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1926 Stirling St, Rapid City, SD 57702 - Phone: 605-388-5375 Fax: 605-343-3074

Oversight Hearing on Youth Suicide in Indian Country

Senate Committee on Indian Affairs

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Testimony Provided

Robert Moore, Councilman, Rosebud Sioux Tribe,

Great Plains Tribal Chairman's Association (GPTCA)

Aberdeen Area Tribal Chairman's Health Board (AATCHB)

Introduction

Mr. Chairman and other Members of the Committee, thank you for your hard work to ensure that the appropriate authority and funding for health care services is available to meet the needs of the 17 Tribal Nations of the Great Plains, and thank you for the opportunity to provide this testimony on behalf of the Rosebud Sioux Tribe and all the Tribal Nations of the Great Plains Tribal Chairman's Association. I am Robert Moore, Elected Councilman of the Antelope Community, Rosebud Sioux Tribe of South Dakota. I am here today representing the Great Plains Tribal Chairman's Association (GPTCA), and the Aberdeen Area Tribal Chairmen's Health Board (AATCHB) —an Association of seventeen Sovereign Indian Tribes in the four-state region of SD, ND, NE and IA. The Great Plains Tribal Chairman's Association is founded on the principles of unity and cooperation to promote the common interests of the Sovereign Tribes and Nations of the Great Plains and their citizens.

Great Plains Region

The GPTCA stands on the Fort Laramie Treaty of 1868 (15 Stats. 635) Articles IV, V and IX that guarantees that the United States will provide health care services at the local level to our

people and will reimburse the Tribes for any services lost. It was clearly understood by the Indian signers of that Treaty that necessary assistance would be provided to the signatory Tribes by the Indian agent and a local physician (or Superintendent or the Director of Indian Health Service in the modern era) and that sufficient resources would be made available to the physician to allow him to discharge the duties assigned to him. Indian health care fulfills a fundamental Treaty obligation and our Tribal people take this obligation very seriously. It is important to note that as Tribal members, we are the only population in the United States that is born with a legal right to health care. This right is based on treaties in which the Tribal Nations exchanged land and natural resources for several social services, including housing, education and health care.

The Great Plains Region, aka Aberdeen Area Indian Health Service, has 21 I.H.S. and Tribally managed service units. We are the largest land based area served of all the Regions with land holdings of Reservation Trust Land of over 11 million acres. There are 17 Federally recognized Tribes with an estimated enrollment of close to 200,000 tribal citizens. **The Tribes of the Great Plains are greatly underserved by the I.H.S. and other federal agencies with the I.H.S. Budget decreasing in FY 2008 over the FY 2007 amount. This is in spite of increased population size and worsening health disparities.** The GPTCA/AATCHB is committed to strengthening direct health care systems and all Federal Programs in a comprehensive delivery to improve the lives of our enrolled members and in particular our Youth of the Seventh Generation. In the past few years, unfortunately, our Tribes have experienced an increase of Suicides.

Health Data and Overview

As documented in many reports, the Tribes in the Great Plains region suffer from among the worst health disparities in the Nation, including several-fold greater rates of death from numerous causes, including diabetes, alcoholism, infant mortality and suicide. For example, the national infant mortality rate is about 6.9 per 1,000 live births, and it is over 14 per 1,000 live births in the Aberdeen Area of the Indian Health Service—more than double the national rate. The life expectancy for our Area is 66.8 years—more than 10 years less than the national life expectancy, and the lowest in the Indian Health Service population. Leading causes of death in our Area include heart disease, cancer, unintentional injuries, diabetes and liver disease. While the numbers are heart-breaking to us, as Tribal leaders, these causes of death are preventable in most cases. They, therefore, represent an opportunity to intervene and to improve the health of our people. Additional challenges we face, and which add to our health disparities, include high rates of poverty, lower levels of educational attainment, and high rates of unemployment. All of these social factors are embedded within a health care system that is severely underfunded. As you have heard before, per capita expenditures for health care under the Indian Health Service is significantly lower than other federally funded systems, including the health care provided to Federal prisoners.

Specifics on Suicide:

Unfortunately, youth suicide has had a severe and devastating impact on the Great Plains tribes. The national death rate from suicide is approximately 10 per 100,000 population, and it is 17 per 100,000 in the IHS population. In the Aberdeen Area IHS, the suicide rate is **over 22** per 100,000 population—more than double the national rate. Adding to these disheartening numbers is the fact that suicide is more common among American Indian and Alaska Native **youth**,

whereas suicide rates tend to increase with advancing age among the general population.

According to the Centers for Disease Control and Prevention (CDC), from 1999-2005, among youth age 10-19 years nationally, the suicide death rate was **4.5** per 100,000 population.

In South Dakota, where I am from, among American Indians during the same timeframe, the suicide rate was **over 38** per 100,000 population—more than eight times the national rate. The result is that not only do we have a higher percentage of people committing suicide, we have a higher percentage of **young** people killing themselves—resulting in an even greater number of years of potential life lost in our populations. In addition, the Great Plains region suffers from extreme disparities in health, educational opportunities, and poverty, and suicide among our young people is limiting the potential of future generations to overcome these challenges.

Our young people live in great despair—witnessing the extreme emotional and social impact of high rates of infant deaths, living with poverty and often within abusive households, and watching other young people taking their own lives. The result is that we tend to see clusters of youth suicides in many of our communities, including my home in Rosebud, SD.

Over the past several years, the lack of resources, funding and staffing has taken its toll on our Tribal communities. It takes a community to raise a healthy child, and when you have school systems that needs strengthening due to lack of funds, a law enforcement department that is not operating at full capacity, a health care system that is inadequate, lacking proper funding and adequate staffing (such as no mental health care) combined with poverty, substance abuse, lack of jobs and quality of life, our People suffer. And, our Children suffer most of all.

The following are words directly from a teenager whose 14 year old sister committed suicide last November in North Dakota:

Jami was in a sitting position against the wall on her bed with a belt around her neck. The belt was tied to the bars of the top of her bunk bed which was leaning against the wall. I ran into the living room and told my boyfriend what Jami had done, then I ran back into Jami's room and he followed. I tried to take the belt off of her neck but it was too tight. Then my boyfriend cut her down. After that, I called my Mom and Dad. I sat there holding her till they came. I was crying uncontrollably talking to her asking her, "Why?"

I couldn't comprehend what had just happened. Then I heard my Mom and Dad come running in. My Dad started to do CPR on her, and my Mom was on the phone calling the Police Department to get the ambulance here. Then not even five minutes later they were here. The paramedic worked on her with no response, they did get a slight pulse at one time, and then they rushed her to the hospital.

She was already gone by the time they got there. The doctor at the hospital said if she would've survived she would have been brain dead.

The experience of losing my sister, best friend, someone I confided in, is very painful and hard to accept. I feel lost, lonesome, alone, and sometimes angry because I don't know why she did this while I was just in the other room. We always told each other "everything". She didn't tell me how she felt. I know she thought that I had enough of

my own problems and didn't want to burden me with hers, but she still could have told me.

It's been a few months now and I still feel lost, lonesome, and alone, but what I have learned from this is; don't keep things to yourself, talk to someone because there is always someone there for you who is willing to listen and help you.

Over the last several years in the Rosebud Sioux Tribe alone, we have witnessed dozens of suicides and **hundreds** of documented suicide attempts. The situation became so bad that in 2007 our Tribal President declared a State of Emergency in order to draw attention and resources to the problem. This year, 2009, there has already been 1 suicide and more than a dozen attempts in less than 2 months.

Rosebud Model

Chairman and Members of the Senate Indian Affairs Committee, to lose one of our Youth hurts our entire Community and Tribe. Our Tribal Leaders and community health advocates have worked tirelessly to find out what the roots of the problem are, and to see how we can improve our situations and prevent more suicides. Several projects have begun to address the problem of youth suicide. For example, on Rosebud we have started or expanded several programs, including:

- Wiconi Wakan Health and Healing Program
- "Safe Schools Project" in collaboration with Todd County Schools
- Suicide Task Force
- White Buffalo Calf Pipe Women's Program

- Alcohol and Drug Treatment Program
- RST Tribal Health Program (including Tribal Education and CHR Program), with the support of IHS's "point man" for Suicide Prevention/Intervention, Austin Keith (just arrived last week) will be able to physically follow up on every suicide completion and attempt, and begin tracking every suicide attempt with a Rapid Response Team approach.
- Suicide Prevention Grant
- Suicide Summits and Meetings with community members and leadership

The response and efforts conducted in the Rosebud Sioux Tribe have been remarkable, and we are hoping to have an impact on reducing suicide permanently in our community. Unfortunately, these efforts were not started in time to save many of our young people, and in the sixteen other tribal nations in our region, not enough is being done to focus on suicide prevention. In addition, we need a well-coordinated data, surveillance and response plan to meet the needs of all our communities. Regrettably, most of our communities do not have access to Area-wide and community-specific data that is managed by the IHS. In our region, most medical services and datasets are managed by the IHS at the federal level, and most of our public health programs are managed by the tribes. We **need** improved collaboration, cooperation and data sharing between the IHS and the tribes. According to Dr. Donald Warne, Executive Director of AATCHB, the Health Board has no reports or data sets with Area level data specific to suicide. As we attempt to improve our system of epidemiology related to suicide and mental health, this is precisely the problem. Although the IHS collects and maintains administrative and clinical data on patients seen in IHS clinics, these data are not readily accessible nor useful for the traditional public

health functions of population monitoring, investigation, program planning, and evaluating the effectiveness, accessibility and quality of health services.

For suicide, we need to develop a public health care infrastructure that is capable of supporting a “Rapid Response” approach and follow up to suicide events attempts/ gestures and completions in all of our communities. This implies creating a data collection and monitoring system that allows ready access to actionable data at a moment's notice. Such a system cannot rely on passive surveillance alone (i.e., voluntary), which is currently the case. Therefore, I would first recommend that suicidal behavior be elevated to the status of a reportable event throughout the Aberdeen Area. That means mandated reporting of all suicidal behavior in a timely manner by all providers (including first responders). Secondly, surveillance should apply to all levels of jurisdictional access (community, Tribal, Area) on a need-to-know basis. Suicidal contagion gives no credence to reservation boundaries. An electronic, integrated, surveillance system could accomplish these objectives. Finally, an active suicide surveillance system could serve as the starting point for the development of a more extensible infrastructure that supports focused, targeted interventions and coordination of care through automated analysis of factors relevant to crisis management and suicide prevention/intervention (i.e. who intervenes, when they intervene, with whom, and others).

IHS must change its health care paradigm to one of “Disease Prevention and Health Promotion” rather than just treating medical and behavioral problems after they begin. Our People need wellness education programs, exercise and healthy foods that are closely integrated with our traditional belief systems. Our Children need improved self-esteem and a stronger sense of hope for the future if they are to live in a healthy way. To achieve these goals, we need more

resources to develop healthy communities. The health of the community often determines the health of the families and the health of the children. Suicide is preventable, but we need resources in order to continue our community healing efforts.

Sufficient Resources

What would it take to give the Indian Health Service (IHS) sufficient resources to address our health care needs? The current appropriation for IHS clinical services is about \$3.4 billion. Our estimated funding percentage based on documented level of need is approximately 50-60% of that need. In order to bring IHS up to a more appropriate level of funding, an additional \$2 billion for clinical service would be needed nationally making our annual Federal appropriation closer to \$5.4 billion. This would be a major increase, but a small one relative to the \$700 billion budget for the Department of Health and Human Services (DHHS). A significant portion of these additional resources need to be directed toward behavioral health, suicide prevention and holistic care that meets the needs of our young people and our future generations.

Summary

In closing, we do not want to lose any more of our Youth. We seek to take on directly the terrible disparities that make our population's health status comparable to a third world country. As the nation takes on the ideas of health care reform, as President Obama noted in his address before Congress on Tuesday evening, February 24, 2009, please ensure that American Indian and Alaska Native communities and leaders are included its development. Also, please ensure that national efforts at health promotion take into account the unique needs and health disparities of our nation's first inhabitants. Thank you, again, for this opportunity and your attention to these vital matters.