system could provide 24/7 access to emergency and routine behavioral health service in any setting with adequate telecommunications service and appropriately trained staff.

The TBHCE also provides opportunities for mutual provider support. For example, currently when psychiatric providers are on leave or are attending a training conference there are often no direct services available during that time period. Sufficient services could be provided via tele-health connections to improve continuity of care with providers who are familiar with treating AI/AN patients. IHS also encourages families to participate in care through tele-health in circumstances when their youth may be transitioning from a treatment facility or residential program.

Providers with particular specialty interests can also share their skills and knowledge across a broad area even if they themselves are located in an isolated location by videoconferencing, providing clinical supervision and working with multidisciplinary teams. Universities providing distance-based learning opportunities have demonstrated for years that educational activities can be facilitated by this technology and reduce burn out due to professional isolation. Recruitment also becomes less problematic because providers can readily live and practice out of larger urban or suburban areas and are thus more likely to continue providing service over time.

The TBHCE also provides virtual training to primary care providers, nurses, and behavioral health providers on current and pressing behavioral health topics in an effort to increase the Indian health system's capacity to provide integrated behavioral health care with primary care. In

FY 2014, over 8,000 providers received training.

Recruitment and Retention

The rural and remote geographical locations of AI/AN communities present challenges with recruitment and retention of qualified behavioral health providers. Many of the facilities that serve AI/AN populations are in what the Health Resources and Services Administration (HRSA) has designated as health professional shortage areas.[2] The IHS offers financial incentive programs to recruit and retain behavioral health providers. The IHS Loan Repayment Program offers financial support in exchange for a service obligation in IHS-designated facilities upon completion of training and licensure. The IHS Indian Health Professions Scholarship Program is designed for AI/AN recipients entering the healthcare field. The recipients receive full or partial tuition support and a monthly stipend in exchange for a service obligation upon completion of training and appropriate licensure for placement within IHS-designated facilities located in designated shortage areas. The Indians into Psychology grant provides funding to colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs to encourage AI/AN students to enter the behavioral or mental health field. Recipients of the program receive tuition, fees, and a monthly stipend. Upon graduation with a Ph.D., these professionals are placed within IHS-designated facilities.

The National Health Service Corps (NHSC), administered by HRSA, has both a scholarship program and a loan repayment program. The NHSC adds another source of service-obligated providers to IHS, Tribal, and Urban Indian health programs, including behavioral health professionals. IHS and HRSA collaborated to increase the numbers of IHS, Tribal, and Urban Indian health program sites that are eligible for assignment of NHSC personnel. The NHSC Loan Repayment Program is another opportunity for behavioral health providers to serve in communities with limited access to care and have their student loans repaid.

Conclusion

Suicide prevention needs to be addressed in the comprehensive, coordinated way outlined in the

[2] See: Health Resources and Services Administration Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations. Available at: www.hrsa.gov/shortage/find

National Strategy for Suicide Prevention. No one agency or one approach will solve the tragedy of suicide in AI/AN communities. Suicide is complex and thus has many factors that must be considered. Reducing the number of suicides requires the engagement and commitment of people in many sectors in and outside government. IHS is committed to being a partner in the response to end Native youth suicides. As a central provider of health care for American Indians and Alaska Natives, we must do better in reaching youth with behavioral health and other help they need. We want to work with you to get us closer to the Zero Suicide goal. We all recognize that the challenges faced by Native youth run deep – we must all work together in offering them hope for a better future.