

## **Senate Indian Affairs Committee Field Hearing: Addressing Trauma and Mental Health Challenges in Indian Country**

**August 17, 2016**

My name is Dr. Kathryn Eagle-Williams (Red Cedar Women) I am the Chief Executive Officer of Elbowoods Memorial Center of the Three Affiliated Tribes and an enrolled member of the Arikara. First of all, I would like to thank for your interest in addressing trauma and mental health challenges in Indian Country and in particular in North Dakota. I am going to start by informing the committee that I am a survivor of suicide. On September 7, 2011 I lost my daughter to depression. She died by way of hanging. As a result of her death we have an entire immediate family of approximately 50 plus individuals affect by her death, and an even large number of extended family and community members. She died in Tucson, Arizona where we made our home. Within 7 months of her death I moved home to North Dakota and this is where my healing process began. Although, we were in Arizona at the time the picture is still the same. In general, access to basic health services is limited as is funding and expertise in working with Native American populations in regard to mental health and trauma. Access to mental health services is more limited due to lack of mental health providers, programs, and funding.

As health care providers in behavioral health we are aware of the fact that adverse child experiences contribute significantly to the health outcomes of any individual within a population, but must be mindful of the disparities within our Native American populations.

Based on the latest statistics from 2009-2013 the suicide rate among AIAN was the highest in the United States.

- 34.3 deaths per 100,000 for men
- 9.9 deaths per 100,000 for women
- AIAN males are twice as likely to complete suicide compared to other gender, racial and ethnic subgroups
- Suicide is the 2nd leading cause of death for AIAN persons age 15-24 and 4x the national average

Losing a child to depression is my story, but we all know there are many more stories of our men, women, and children who are suffering and have died from mental illness. We as Native have heard the stories of our historical trauma and are still suffering from not only those traumas that affected our ancestors, but also the traumas that are a daily occurrence on our reservations and among our family and community members. We are still trying to overcome the Garrison Dam experience, we have a few elders still living who actually recall life before the dam and who remember a life that was much happier with few social and health issues and who recall the devastation of having to move from the bottom lands to higher ground.

Through my personal journey with the help of friends, collages, and my tribe have been able to work on healing and for that I am grateful. Much my healing experience did not come from sitting in a counselors office, but from the support of my community and spiritual leaders. Our work in the area of health and wellness work is has only begun, we need mental health first responders or behavioral health technicians to help with sudden unexpected deaths and trauma such as domestic violence and sexual assaults; we need grief counselors, and must destigmatize mental illness.

In order to begin to heal a community we must first identify and recognized the trauma before we deal with it. Our people are living in crisis situations as I once was and are simply just trying to survive. At Elbowoods Memorial Health Center we are fully aware of the need for and protective factors associated with traditional medicine, but it seems as though the federal and state governments have not recognized the importance of spirituality and identity, which limits are ability to create programs that are meaningful and successful. We would like to see more of an investment into these modalities of therapy and health practices. We would like to offer these practices here with the possible consideration of medical reimbursement.

Today I would like to share with some of what we experience on the Fort Berthold Reservation otherwise known as the Three Affiliated Tribes.

The core of our challenges are as follows:

1. Limited access to services as a result of underfunding, criteria requirements, and licensure required for clinicians (locally), and lack of availability regionally.
2. Lack of access to hospital beds required for acute care and life threatening mental health conditions.
3. Lack of a plan to transport emergency life threatening mental health conditions requiring ambulance verse civil transports to the accepting hospitals.
4. Limited human resources and expertise: inability to staff our already under funded behavioral health programs.
5. Lack of funding, funding is often competitive and requires data that is often not available or scattered.
6. Lack of culturally sensitive trauma informed care models and training.
7. Limited resources in regard to prevention and intervention programs associated with suicide and mental “brain” health.
8. Stigma associated with mental illness
9. Social determinates of mental health
10. Need of mental health first responders program to be established reservation wide

So, the question is how do we address these core challenges? First of all, it is through support of our leadership, tribal, state, and federal that we can begin to impact the disparities. Secondly, we must educate and inform our policy maker and funding agencies the importance of working with

tribes and understanding the true demand may not always be established through data as we may not have access to meaningful data. Finally, the continuation of tribal consultation is a necessity initially and throughout the process of planning and development of programs.

With that being said we are appreciative of the state's respect and consideration to ask for tribal consultation and would like to be an integral part of a state wide plan to the development of realistic services and training that are not only on paper, but are being implemented throughout the great plains. Dr. Monica Taylor-Desir, Chief Medical Officer for Elbowoods Memorial Health Center, who we are very fortunate to have, has reviewed the ND suicide prevention plan. Dr. Taylor –Desir has identified the plan includes working with Native Americans but there is no evidence in the last 6 months of the enactment of that plan in particular with our tribes. We need action not just words. We need support to educate and train our own people to help address the lack of human resources and access.

We need help in addressing the social determinants of mental health which include the following:

- Discrimination and social exclusion
- Adverse childhood experiences
- Poor education
- Unemployment, underemployment, job insecurity
- Income inequality, poverty and neighborhood deprivation
- Food insecurity
- Poor housing quality and housing instability
- Poor access to mental health care

It is our recommendation that when working with Native American people we must work from a strength based approach. It must be recognized that our cultural traditional ways of life and living are important protective factors in regard with mental, spiritual wellbeing of our people. We must destigmatize mental illness and focus on brain health and wellness. We must incorporate cultural practices into approved grants and other funding opportunities. We must promote commitment to cultural spirituality as well as promote strengthening of family ties and relationships. Incorporating, traditional spirituality and wellness must be recognized as a best practice. And in order to get at the heart of mental health we must incorporate trauma informed care while addressing addictions. We must not criminalize the addict or the broken spirit.

As I conclude I would once again like to say thank you for your interest and consideration as we attempt to meet the health needs of our people. In writing this testimony I am honored and humbled to share my story which is an experience I unfortunately share with far too many of my people.

Below you will find more information that has been gathered by our Behavioral Health Director, Dr. Lisa Keller-Schafer, a trained psychologist.

Behavioral Health (BH) Obstacles for NA residing on and off Fort Berthold reservation

1. Access to mental health services is severely limited for those living on and off the reservation due to:
  - a. Lack of insurance
    - i. 33% reported not having insurance compared to 11% of Whites; with 46% reported they could not afford the cost of healthcare
    - ii. 57% rely on IHS for care
  - b. Lack of tribal funding
    - i. Due to changes in budgeting and outside payee sources many programs' funding has been cut – some – including behavioral health, up to 50%
  - c. Lack of transportation
    - i. Of those who own a car, most cannot afford to fix minor repairs, pay for gas, or general upkeep.
    - ii. Others rely on relatives/friends to transport them, which often is money paid out of their pocket. An elderly lady reported having to pay \$100 to her relative for each trip she took to a store
  - d. Lack of providers
    - i. currently Fort Berthold has one provider to cover the entire reservation
    - ii. of those who apply for counseling positions, most are underqualified or not licensed
    - iii. the only recruiting incentive is student loan repayment programs for those who are licensed
    - iv. In regards to reasons tribal members do not seek BH services: 39% of tribal members reported a lack of providers and 48% reported limited clinic hours kept them from seeking mental health services; another 40% did not trust their information would not be kept confidential
  - e. High poverty rates

- i. The percentage of the reservation population with income below the poverty level is at 23.1%. In comparison, this is more than double the average North Dakota poverty rate of 11.2% and is higher than the U.S. rate of 15.9%. In respect to children, the situation is worse, with 31.6% of the reservation population under the age of 18 living below the poverty line compared to 13.2% in North Dakota and 22.6% in the U.S. overall

f. Emergency Service Barriers

- i. 78% of tribal members report there are no emergency services available in their area
- ii. ambulance drivers can refuse to transport individuals presenting with psychosis or a danger to others claiming they are at greater risk of harm because those individuals are violent – WHICH is a myth
- iii. there are no police transports for individuals presenting with severe mental illness – even those with homicidal and suicidal ideations due to boundary issues – basically TAT police are required to place criminal charges on individuals who they transport. This means for clients presenting with mental illness, they would have to be criminally charged before police can transport. AND even if police could transport they could only bring a client to the reservation line and then another police officer from the next county would need to take the client from there. AND the client would not be escorted to a hospital ED, but instead because criminal charges were placed on that client – the client would go to jail until his/her hearing.
- iv. There is no clean-cut civil commitment on the reservation. Family and friends who are attempting to get their loved ones help and the loved one is over 18 years must complete affidavits indicating why the loved one is a danger to the self or others. This goes to the judge who decides if the individual should be detained – but that is if the loved one can be easily found – given the PD are also understaffed.

g. Lack of awareness about mental health issues and services AND Stigma

- i. Many elderly believe talking about mental health issues such as suicide will make things worse
- ii. Approximately 78% of all individuals presenting for mental health services have reported a dislike of psychotropic medications, but have used licit and illicit substances to relieve their symptoms
- iii. Many do not believe their information will remain confidential

- iv. *misguided views* that people with mental health problems may be more violent or unpredictable than people without such problems, or somehow just “different”, but none of these beliefs has any basis in fact; Psych ward – insane asylums – bloodthirsty killers in straightjackets –
- v. *early beliefs* about the causes of mental health problems, such as demonic or spirit possession, were ‘explanations’ that would almost certainly give rise to reactions of caution, fear and discrimination.
- vi. Even the *medical model* of mental health problems is itself an unwitting source of stigmatizing beliefs. First, the medical model implies that mental health problems are on a par with physical illnesses and may result from medical or physical dysfunction in some way (when many may not be simply reducible to biological or medical causes). This itself implies that people with mental health problems are in some way ‘different’ from ‘normally’ functioning individuals. Secondly, the medical model implies diagnosis, and diagnosis implies a label that is applied to a ‘patient’. That label may well be associated with undesirable attributes (e.g. ‘mad’ people cannot function properly in society, or can sometimes be violent), and this again will perpetuate the view that people with mental health problems are different and should be treated with caution.
- vii. stigma directed at adolescents with mental health problems came from family members, peers, and teachers.
- viii. stigma perpetrated by teachers and school staff, who expressed [fear](#), dislike, avoidance, and under-estimation of abilities
- ix. Mental health stigma is even widespread in the medical profession, at least in part because it is given a low priority during the training of physicians and GPs

h. Limited services available on the reservation

- i. There is no speech or occupational services – 46% have requested these services
- ii. There are no pain clinics – 41% have requested these services – these services are essential for those using opiates to mask mental illness
- iii. No alternative care such as massage, acupuncture – 35% have requested these services
- iv. There is no CT, MRI, Pet Scans

- v. There is no sleep study program, respiratory care, EEG

### Consequences

1. **Suicide:** There are currently no statistics for the Fort Berthold Reservation in regards to the number of suicides. However, the Aberdeen IHS office has presented the following example from other reservations in its' area. "It could be argued that the senseless stabbing death of a young teenage girl in January 2007 by two other young teenage girls being egged on by a circle of peers really set the tone for the 2014 year: one of dread and despair that led to a continuous cycle of death... *of 16 other adolescents who took their own lives.* In spite of efforts over the past 12 months to reach-out to youth and families, to train all community members on prevention and intervention strategies, to partner with state and federal agencies for an increase in services, these lives lost are the best indicator that there are gaps, inadequacies, and barriers to current service structures. As shown above, in the number of agencies and organizations devoting resources to youth, there is dedication of purpose. **These purposes and efforts, however, have not yet led to a transformed community where the choice for life far outreaches the choice for death.**"
2. Serious Emotional Behavioral Disorder (SEBD) reflects an individual (ages 8 to 89 years) who:
  - a. Is angry, bitter, hostile, and aggressive, prone to fighting and bullying, uses excessive profanity, who is constantly getting into trouble, prone to steal, arson and gang activity and who may act out sexually;
  - b. Appears withdrawn, upset, frustrated, pouting and sulking, lazy and lethargic, confused, lacking attention, and who has poor hygiene, inadequate nutritional intake, sleep disturbance, and prone to lying, running away from home, self-mutilation;
  - c. Shows a lack of respect, failure to thrive, has health problems and depression, is defiant, has low self-esteem, has attachment issues and prone to gang participation, has poor academic performance; and,
  - d. Is prone to suicidal thoughts and ideations, social phobias and fear of certain people, has a false pride and demonstrates grandiosity or 'big head'.
3. **Methamphetamine** use is increasing. The Aberdeen Area Indian Health Service (IHS) reported that on average Behavioral Health Units (Alcohol Programs as well as IHS Mental Health Programs) are seeing an average of 48.5 cases of confirmed methamphetamine use per month per site.

4. **Liver diseases** are “broken spirit” diseases for Indian people. HIV and Hepatitis (HBV and HCV) affects AI/AN in ways that are not always apparent because of small population sizes. Of all races/ethnicities, AI/AN had the highest percentages of diagnosed HIV and Hepatitis infections due to injection drug use. AI/AN face HIV and Hepatitis prevention challenges, including poverty, high rates of STIs, stigma, and lack of psychiatric care to treat predisposing mental illnesses.
5. A national study on **Violence Against Women** reported that American Indian women and experience the highest rate of Domestic Violence in the United States, and that three-fourths of Native American women and children have or will experience some type of sexual assault in their life time; with approximately 76% of women being raped by their significant other at least one time. Although recent reports of violence vary and specific numbers are not known, it is estimated that over the past 3 years Fort Berthold shows an increase in the number of violence-induced injuries including 664 assaults, 60 stabbings, and 31 possible rapes. This report is a rough estimation of persons seeking medical or legal intervention on and off the reservation.
6. The poverty of the area has a major impact on the health and wellness of the people. The Aberdeen Area Indian Health Service IHS which provides health care to Fort Berthold, and the tribes in South Dakota and Iowa, has some of the most startling health statistics of the twelve national IHS service areas (Indian Health Service, 2007):
  - The age-adjusted death rate (all causes) is more than double the U.S. All Races rate, and is the second highest Area rate in the Indian Health Service.
  - Other Data on Mortality rates: the 2<sup>nd</sup> highest Suicide Death Rate; the highest Alcoholism Death Rate; the second highest Diseases of the Heart Death Rate
  - The Diabetes Mellitus Death Rate is five times the U.S. All Races Rate. Diabetes is the fifth leading cause of death for Tribes in the Aberdeen Area (following heart disease, cancer, accidents, liver disease and cirrhosis).
  - The lowest Life Expectancy at Birth: 64.8 years compared to 75.8 years for the U.S. All Races and 71.1 years for the All IHS service populations.
  - The highest Years of Potential Life Lost Rate: 119.5 years/ per 1,000 persons under the age of 65, which is 2.5 times the U.S. all races total.