

National Indian Health Board



**“H.O.P.E. for the Future: Helping Our People Engage to Protect Our Youth”
U.S. Senate Committee on Indian Affairs Oversight Field Hearing
Anchorage, Alaska**

**Presented by H. Sally Smith
National Indian Health Board
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Good Afternoon Chairman Akaka, Vice Chairman Barrasso, Senator Murkowski, distinguished members of the Senate Committee on Indian Affairs, Honorable Tribal Leaders, and guests. My name is Sally Smith, Secretary and Alaska Area Representative to the National Indian Health Board (NIHB). I also have the honor of serving as Chair of the Board of Directors for the Bristol Bay Area Health Corporation. Since its establishment in 1972, the National Indian Health Board (NIHB) serves federally recognized American Indian/Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to AI/AN people. The NIHB ensures that the Federal government upholds its treaty obligations to AI/AN populations in the provision and facilitation of quality health care to our people. Thus, it is on behalf of the 565 federally recognized Tribes and Villages that I present this testimony today. The NIHB is grateful for the opportunity for a frank discussion on what has become an all-too-frequent reality for generations of America’s first people: suicide.

Current Snapshot

While suicide is a major problem across the United States, it is a problem of epidemic proportions for our people. As with other disparities in physical and mental health, AI/ANs suffer disproportionately from tragically high rates of suicide, especially in our youth. Please allow me to present some of the devastating statistics:

- The rate of suicide among AI/AN youth, ages 15 to 24, is the highest of any racial or age group in the United States;
- Suicide is the second leading cause of death for AI/ANs between the ages of 10 and 34 years;
- AI/AN youth have an average suicide rate 2.2 times higher than the national average for their adolescent peers of other races;
- AI/AN suicide rates are highest among the 15 to 19 year-old age group;
- Males account for up to five times more suicides than females in Native youth;
- Suicide rates among AI/AN male youth is two to four times higher than males in other racial groups and up to 11 times higher than females in other racial groups.



- According to unpublished Indian Health Service (IHS) data, suicide mortality is 73% greater in AI/AN population in IHS service areas compared to the general U.S. population.

In concert with these catastrophic numbers, AI/ANs experience contributing mental illness and other risk factors at very high levels. AI/AN youth experience higher rates of mental health disorders that contribute to suicide, such as anxiety, substance abuse, and depression. In fact, they rank first among ethnic groups as likely to experience these types of disorders, with 23% of the AI/AN population reporting that they are frequently anxious or depressed.¹ Furthermore, AI/AN communities experience heightened rates of social risk factors, including low household income and high unemployment, with the chances of sexual assault for AI/AN women being 2.5 times the national average.

Encountering multiple social risk factors at an early age is all too common for our Native youth and is a major root cause of suicide. Although it has not been measured throughout Indian Country, Adverse Childhood Experiences (ACEs) or incidents of unresolved childhood trauma are likely much higher for AI/ANs than the general population. A 1996 study published by Kaiser Permanente, which first coined the term ACEs, examined the incidence and consequences of these traumas in 17,400 patients of their San Diego Health Appraisal Clinic. In the study, researchers defined 10 separate ACEs in three categories:

Abuse of the Child

- Psychological abuse
- Physical abuse
- Contact sexual abuse

Trauma in the Child's Household Environment

- An alcohol and/or drug abuser in the household
- An incarcerated household member
- Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- Absent biological parent from the household

Neglect of Child

- Emotional neglect
- Physical neglect

In their results, researchers saw how influential ACEs could be to future adult behavior. They concluded that the presence of one or more ACEs is directly linked to higher rates of smoking, alcohol abuse, drug use, suicide attempts, depression, anxiety, promiscuity, sexually transmitted diseases, overeating, and unhealthy relationships in adults. And at least one ACE was reported by 64% of participants, with 16% reporting four or more. Among other issues, those who reported four or more ACEs were 460 percent more likely to be suffering from depression and 1,220 percent more likely to have attempted suicide.

¹ "Access to Mental Health Services at Indian Health Service and Tribal Facilities," Department of Health and Human Services, Office of Inspector General, September 2011.

Although similar data does not exist that addresses the incidence of ACEs the AI/AN population specifically, I am sure that the Members of this distinguished Committee, through information gleaned in past hearings, can join me in concluding that the number of ACEs in Indian Country is likely much higher.

Perspective from Youth: NIHB Youth Summit at the Annual Consumer Conference

Indian Country has experienced generation upon generation of trauma and the data that is available reveals that AI/AN people continue to suffer disproportionately. Most recently, NIHB hosted our Annual Consumer Conference in Anchorage, Alaska, which featured a youth track that focused heavily on suicide prevention. The AI/AN youth in attendance represented communities with some of the highest rates of youth suicide: Alaska Native villages and the White Mountain Apache Tribe. Attendees were able to identify and articulate risk factors and the barriers to overcoming those challenges in each of their respective homes. In a consensus-building workshop at the close of the youth track, participants were invited to review community strengths and weaknesses, and to develop strategies to address health and wellness issues currently facing Native Communities from a Youth Perspective. The following are strengths and weaknesses that the youth saw in their own communities:

Strengths

- Community Support
- Boys & Girls Club
- Basketball/Wrestling/other sports
- Elders keeping culture alive
- Open gym
- NIHB Program
- Young Life Club
- Pot lucks/ Indian Dance

Weaknesses

- Schools low on money
- Homelessness
- Academically not dedicated
- Adults providing alcohol and drugs to the teens/youth
- Low paying jobs
- Not enough jobs provided for the teens/youth
- Substance Abuse
- Completing Suicide
- Financial Problems
- Drug Tests
- No Positive Role Models
- Teen Pregnancy

Clearly, the resulting adverse behavior from ACEs is present in the lives of these Native Youth and not enough is being done to address it. As one youth participant said, “In our future

community, I would like to see success by more kids going to college and more sobriety. I would like to see more kids involved in our culture, by learning to dance, learning our language, and learning our way of life.” Said another, “[Tribal Leaders] need to talk to all the people who do drugs or drink alcohol because they ain’t setting a good example either. And get programs for the drugs and alcohol, teen pregnancy, and all the other negative things younger adults and teens are doing these days.”

Recommendations

As with other public health epidemics in Indian Country, there are a great variety of barriers that truly affect and address the overwhelming rates of suicide in our communities. While it may be difficult for the Committee and Congress as whole to affect some, NIHB would like to suggest a number of opportunities to bring about change through programs, data and funding.

First, the NIHB recommends the establishment of a special federal program to address AI/AN youth suicide prevention. NIHB proposes that this special program for youth suicide prevention mirrors the Special Diabetes Program for Indians (SDPI) in structure. In 1997, Congress created the SPDI to address the disproportionate burden of type 2 diabetes on AI/AN populations and today, the program supports over 450 Indian Health Service, Tribal, and urban Indian programs in 35 states. SDPI is producing a significant return on the federal investment and has become our nation’s most strategic and effective federal initiative to combat diabetes and its complications. This success is due to the nature of this grant program to allow communities to design and implement diabetes interventions that address locally identified community priorities. NIHB proposes that this community-based approach and grant structure can be replicated in addressing youth suicide and has great potential for the same success.

Additionally, the NIHB would like to reiterate its support for swift action on S.740, *The Garrett Lee Smith Memorial Act Reauthorization of 2011*. This bi-partisan legislation has been co-sponsored by at least two Members of the Committee, including Senator Murkowski, and NIHB is thankful for your support. The legislation addresses the crisis of youth suicide from three fronts; providing grants for Suicide Prevention Resource Centers, providing grants for states and tribes to develop and implement a state sponsored youth suicide early intervention and prevention strategy, and providing grants for College campuses. Since 2004, the Act has allowed SAMHSA to provide millions of dollars in funding to the suicide prevention efforts of Tribes and Tribal organizations, and there continues to be great need for these dollars. Please do everything to ensure that S.740 is passed.

As noted above, AI/AN specific data that identifies the factors link to AI/AN youth suicide is needed. Studies in Canada have identified how culture moderates the suicidal behavior of First Nation Canadians.² NIHB recommends that funding is needed to apply this research to tribes in the United States. NIHB also supports the replication of the Kaiser Permanente ACEs study across Indian Country. While anecdotal evidence points to a much higher incidence of ACEs and the

² See Chandler, M. J. & Lalonde, C. E. (2008). Cultural Continuity as a Protective Factor against Suicide in First Nations Youth. *Horizons --A Special Issue on Aboriginal Youth, Hope or Heartbreak: Aboriginal Youth and Canada’s Future*. 10 (1), 68-72

resulting negative behaviors, our communities lack concrete data to support this. Benefits of these types of studies would include greater understanding of suicide and mental illness in Indian Country and provide empirical support for greater funding directed to mental health services and for tailor services on a cultural and regional basis.

A major source of many of the health disparities that AI/AN people face is historic and ongoing lack of funding to Indian Health Services (IHS). This disparity in mental health is no different. The IHS, as the Committee is aware, serves 2 million AI/ANs in some capacity. A recent study conducted by the Department of Health and Human Services (HHS) Office of the Inspector General found that the AI/AN community served through IHS and Tribal facilities suffers from a lack of access to mental health services. Although 82% of those facilities studied reported providing some type of mental health services, these facilities, as well as those who were unable to provide mental health services, frequently cited staffing shortages as a barrier to care. Only 39% are able to provide round-the-clock crisis intervention. The HHS study made recommendations to IHS on how to increase access to mental health care, but NIHB would like to make a recommendation to the Committee and to Congress: increase funding to IHS. Greater funding would allow the agency to dedicate more capital to attracting and retaining qualified staff. It would allow facilities to stay open longer and to serve more patients.

In the same vein, funding is sorely needed at the Tribal level. Tribes have had much success with creating culturally appropriate, community-centered suicide prevention programs. Frequently, Tribes have difficulty accessing grant money for this purpose, either because they must become a sub-grantee of their state or because of difficulties with the competitive grant process. In the President's FY2012 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration proposed the creation and funding of a new Behavioral Health - Tribal Prevention Grant (BH-TPG). This multi-year discretionary, grant program provides predictable, sustained funding for federally recognized Tribes to implement evidence-based and culturally appropriate substance abuse and suicide prevention strategies. Utilizing \$50 million from the Prevention and Public Health Fund, the BH-TPG would provide all Tribes with \$50,000 in direct, non-competitive funding for the prevention of substance abuse and suicide. Unfortunately, an authorization for this program has yet to be included in the Labor, HHS, Education, and Related Agencies Appropriations bill for FY 2012. NIHB urges the Committee to fight for its inclusion in any final appropriations legislation for FY 2012.

I thank the Committee for allowing me to present this testimony and for its past work concerning the disproportionate rates of suicide among AI/AN youth throughout Indian country. I am happy to answer any questions.