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The Preventable Epidemic: Youth Suicide and the Urgent Need for Mental Health Care Resources in Indian Country

Good morning Chairman Dorgan, Ranking Member Barrasso, and members of the Committee. I am honored to appear before you today to present testimony about the tragic and ongoing problem of youth suicide in Indian Country. My name is Laurie Flynn and I am executive director of the TeenScreen National Center for Mental Health Checkups at Columbia University. I have served in this capacity since January 2001, and I am pleased to share information about our program and our role in addressing adolescent suicide.

The mission of the TeenScreen National Center is to prevent adolescent suicide and reduce disability associated with mental illness by mainstreaming mental health checkups as a routine procedure for adolescents in health care, schools, and other youth-serving settings. From our beginning, we have provided tools, training and technical assistance at no cost, and we now support mental health screening in more than 900 sites in 43 states, including tribal settings.

We are fortunate to be funded by a generous family foundation. Our benefactors share our dedication to reducing the devastating impact of undetected depression and other serious mental health problems on adolescents and their families. As a parent whose oldest daughter made a very serious suicide attempt at age 17, I can understand the ongoing pain of families in Indian Country as they struggle to find help and hope for their children.

Depression and Suicide among Native American and Alaska Native Youth

Today's hearing is important because youth suicide remains a significant public health challenge in the United States. Suicide is the third leading cause of death for all youth 11 to 21 years of age, and it accounts for approximately 12 percent of all deaths in this age group. As alarming as these statistics are, we know that the problem is much worse among American Indian and Alaska Native youth. The suicide rate for American Indian and Alaska Native youth is almost twice that of young people generally, and suicide is the second leading cause of death among 15 to 34 year olds in these populations.

Unfortunately, suicide rates do not capture the full extent of the problem. According to data cited by the Centers for Disease Control and Prevention (CDC), there are approximately 100 to 200 suicide attempts for each completed suicide among young people 15 to 24 years of age. Among American Indian and Alaska Native youth attending Bureau of Indian Affairs schools, a 2001 Youth Risk Behavior Survey found that 16 percent had attempted suicide in the preceding 12 months.

Despite these alarming numbers and widespread recognition of the epidemic of youth suicide among American Indian and Alaska Native youth, we are still not doing enough to identify and assist young people suffering from depression and mental illness. National Institute of Health (NIH) research shows that more than 90 percent of all individuals who commit suicide are suffering from diagnosable mental illness in the year preceding their death. Yet, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) more than half of all persons who die by suicide

have never received treatment from a mental health provider. Once again, the picture is even worse in tribal communities, with even fewer individuals receiving treatment.

This epidemic of preventable suicide among young people has been exacerbated by shortfalls in funding for the Indian Health Service (IHS), provider shortages, and the difficulty of providing services in rural, isolated locations. Each year, funding shortfalls within IHS limit referrals for medically necessary contracted health services. The vacancy rate for physicians in the IHS is approximately 20 percent, and 27 percent of the IHS workforce – nearly one-third – will be eligible for retirement in 2011. And the rural nature of Indian Country provides additional hurdles for both patient access and provider recruitment.

Despite these challenges, there are effective and efficient ways to improve the early identification and treatment of mental illness and reduce needless deaths by suicide. Mental health screening can identify youth most at risk and provide intervention early, when it is most effective.

Defining Mental Health Screening

Mental health screening, also referred to as a mental health checkup, refers to the administration of a standardized, evidence-based mental health questionnaire, such as the Pediatric Symptom Checklist (PSC) or the Patient Health Questionnaire 9 Adolescent (PHQ-9A). These mental health screens include between nine and 35 questions and take five to 10 minutes to complete. The questionnaire is then scored to determine whether additional follow-up is necessary. It is important to note that a positive mental health screen is not a diagnosis of mental illness. Rather, a positive score on a mental health screen is an indication that further evaluation by a health or mental health provider is necessary. Whether provided in a school, community, or medical setting, the TeenScreen mental health checkup involves providing assistance with referral for mental health evaluation or treatment to interested youth and their families, who may accept or decline to receive services. In school and community settings, where a formal referral network like those in many medical settings may not exist, active steps to engage parents and assist them in linking to services are encouraged.

While some have raised concerns about whether mental health screening might increase thoughts of suicide, research published by Gould et al. in the *Journal of the American Medical Association* demonstrated that there is no increased risk posed by mental health screening. Inquiring about mental health status, suicidal ideation and previous suicide attempts does not increase distress or suicidal thoughts in youth. The research also found beneficial effects for depressed youth and previous suicide attempters post-screening. Anecdotal evidence suggests that many young people are relieved to have the opportunity to discuss their mental and emotional concerns in a confidential setting.

Why Screen for Depression – Science and Research Support

The importance of early detection, through screening of mental illness, has been well documented through medical research and by governmental entities. In 1999, the Surgeon General released both *The Surgeon General's Call to Action to Prevent Suicide*

and *Mental Health: A Report of the Surgeon General.* These publications highlighted mental health screening as an effective tool for suicide prevention and suggested that primary care providers and schools could provide effective settings for the detection of mental illness. In 2003, the President's *New Freedom Commission on Mental Health* recommended an increase in early identification efforts by primary care providers. More recently, the Institute of Medicine (IOM) and National Research Council (NRC), in their report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, recommended that the federal government make preventing mental, emotional and behavioral disorders, and promoting mental health in young people a national priority. Medical panels and professional groups have also recommended mental health screening for adolescents, including the United States Preventive Services Task Force (USPSTF), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American Medical Association (AMA).

A mental health checkup using an evidence-based, standardized tool should be incorporated into the annual well-child visit for all adolescent youth as part of routine preventive care. We now know that in youth up to age 21 there is a window of opportunity of two to four years, between the first symptoms and the onset of the full-blown diagnosable disorder, when treatment is most effective at reducing the severity of specific disorders.

However, we also know that primary care providers often rely on informal, unproven mental health screening methods and that mental health issues are sometimes not addressed at all. Further compounding the problem, many young people do not receive regular preventive care visits. This is especially true for American Indian and Alaska Native youth in rural settings, where the closest pediatrician may be several hours away. In fact, according to the AAP, the average number of well-child visits within the American Indian and Alaska Native populations has dropped more than 35 percent over the last decade. As a consequence, it is important to incorporate mental health screening into a wider array of youth serving programs, such as those offered in school and community-based settings.

TeenScreen Schools and Communities - Our Work with Tribal Communities

The TeenScreen Schools and Communities program has been affirmed as an evidence-based method of addressing youth suicide. The TeenScreen Schools and Communities program is included in the Best Practices Registry for Suicide Prevention put out by the Suicide Prevention Resource Center (SPRC). The program is also included in the SAMHSA National Registry of Evidence Based Programs and Practices (NREPP). TeenScreen has assisted a number of school and community based sites in providing mental health screening and referral to youth in Indian Country. Together, these programs have offered mental health screening to thousands of young people. I would like to highlight a few of these programs.

A number of Garrett Lee Smith grantees have chosen to incorporate TeenScreen into their suicide prevention efforts. Signed into law on October 21, 2004, the Garrett Lee

Smith Memorial Act (GLSMA) was the first federal suicide prevention program targeted toward youth and it created grants for states and tribal organizations to create and implement statewide/tribal suicide prevention plans. In all, at least 13 grantees in 12 states have incorporated TeenScreen into their suicide prevention programs, including both campus and state/tribal grantees.

Gila River Behavioral Health Authority

One such grantee is the Gila River Behavioral Health Authority Youth Suicide Prevention Project in Sacaton, Arizona. This program serves the Gila River Indian community, which includes a population of 14,000 located on 372,000 acres south of Phoenix. The Gila River grant-funded services include TeenScreen.

The Gila River Regional Behavioral Health Authority began providing mental health screening to youth in schools within the region during the 2007-2008 school year. In the first year of screening, they were able to provide just 80 screenings, due to a low rate of parent consent. They also noted that a lack of good communication channels has made implementing large scale programs, such as TeenScreen, more challenging.

With continued effort and by building trust in the community, the Gila River Regional Behavioral Health Authority was able to increase their screening rate considerably during the 2008-2009 school year, with a total of 455 youth screened. This was an increase of more than 400 percent, and the program has trained 11 teachers, counselors and staff at four sites to implement the TeenScreen program and promote its sustainability.

Among students screened in the program, 87 youth (approximately 19 percent) screened positive due to risk of suicide or need for early intervention services. All youth identified were referred for some type of support services: 74 youth were referred for mental health services and 13 were referred for non-mental health services, such as social support services.

The Gila River program is continuing its screening program in the 2009-2010 school year, and the grant funding is currently authorized through September 2011.

Turtle Mountain Schools of Belcourt, North Dakota

In 2002, Paul Dauphinais, Ph.D., a practicing school psychologist employed by the Turtle Mountain Community School District, learned of the TeenScreen Program and decided to work to bring mental health screening to Turtle Mountain Schools. The schools are located in Belcourt, North Dakota and on the Turtle Mountain Chippewa Indian Reservation.

At the onset, Dr. Dauphinais knew that community support would be critical to the success of the screening program. By educating community members and giving presentations on the subject to key stakeholders, he was able to garner support from the Tribal Chairman, parents, school administration, and area treatment providers who would

provide clinical interviews and referral resources for youth identified through the screening process.

By 2004, Dr. Dauphinais developed a screening plan that would enable him to offer screening in Turtle Mountain's middle and high schools. He developed and strengthened relationships with local entities and staff that would participate in administering and supporting the screening program. Eventually, his screening team was comprised of school personnel, Indian Health Service (IHS) clinicians, community treatment providers and one case manager, whose position was funded by a Safe and Healthy Students Grant. (This position was first funded during the program development phase of the project, and has continued to be funded in each subsequent year.) Coordination with IHS staff and clinicians provided a unique opportunity for collaboration, which benefited the families that both the schools and IHS exist to serve. The well-orchestrated screening program also ensured that no single system was overwhelmed with referrals at any given time, and that each youth and family, starting with the most critical cases, received appropriate referral services and case management.

During the 2004-2005 school year, fewer than one hundred students participated in the program. Despite seeing lower numbers than the screening team anticipated, this first year allowed the team and supporting organizations to familiarize themselves with the screening process and work to best utilize the community's limited resources for the youth who required follow-up interviews and referral services. Over two hundred youth (225 total) were invited to participate in the program during the 2005-2006 school year. One hundred twenty-five youth received parent consent and were screened. Of those youth, 33 scored positive on the screening instrument, requiring a clinical interview with program staff.

Unfortunately, personnel difficulties and a lack of funding resulted in a stalled program, i.e. they were no longer able to provide screening, in 2008.

Riverside Indian School of Anadarko, Oklahoma

Riverside Indian School (RIS) is a federally operated off-reservation boarding school located in Anadarko, Oklahoma. RIS is the largest Bureau of Indian Affairs boarding school in the United States, with an enrollment of 600 students in grades four through 12 and students from more than 100 different tribes across the United States. The student population is 100 percent American Indian.

Gordon Whitewolf is a school therapist and counselor at RIS. Mr. Whitewolf provides counseling and therapeutic services for students experiencing variety of behavioral and mental health problems. He is an Oklahoma Licensed Behavioral Practitioner, and an Internationally Certified Alcohol/ Drug Counselor.

By 2002, Mr. Whitewolf was well into his tenure at RIS and witnessed first-hand the alarming rates of mental illness, substance abuse and suicide risk among his students. He felt that through his work at RIS, he and his colleagues could proactively identify youth

who might be at the highest risk for suicide or other mental health concerns. Mr. Whitewolf found that many students came to RIS with a variety of mental health problems that were not previously identified. Some youth were struggling with depression and suicidality; others were dealing with anxiety-related disorders, associated with separation from their family and friends, and learning to adjust to a new environment.

Mr. Whitewolf set out to identify a program or intervention that would enable the RIS counseling and medical staff to identify students in need of immediate intervention, as well as those students who would benefit from additional support throughout the school year. A colleague presented him with preliminary information about a new mental health checkup program being offered by Columbia University. After collecting information on the program and presenting it to the Director of Student Services, he was granted permission to bring the TeenScreen Program to RIS during the 2002 school year.

“Native American’s have survived centuries of historical trauma and infirmity,” Whitewolf says. “Today, Native American youth face similar discord constructed by society such as violence, racism, substance abuse, and mental health problems. These problems impact youth in different ways, and may bring about a feeling of hopelessness or worthlessness. That is why Riverside Indian School implemented the Columbia University TeenScreen Program. The Program helps staff identify those students showing evidence of suicidal ideation, previous suicide attempts, possible mood disorder, as well as substance use.”

In the program’s first year, Mr. Whitewolf and the counseling team offered screening to the entire student body. The screening team consisted of two school therapists who administered the screening questionnaire and provided clinical interviews, and a nurse practitioner who provided case management services. In addition, close consultation and cooperation with Parent Liaison staff and Medical Center staff ensured that every element of the student’s care and well-being was considered.

The results of the screening in the first year were telling: staff found that 17 percent of youth screened reported suicidal ideation or a previous suicide attempt; 20 percent reported problems with substance abuse; and 19 percent reported symptoms of depression. Mr. Whitewolf and RIS counseling staff assisted youth at highest risk immediately, and provided follow-up assessments (and treatment when necessary) for all students who screened positive. With such a large segment of the student population suffering from mental health and substance abuse problems, screening allowed the counseling team to provide triage evaluations to all students, and identify youth at highest risk, ensuring that cohort of students receives the critical care they need.

Since his initial success in 2002, Mr. Whitewolf and colleagues routinely offer mental health screening to all new students at the beginning of each school year. “The TeenScreen Program provides an opportunity for therapeutic intervention for students in need of services, and the ability to assist each student both at school and when they return to their respective tribal community upon completion of the school year,” Mr. Whitewolf

has explained. In addition, he has stated that screening has allowed counseling staff to communicate more effectively with the medical unit on campus, creating a unique system that fosters better over-all care for RIS students.

Lessons Learned

These case studies highlight both the successes and the challenges of reaching at-risk youth in Indian Country through mental health screening. Thousands of young people have received a screening, and hundreds have been connected to needed support services. More importantly, for many youth, the screenings serve as an opportunity to start a conversation about mental and emotional health.

However, much as in medical settings, we cannot reach all young people through these screening programs. Funding shortfalls often lead to the end of a screening program; when a grant runs out, the program stops. We also know that some of the most at-risk young people cannot be reached in a school setting. Mental illness is the leading cause of disability-related school dropout, and youth suffering from mental illness are much more likely to leave school before graduation. In fact, a 2010 report from the University of California, Los Angeles (UCLA) Graduate School of Education and Information Studies found that fewer than 50 percent of American Indian and Alaska Native youth in the Pacific and Northwest of the United States graduate from high school.

Recommendation– Integrate Screening into Multiple Youth Serving Settings

In order to provide comprehensive services and reach as many at-risk youth as possible, it is imperative that we provide opportunities for prevention and early intervention in all youth-serving settings where appropriate supports can be arranged. This may include, but is not necessarily limited to, medical, school and community settings.

In American Indian and Native American communities, cultural programs can play an important role in promoting and providing access to mental health screening. TeenScreen site coordinators in Indian Country have repeatedly stressed the importance of engaging tribal leaders to communicate about the importance of mental health screening and to build trust within the community. Many suicide prevention programs incorporate initiatives to celebrate and preserve Native culture into their efforts, and these settings should play a role in helping to identify at-risk youth through screening.

The health care reform bill signed into law by President Obama on Tuesday will go some way to helping to expand mental health screening in the medical setting. The language includes provisions to provide United States Preventive Services Task Force recommended services without cost-sharing in benefit plans, which includes annual depression screening for adolescent youth ages 12 to 18. However, we know that mandating coverage of a service does not always translate into the service being provided in clinical practice. Therefore, we must continue to work to raise the visibility of the need for mental health screening as we expand access in multiple youth-serving settings.

Recommendation – Expand Telemedicine with focus on mental health of youth
Identifying youth in need of mental health services through screening is of little utility if we are unable to connect them to necessary services. As we referenced earlier, the IHS suffers from a provider shortage for all types of providers, and child and adolescent psychiatrists are in short supply, not just in the IHS, but the system more generally. Furthermore, the rural and often isolated locations in which many American Indian and Alaska Native youth reside contribute to the difficulty of connecting them to appropriate mental health providers.

An important solution to addressing these challenges has been the expansion of the use of telemedicine services, including telepsychiatry. For example, the University of New Mexico's Center on Rural Mental Health has been providing telepsychiatry services, also referred to as tele-behavioral health services, to the Mescalero tribe and others in New Mexico. Through a contract with the IHS and the State of New Mexico, the Center is able to offer patient diagnosis, treatment, and supervision services. The Center is also able to help address the workforce shortage by providing additional training and supervision to mental health providers, such as social workers.

The success of such programs has spurred an increased investment in tele-behavioral health services. The Methamphetamine and Suicide Prevention Initiative (MSPI) included funding to establish a National Tele-Behavioral Health Center of Excellence, and at least 50 IHS and federal sites are using or in the process of creating tele-behavioral health services. The American Recovery and Reinvestment Act of 2009 (ARRA) also provided funding to expand the infrastructure necessary to support telemedicine.

The health care reform legislation signed into law earlier this week also includes provisions that will help expand access to services for American Indian and Alaska Native youth. New grant moneys for telepsychiatry projects are included in the legislation, as well as provisions targeted toward addressing IHS workforce recruitment; improving rural health services; reducing health disparities; and expanding access to preventive services.

These are all steps in the right direction, but we remain far from being able to serve all youth who are in need of mental health services adequately. We must continue to address the shortage of services through common-sense, proven approaches such as telemedicine.

TeenScreen National Center as a Resource
Thank you for the opportunity to testify. The TeenScreen National Center stands ready to serve as a resource, and I look forward to working with the members of this Committee as you develop policies to improve the lives of American Indian and Alaska Native youth.