TESTIMONY

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SENATE COMMITTEE ON INDIAN AFFAIRS

On

YOUTH SUICIDE PREVENTION

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Thank you, Mr. Chairman, Ranking member Dorgan, and members of the Committee for the opportunity to address this hearing today on the tragedy of suicide among American Indian and Alaska Native (AI/AN) youth. I am Joseph B. Stone, an enrolled member of the Blackfeet Nation of Northern Montana and a descendent of the Turtle Mountain Chippewa of North Dakota and Lakota of South Dakota. I am an honorably discharged veteran of the U.S. Navy. My professional credentials include being a licensed psychologist in Oregon and Washington, and an internationally and state-certified addiction counselor and alcohol and drug counselor in Arizona and Oregon, respectively. Currently, I am the Confederated Tribes of Grand Ronde Behavioral Health Program Manager and Clinical Supervisor. It is my pleasure to represent the American Psychological Association (APA), of which I have been a member since 1998. The APA represents 150,000 members and affiliates, and works to advance psychology as a science, a profession, and as a means of promoting health and human welfare.

In order to address the issue of youth suicide prevention, I would like to first draw the Committee's attention to some statistics about native youth and suicide:

Economic issues and lack of opportunity: Tribal families live in a crucible of economic oppression and lack of opportunity. The two poorest counties in the country are Shannon County in South Dakota (Oglala Lakota) and Glacier County in Montana (Blackfeet Nation), with most of the tribal residents of these counties living at or below the poverty level. Nationwide, 26 percent of the native population lives in poverty (including 38% of native children) versus 13% of all racial groups (including 18% of the

children of all races), and only 8 percent of white Americans. Only 66 percent of native people are high school graduates. AI/AN are twice as likely to be unemployed than whites.

Health care benefits and access: When they are employed, native people typically take low paying work and often do not qualify for or receive benefits. In the general U.S. population, 15 percent of people have no health insurance. Among native people, 24 percent have no health insurance. In 2003, Medicaid was the primary insurance for 25 percent of native people. Only 50 percent of tribal people had employer-based insurance versus 72 percent of whites. Because over 50 percent of tribal people live in off-reservation settings, the majority of Indian Health Service (IHS) facilities, which are typically located in rural and frontier reservation facilities, are unavailable to them. Funding for urban health care for tribal people is capricious and unreliable.

Behavioral health care issues: Tribal people in the U.S. are the most likely subgroup to be victims of a violent crime -- 124 out of 1000 (two and one half times the prevalence for all other races). Seventy percent of this violent crime against tribal Americans is by members of other races (perpetrators are 60% white and 10% black). The rate of alcoholism among American Indians ranges between 500% and 625% that of all other races; on average, between 20 and 25 of every 100 native people meet the criteria for alcohol dependence versus 4 out of 100 in the general population. Related to the alcohol statistic, the accidental death rate for native people is 212%, or more than double the accidental death rate for all other races.

In many tribal settings, the rates of posttraumatic stress are much higher for native people (22%) than the general population (8%). Some recent dissertation studies have

defined this as much higher for some specific tribes, such as the Klamath of Oregon (posttraumatic stress disorder being 10 times that for the general population). Lifetime prevalence of posttraumatic stress for AI/AN (45 – 57%) is much greater than that of all other races. Large-scale epidemiological studies of other behavioral disorder rates in the tribal communities have not been completed.

Behavioral health issues for tribal youth: Tribal youth are raised in native families and communities subjected to ongoing cultural oppression, health disparities and lack of equal access to services, lack of economic opportunity and chronic poverty. Parents in these families often experience substance abuse and mental health problems secondary to this sociological asymmetry. For tribal families, these factors translate to double the number of native youth reporting using marijuana, cocaine, tobacco, and alcohol in past month prevalence data than youth of other races. By age 12, lifetime prevalence rates for use of almost all substances are higher for tribal youth than for any other racial group. Nearly one in five native youth are involved in substance abuse to a level that is a threat to themselves or their community. The alcoholism death rate for tribal youth aged 15 to 24 years is over 17 times the rate for all other races. One study indicated that at least 75 percent of native youth with a substance abuse disorder had a co-occurring mental health disorder, usually conduct disorder, depression and anxiety, along with trauma-related symptoms, self-esteem, alienation issues, and suicidal behavior.

Death, homicide, suicide, and youth suicide in the tribal community: The accidental death rate for tribal children aged 5 to 14 is double the U.S. rate. Thirteen percent of tribal deaths occur to natives under the age of 15 versus 4 percent in the

general population. Violent death (by accidental injuries, homicide, and suicide) accounts for 75% of deaths in tribal people in their second decade of life. The prevalence rate for native suicide is 1.5 times the national average. The suicide rate for native youth aged 15 to 24 is 2.4 times that of the general population; native males aged 15 to 24 account for two-thirds of all native suicides.

I've provided some statistics, which show us the crisis facing AI/AN, but allow me to make these numbers come alive by elaborating briefly on my all too frequent personal and professional experiences with native suicide by providing some case studies.

Case Studies

At this point, I would like to describe a week in which suicide and suicidal behavior deeply affected the tribal community for which I was working as a psychologist at the time.

First Case Study - On Sunday night, a despondent 21-year-old male tribal member killed himself. Friends and relatives reported that although he had suicidal ideation, a severely depressed mood, anxiety over fiscal issues, ongoing substance abuse, and a history of suicide attempts, this young man had never presented himself for help at my office, the community mental health center, or the tribal medical clinic. He had not sought clinical services at the community mental health center, because he did not believe they possessed adequate cultural sensitivity. I was the only person he would have seen, and he was too ashamed to contact me. Unfortunately, I was so overwhelmed with clients that I had no time for outreach activities to reduce the stigma of seeking tribal mental health services. That week and on average, I had over 40 active clients, and I

worked with between 20 and 25 clients a week. There was an average waiting list of more than 20 persons.

The suicidal act is symbolic of this young native man's current situation. He recently learned to scuba dive professionally and hoped to dive for harvesting sea cucumbers and other delicacies. However, he was in deep financial trouble; he had never graduated from high school and had never held a decent job. On this Sunday evening, he was using methamphetamine and drinking with friends. When they stopped their car by a bridge in the community, he got out and walked to the bridge rail, mounted it like a professional diver, turned around and flipped over backwards as though he were entering the water in scuba gear from the transom of a boat. He fell eight stories to his death. Afterward, we tried to determine if this was actually a planned suicide or an incident of substance-induced misjudgment. No matter what his original intent, his action resulted in suicide. The entire tribal community went into shock. Tribal enterprises and businesses were shut down for grieving. Although mental heath professionals spent extra time asking patients about suicidal ideation, and educators began talking to children about the issue of self-harm (with children as young as four and five counseled), the outreach to the family and community was not sufficient.

Second Case Study **-** By Wednesday of that week, a second teenage native male died from a self-inflicted hanging. This young man, a family relative of the first suicide victim, lived hundreds of miles away in Canada. According to his relatives, he had been despondent, anxious over finances and romances, and had a depressed mood. When he found out about the first suicide in our community, he reported to family members that the first young man was fortunate because he had found a way "out of his pain."

Culturally appropriate clinical services for this young man were not available, and there was no professional outreach. The family had not sought mental health intervention despite the young man's report that he might also end his pain through self-harm. The psychological effects of this second suicide reverberated in the community, with expressions of fear and concern. Which young tribal member would be next? The community felt powerless.

Third Case Study - That Saturday, a week and a day after the first suicide, a pregnant native 17-year-old female, and a friend of the first native suicide victim, attempted to kill herself by consuming a massive dose of Tylenol and other pills. This attempt followed serious alcohol binging by the girl and her friends. They reported that once she became inebriated, she said, "He was the lucky one." She did not succeed in killing herself. Yet, she did destroy most of her liver and required transfer from the local hospital to a Seattle Medical facility, where she received care for over a month. She lost her child. Her liver remains severely compromised, and it is likely that she will require a liver transplant by age 30.

Aftermath to suicides in a vulnerable population - During this week, several of my regular mental health clients reported greater then average thoughts about suicide and less fear in attempting it. In addition, I was receiving increased phone calls about the issue and concerns not only from tribal members, but also from tribal police. Other tribal health providers were also expressing concern. Professionals began expressing doubts about their capacities and concern they might lose control of the situation. I called the University of Washington School of Nursing for assistance and contacted Dr. June C. Strickland, a Cherokee and an expert in suicide and its assessment. Together we worked

with tribal health professionals and tribal police to plan and present workshops scheduled for Friday. One workshop was conducted for children and youth, and a second workshop was for family members and tribal members. Workshops were also held for mental health and medical professionals who feared that more suicides were going to occur, and they felt powerless to intervene.

Acting out and suicidal ideation in tribal youth- One of my clients was a young tribal male, aged 12, who lived with his grandmother and dealing with his mother's alcohol abuse, feelings of abandonment and cultural oppression. He was diagnosed with posttraumatic stress, depression, attention deficit disorder, and intermittent explosive disorder.

When local police officers came to his grade school, they stated that they or the school counselors could provide help for parents' alcohol or drug abuse. This young man was desperate for help. He hoped that by contacting the school counselors, they would work together with the police to arrange substance abuse treatment for his mother. Instead, they used the information as the basis for removing him from his mother's care. She was prosecuted and put in prison for 18 months. He lost contact with his mother over this period and lost all trust in authority figures. He went to live with his disabled grandmother, who was living in a two-room apartment on $580.00 a month. This boy was not performing well in school and exhibited significant behavioral problems. On Thursday, he hit a teacher, trashed a room, overturned desks and threw materials everywhere. When brought to my office, he reported that he hated everyone and that he wanted to kill himself. When I asked how he would do this, his reply was "Jump off a bridge!"

I was not able to have county workers hospitalize him, due to prohibitive costs associated with hospitalization, their sense that he would not talk to them, and their belief that I was over-reacting. During the past year, three tribal clients in this western state killed themselves after having reported suicidal intent to tribal health providers but county workers denied them residential care as a cost containment measure. As a tribal mental health professional, I did not have the authority to commit this boy to a hospital. I was powerless, and so I arranged for his grandmother to call me hourly until the crisis passed. This was the best I could offer them.

On Thursday night, a 17 year-old male tribal member, with whom I had been working on issues of depression, substance abuse, and being a teen parent with limited resources was arrested (for methamphetamine) and placed in juvenile detention. He reported suicidal intent and was placed in a safe room, with rubberized walls and a television monitoring system. He attempted to injure himself by running head first into the wall as hard as he could in order to "break his neck." No assessment or intervention by the county was provided. That night, the specialist from the University of Washington came, and we planned two community workshops. The next day, we provided community suicide prevention workshops – one for adults (both tribal members and tribal professional staff) dealing with emotional trauma who felt a sense of helplessness and powerlessness. We also provided a large workshop for the children and adolescents. This workshop was open to older tribal members, many of whom observed quietly.

The following Monday, one week and two days after the first suicide, I was driving home after work and noticed a large crowd of tribal members and police in front of a huge tree at the corner of the road. Forty feet up that tree was a 9-year-old tribal

member I had been seeing in therapy for about a year. This boy's mother had been a victim of sexual and physical abuse and had a volatile relationship with her partner, who was a chronic alcoholic and was often arrested for domestic violence. He lived with his 16-year-old sister, who had chronic depression, and with two brothers ages eight and ten. This boy was diagnosed with bipolar disorder, attention deficit disorder, and posttraumatic stress disorder. This 9-year-old boy was threatening to jump from the tree. Despite the fact that neither the officer on duty nor I were trained to talk to persons threatening to jump, we first climbed onto the lower branches so as to be available to break a fall if it occurred. Fortunately, we were able to talk him into coming down from the tree. The county refused to hospitalize him and, again, we provided the family with the option of hourly calls to me and frequent drive bys by the police officer on duty. I increased our sessions together and began seeing him bi-weekly for the next six months.

Other personal and professional experiences with suicide - As a tribal person who was raised on a reservation, I was exposed, early and frequently, to violent death and suicide. It has been a common occurrence in my home community, amongst my tribe, and in each native mental health and substance abuse setting in which I have trained or worked in over the past 15 years. In 1978, my youngest brother, Mike Desjarlais, killed himself at the age of 18 with a self-inflicted gunshot to the head, following issues with drug abuse. That same year, a 19-year-old male tribal member and family friend whose sister I once dated in high school, hung himself in the jail in Cut Bank, Montana, following his arrest on alcohol-related charges. Later, in 1980, when I was in the Navy, my younger brother Kevin sent me word that one of my 20-year-old cousins, whom we all called Conan because of his physique and athleticism, had hung himself following a

bout of drinking. Recently, the 17-year-old son of a licensed native mental health professional with whom I was working killed himself with a gunshot to the head. The lack of available residential treatment services for substance abuse prevented us from referring this young man to the appropriate level of care.

My staff and I all have clients on our caseloads who report a higher than average baseline propensity for suicide. This is regarded as the leading source of worker stress in the mental health provider field. It is a common addition to the otherwise extremely complicated caseloads we all maintain and likely would not be an acceptable level of risk for a private practitioner or in most agencies. These individuals would be moved on – one way or another. However, we must aid these individuals because they have nowhere else to go. This contributes to worker burnout.

There is a lack of qualified native professionals and informal de facto cost containment at native client's risk - During my third year of graduate school, I had been providing individual counseling to an adult female native woman at the Indian Alcohol and Recovery House Program in Salt Lake City. I was concerned when I left the area for another training placement that she could not find another native mental health provider in the community to work on her issues. Feeling isolated and helpless, she committed suicide.

Native youth suicide issues are one of the most frequently voiced concerns when I am asked to consult with other community program treating native clients. Often, these conversations hinge on whether or not I have access to fiscal resources to pay for more intense treatment. I have found that both county and state agencies are often reluctant to hospitalize mentally ill native clients and / or suicidal native clients whenever it is

apparent that the costs must be born by the county or state. However, this reluctance is never openly acknowledged as a cost containment measure and always takes the form of "diagnostic disagreements" with my and other native professional's clinical judgment and recommendations regarding the suicidal native client's need for residential treatment. In some of these cases, native suicide has occurred.

Clearly, steps to ameliorate suicide in the tribal communities are required and the American Association and I propose the following recommendations to the committee.

Recommendations

Suicide Prevention Initiatives

- Designate suicide prevention as the top preventative focus for the IHS.
- Dedicate funding to support urban AI mental health and suicide prevention programs.
- Establish a national center for excellence for suicide prevention in native and tribal communities, which is operated and managed by AI/AN experts and professionals.
- Develop school-based mental health services to promote a positive school environment and help prevent youth suicide:
    - Mental health professionals would identify children with mental health problems early on (with the support of trained school personnel) and provide needed treatment that is culturally appropriate for AI/AN children and their families.

Collaboration and Access

- Professional tribal mental health providers should be able to make direct referrals to residential treatment centers.
- Increase the collaboration between county and state system gatekeepers and tribal mental health providers to ensure adequate access to suicidal AI/AN clients.
- The exclusion of AI/AN clients must be formally examined, and appropriate changes should be made in policies, which have excluded tribal youth from access to residential treatment centers.

Education and Workforce

- Increase the number of qualified native mental health professionals in the field to a number proportionate to that in the general population:
    - Funding for Indians into Psychology (INPSYC) Programs should be doubled with at least two additional university INPSYC sites established to provide mental health training for AI/AN in the filed of psychology;
    - Funding for professional programs to train native and tribal social workers and professional counselors should be increased; and
    - Develop university sites to train professional AI/AN social workers and professional counselors should be established.

Funding

- Provide an additional $170 million, as recommended by the *Friends of Indian Health*, to IHS to address the level of need for health and mental health care:

- Ensure that the number of IHS mental health care providers meets the ratio of mental health and care providers for the general population; and
- Each IHS Area should ensure that there exist community-based mental health and suicide prevention programs.

In conclusion, I encourage this committee, when you are considering and discussing the needs of American Indians, that you consider the need for adequate resources to prevent tribal suicide. Thank you for your time and attention to this matter.