

STATEMENT OF THE
NATIONAL INDIAN CHILD WELFARE ASSOCIATION

SUBMITTED TO THE SENATE COMMITTEE ON INDIAN AFFAIRS

Regarding

SUICIDE PREVENTION AMONG NATIVE AMERICAN YOUTH

JUNE 22, 2005

The National Indian Child Welfare Association submits this testimony to the Senate Committee on Indian Affairs on suicide prevention among Native American youth. The focus of our testimony will be a national look at the needs within Indian Country and strategies for suicide prevention among Indian youth. A brief description of the National Indian Child Welfare Association is provided below.

National Indian Child Welfare Association – The National Indian Child Welfare Association (NICWA) is a national, private non-profit organization dedicated to the well-being of American Indian children and families. We are the most comprehensive source of information on American Indian child welfare and work on behalf of Indian children and families. NICWA services include: (1) professional training for tribal and urban Indian child welfare and mental health professionals; (2) consultation on child welfare and mental health program development; (3) facilitation of child abuse prevention efforts in tribal communities; (4) analysis and dissemination of public policy information that impacts Indian children and families; (5) development and dissemination of contemporary research specific to Native populations; and (6) assisting state, federal, and private agencies to improve the effectiveness of their services to Indian children and families.

In order to provide the best services possible to Indian children and families, NICWA has established mutually beneficial partnerships with agencies that promote effective child welfare and mental health services for children (e.g., Substance Abuse and Mental Health Services Administration, Indian Health Services, Administration for Children, Youth and Families, National Congress of American Indians, Federation of Families for Children's Mental Health, and the Child Welfare League of America).

Introduction

Although the overall rate of suicide among youth has declined slowly since 1992, rates remain unacceptably high (Lubell, Swahn, Crosby, and Kegler, 2004 as cited in National Center for Injury Prevention and Control, 2004). Compared to other non-white groups, the suicide rate for American Indians/Alaska Natives is the highest (American Association of Suicidology, 2004). More specifically, between 1981 and 2000, suicide was the second leading cause of death for American Indian/Alaska Native youth aged 15 – 24 (May, Serna, Hurt, & DeBruyn, 2005). Additionally, according to recent data from the Indian Health Service (IHS), the suicide rate for American Indian/Alaska Native youth in this age group is 3.3 times higher than the national average (IHS, 2004). It is obvious that youth suicide is a crisis in Indian Country that must be addressed.

One of the main barriers to addressing this issue in Indian Country is the lack of access to culturally appropriate, family-focused and community-based mental health services. Across the country, more than half of Indian youth who commit suicide have never been seen by a mental health professional. This may be attributable to a lack of trained therapists or counselors on reservations or that the youth do not trust counselors, who are often outsiders (Gunderson, 2005). This testimony will address the above-listed issues by providing information on the following items:

- Suicide risk factors and protective factors
- The benefits of utilizing the systems of care philosophy for children's mental health services
- Successful approaches to addressing mental health needs in Indian Country
- Recommendations for preventing youth suicide among American Indians/Alaska Natives

Summary of Recommendations

- Increase the number of trained child therapists and mental health professionals in Indian Country.
- Require the Indian Health Services to expand their children's mental health programming to include promising practices in Indian Country such as the Systems of Care approach.
- Increase funding for Systems of Care and Circles of Care grants to allow more tribal access to these important programs.
- Require Indian Health Services to regularly report data that describes how many American Indian/Alaskan Native children are being provided mental health services through IHS or IHS contractors, types of services provided, number of mental health referrals received and other significant data developed in consultation with tribes to help inform policymakers and service providers.

Suicide Risk Factors

Recent evidence suggests that over 90% of children and adolescents who commit suicide have mental health needs before their death (Shaffer & Craft, 1999). For American Indian/Alaska Native people, severe life stresses often place them at high risk for mental health problems. On a national level, Indian communities are affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, child neglect, and suicide (Swinomish Tribal Mental Health Project, 1991). According to a 1998 study by the Centers for Disease Control and Prevention, American Indians/Alaska Natives reported much higher rates of frequent distress than the general population (13% and 9% respectively). The findings of this study suggest that American Indians/Alaska Natives experience greater psychological distress than other populations, which could contribute to the high rate of suicide attempts and completions within tribal communities (DHHS, 2001).

Further substantiating the above-listed information, a 1999 Surgeon General's report identified several risk factors for suicide, including but not limited to the following items:

- History of mental health needs, particularly depression
- History of alcohol and substance abuse
- Barriers to accessing mental health services
- Unwillingness to seek help based on the stigma attached to mental health and substance abuse disorders or suicidal thoughts.

Protective Factors

The 1999 Surgeon General's report also identified several protective factors that buffer people from the risks associated with suicide. These include, but are not limited to:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Family and community support
- Support from ongoing medical and mental health care relationships

All of the above-listed risk and protective factors can be addressed through programs built around the systems of care philosophy of culturally competent, community-based, child-centered and family-focused services. This philosophy has been utilized successfully by tribal communities since 1998 and is a critical component of effective mental health services for American Indian/Alaska Native children and families.

Systems of Care as the Cornerstone of Behavioral Health

What is a system of care?

Within the field of children's mental health, a system of care is collaboration among the family members, community members, professional organizations, and others committed to enhancing the lives of emotionally disturbed children and their families. The purpose is to bring cohesion to the strategies and services aimed to rehabilitate these children. Specific values set the principles that drive a system of care and evolve into specific practices that create change. The core values of a system of care include a system that is child-centered and family-focused, community-based, and culturally competent.

Systems of care have evolved over the past several years from the growing awareness of the absolute need for all parties involved in children's well-being to work together. Service providers now recognize that simply dispensing medication and providing adjunctive psychotherapy services falls short of what children and their families need to recover from or cope with mental illness. They recognize that the causes of mental health disorders are complex and that the impact of mental illness requires collaboration and partnerships among many individuals and organizations.

Systems of care include formal partnerships between tribal, state, or county agencies (*partnerships*), multi-disciplinary teams (*collaboration*), deep *family involvement* and the accessibility to service providers far beyond the typical 8 a.m. to 5 p.m. workday. In addition to professionals, effective systems of care bring into this planning the significant persons involved in the child and his/her family's life, such as spiritual healers, extended family, and community elders. Professionals may include educators, child protection services, the juvenile justice system, and mental health professionals (Cross, Earle, Echo-Hawk Solie and Manness, 2000).

Collaborative efforts of which successful systems of care are comprised are enhanced through the use of a *wraparound service model*. Wraparound is a model of care in which all aspects of care for a child are fully integrated with that child's environment. Within the wraparound service model, *case management* or *care coordination* services connect all parties providing this full array of services into a collaborative web.

Indicators of Need for Improved Mental Health Services to Children in Indian Country

In general, mental health services are scarce for all children. For Indian children, however, access is more problematic. The disparity in available resources parallels the scarcity of data relevant to Indian children and mental health.

There is very little data on the mental health needs of Indian children and adolescents (Deserly and Cross, 1996; U.S. Congress, Office of Technology Assessment, 1990). We can make some extrapolations about the level of need for Indian children and the importance of addressing those needs from statistics pertinent to the general population, particularly since we know that minorities with mental health disorders are less likely to receive treatment and more likely to be placed in correctional facilities (Knitzer, 1982). We know the following to be true:

1. Mental disorders account for four of the ten leading disabilities in established market economies worldwide (The National Institute of Mental Health: *Science on our Minds: The Numbers Count*, 1999);
2. The cost of mental illness in the United States was \$148 million in 1990 (The National Institute of Mental Health: *Science on our Minds: The Numbers Count*, 1999);
3. Worldwide, depression is the leading cause of disabilities among persons *aged five* and older (The National Institute of Mental Health: *Science on our Minds: The Numbers Count*, 1999); and
4. The estimated national incidence of emotional disturbance is 11.8% of the population under the age of 18 (Gould, Wunsch-Hitzig & Dohrenwend, 1980).

We can see that the cost of mental illness is extraordinary. In Indian Country, where mental health services are extremely scarce and the need is, we can assume that both the life-long personal and financial costs of not providing adequate mental health services to our children will be enormous.

The 2000 Census reports that about 2.5 million¹ American Indian people are living in the United States. Of this number, 38% are under the age of twenty. Research estimates that there are

¹ This number depicts those individuals who reported American Indian/Alaska Native as their only race. An additional 1.6 million people reported being American Indian/Alaska Native in combination with one or more other races.

approximately 93,000 emotionally handicapped Indian children in the United States (Deserly & Cross, 1996).

Although epidemiological research is scarce, we know that Indian children suffer from catastrophic rates of posttraumatic stress, which, if untreated, creates a generation of adults who suffer from severe, chronic mental illness. Boarding school surveys have identified Indian youth as being at high risk for mental health disorders. According to an unpublished paper by the Bureau of Indian Affairs (1995), *Therapeutic Residential Schools – Promise of the Future*, off-reservation, residential school students are either “at risk” or are “very high risk” students. Most of these students have suffered sexual, physical and emotional abuse, abandonment and/or rejection and have been involved in self-destructive behaviors. Supporting documentation shows that many students with mental health problems are on probation from the juvenile court system. In addition, the scope of alcohol and drug abuse among entering students is overwhelming, falling between 80% to 100%. Over 80% of these students come from home environments where one or both parents have been identified as having a substance abuse problem. The paper further reports increasing symptoms and behaviors in all areas investigated in mental health screenings. The majority of students screened (approximately 95%) reported critical medical, social, mental, and educational needs that are not being met.

Promising Practices

Given the high prevalence of mental health need and the effectiveness of the systems of care philosophy in tribal communities, it is important to look at how this philosophy has been incorporated into tribal practices to address the needs of their children and families. Since 1998, 16 tribal and urban Indian communities have been involved in the Circles of Care grant initiative through the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration Center for Mental Health Services. Circles of Care is a children’s mental health planning and evaluation grant that is based on culturally competent and community-based efforts to develop a model system of care for children’s mental health. As a planning grant, the effort is not on providing direct services but building community relationships and a vision for children’s future. There are several examples of work done by these communities that could easily be seen through the perspective of suicide prevention, in that the primary approach to prevention in Indian Country is based on developing cultural identity and establishing and strengthening relationships.

One approach, which appears to have good results, is the use of the Gathering of Native Americans (GONA) process in these Circles of Care communities. This is a 4-day community-based event that leads participants through a series of self-awareness activities and group relationship building activities that build on community culture and strengths. The GONA was developed for the purpose of substance abuse prevention by a group of American Indian trainers for the Center for Substance Abuse Prevention and has an established manual that is available to the public. One of the many Circles of Care projects that made extensive use of the GONA was the Ute Tribe in Fort Duchene, Utah. They had a series of GONA events that were targeted at different population groups in the

community. The youth GONA event had nearly 200 young people from the community participate. As a result of participating, these youth (most of whom would qualify as “high risk”) left the four-day event with a new connection to other youth and to their sense of responsibility as a member of their tribe and with a greater sense of their own identity as an Indian person. The Ute Tribe also had GONA events with groups of men, women, and elders who were each successful in building relationships and sense of community.

The Passamaquoddy tribe in Indian Township, Maine, is one of 10 tribal communities that have received funding through the Comprehensive Community Mental Health Services for Children and Their Families Program initiative of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The tribe has implemented mentorship and respite care services whose primary function is to provide culturally appropriate services to children with emotional disturbance and their families. The secondary effect is one that can be viewed as a suicide prevention strategy. Children who are “at risk” are paired with tribal community members (often respected tribal elders) based on the youth’s interest in developing a certain talent or skill. For example, some youth have spent time with elders learning how to do wood carving, basket making, and beadwork. In addition to learning a skill that may lead to the young person being able to have an avocation, the increased self-esteem, positive cultural identity and relationship with respected community members serves to build strong resilience in these youth. The community as a whole benefits, because they have been able to see these “at risk” youth as contributing members of the community.

Recommendations

- **Increase the number of child trained therapists and mental health professionals in Indian Country.**

The disparity in distribution of human resources is higher when one considers that mental health providers working with children and families spend much of their time working with adults. The greater need is to bridge the gap in availability of services for children.

Additionally, training more individuals in working with children would address problems of misdiagnosis, poor assessment of need, and inappropriate intervention due to workers who lack specialization in these areas. When mental health service providers are unfamiliar with children’s issues, there is a greater likelihood that they will misdiagnose the child, resulting in lifelong consequences, such as inappropriate services, side effects of unnecessary medication, and denial of health benefits.

- **Require the Indian Health Service to expand their children’s mental health programming to include promising practices in Indian Country such as the Systems of Care approach.**

Systems of care is consistent with federal policy for mental health services to children and families. It involves the family and natural, indigenous systems of care that facilitate the empowerment of children and families as well as expanding resources. It helps avoid duplication of services and contributes toward sustainability of behavioral health services within an economy of dwindling resources. Systems of care reduce costs by lowering the numbers of children placed out of the home (juvenile detention, foster care, residential treatment). They promote great success in prevention and treatment of mental health disorders by engaging the community in developing prevention and treatment strategies. The community becomes part of the treatment plan, thereby increasing the number of people supporting the child and the family in need.

Currently, the reauthorization of the Indian Health Care Improvement Act (S. 1057) provides an opportunity to focus on these troubling issues and provide support to promising practices that are operating in Indian communities today through the Systems of Care approach. Indian Health Services, a primary federal agency with responsibility for mental health services to American Indian/Alaskan Native children, is currently funding three tribal community sites to develop Systems of Care based models of mental health services, but obviously many more tribes need this opportunity. Adding language to S.1057 that would reinforce IHS’s efforts to fund and provide support to this proven model could help leverage relationships and program efforts with other federal agencies that are currently engaged in Systems of Care work, such as the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Children’s Bureau. This additional language would ensure that promising practices are being developed and implemented within tribal communities and encourage culturally relevant and effective approaches to wellness. The language would also provide consistency between the current legislation and other Department of Health and Human Services (DHHS) policy regarding systems of care. Below is an example of language that is being recommended:

- 1) Section 703(a)(1): IN GENERAL.-The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations consistent with section 701, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including **Systems of Care and Traditional Health Care Practices**, which shall include-
- 2) Section 707(c)(1): IN GENERAL-The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services, which may incorporate **Systems of Care and Traditional Health Care Practices**, to Indian children and adolescents, including-

- 3) 707(c)(2)(E): “for intensive home- and community-based services, **including collaborative systems of care.**
 - 4) Section 709(c)(3): “(3) community-based and multidisciplinary strategies, **including Systems of Care,** for preventing and treating behavioral health problems.
 - 5) Section 714: **(10) SYSTEMS OF CARE.-The term ‘Systems of Care’ means a system for delivering services to children and their families that is child-centered, family focused and family driven, community-based and culturally competent and responsive to the needs of the children and families being served. The system of care values prevention and early identification, smooth transitions for children and families, child and family participation and advocacy, comprehensive array of services, individualized service planning, services in the least restrictive environment and integrated services with coordinated planning across the child-serving systems.**
- **Increase funding for Systems of Care and Circles of Care grants to allow more tribal access to these important programs.**

The Center for Mental Health Services (CMHS) under SAMSHA recognizes that many Indian communities have gone too long without mental health services and that these communities lack the infrastructure to support a mental health system that can address the needs present within their populations. In its commitment to bridging the gap in services to Indian children, CMHS has funded 16² tribal and urban Indian programs whose mission is to design systems of care (planning grants). These projects, called Circles of Care, are in addition to the nine Systems of Care tribal sites that are providing services.

Although both the Systems of Care and Circles of Care programs have been very beneficial to tribal communities, it is important to increase the level at which they are funded so that more tribes are able to access these important grants. Currently, only 25 out of 563 federally recognized tribes in the nation have been able to access this funding for planning or implementing local systems of care.

Those sites that have received Circles of Care and/or Systems of Care grants have reported that the level of involvement required from both the Indian and non-Indian communities has resulted in saving lives of suicidal adolescents, reducing school absenteeism and expulsion, improving school grades, decreasing the rate of recidivism into the juvenile criminal justice system, increasing self esteem, preventing child abuse, and keeping children within their homes as opposed to placing them into foster care or residential treatment (Cross, Earle, Echo-Hawk Solie, & Manness, 2000). These changes transform the lives of children and families. One can

² Nine tribal Circles of Care sites were funded for this three-year grant in 1998 with seven more sites being funded in 2001. The first round of grantees has completed the grant activities with several securing funding for implementation of their plans.

speculate that the cost savings would be enormous by providing extensive services at the front end versus the exorbitant costs of back end services such as incarceration, protective placement, and in-patient psychiatric hospitalization, as well as general assistance. Providing effective services to children will likely also save costs from social security disability benefits, since chronic, severe mental illness often renders people unemployable.

- **Require Indian Health Services to regularly report data that describe how many American Indian/Alaskan Native children are being provided mental health services through IHS or IHS contractors, types of services provided, number of mental health referrals received and other significant data developed in consultation with tribes to help inform policymakers and service providers.**

While we continue to understand much better what the problems and risk factors are, we do not have sufficient data describing what is occurring when services are provided. Currently, IHS provides basic data on the numbers of American Indian/Alaskan Native *people* receiving services but does not identify how many are children or adolescents. Data describing services provided and referrals is also not readily reported. Without this data, it becomes more difficult to develop either a local or national picture of the need and where resources should be targeted. Our understanding is that the IHS client data system, Resource Patient Management System (RPMS), does collect this type of data, but it is not easily accessible or reported to tribes and policymakers.

Conclusion

The need for mental health systems of care for Indian children, although inadequately documented, is expected to be substantially higher than that of the general population. Access to services is poor for a variety of reasons, including cultural issues, funding, isolation, and the need for human resource development.

Overall, data collection and analysis is vital to comprehending the extent of the mental health needs of Indian children, as well as to justify requests for funding and developing intervention strategies. Indian communities have long been hampered by the lack of supporting statistics in their attempts to pursue funding, which often allows state and county agencies to avoid developing culturally specific programs for Indian children and impedes Indian tribes and urban organizations from successfully competing for grants.

Mental health services for Indian children are currently provided in a hodge-podge fashion, often only in crisis situations and by several different systems, many of which remain inaccessible for most Indian nations' members. Most Indian programs have only a modest capacity for evaluation and treatment, but few non-Indian programs have strategies for serving Indian children appropriately.

In order to address the mental health needs of tribal communities, tribes should be given the opportunity to provide services for their own members through an increase in funding for planning and implementing mental health programs. This would allow the services to be tailored to fit the individual and would also provide tribal members with access to community-based, culturally competent programs to heal their children and families.

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