

PUBLIC SERVICE PERSPECTIVES

The Tragedy of Native American Youth Suicide

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High rates of suicide among American Indian and Alaska Native populations call for significant efforts by lawmakers and public sector psychologists to develop, implement, and evaluate policy and programs that increase our understanding of factors that contribute to these high rates, and lead to effective resources that reduce the suicide crisis among these groups. The author describes how the federal government has responded to this crisis, what the barriers have been, and what is needed in the future from multiple sectors to ensure our nation's health care system is responsive to the tremendous health care needs that have long been evident in American Indian and Alaska Native communities.

Keywords: suicide, American Indian/Alaska Native, Federal Government, health care

Youth suicides in American Indian and Alaska Native communities have reached epidemic levels over the past 25 years (Middlebrook, LeMaster, Beals, Novins, & Manson, 1998). Federal policymakers and health care providers urgently need to develop an effective response to repair the broken health care system that allows this epidemic to persist year after year.

The rate of suicide for American Indian and Alaska Natives is far higher than that of any other ethnic group in the United States—70% higher than the rate for the general population of the United States. American Indian and Alaska Native youth are among the hardest hit. They have the highest rate of suicide for males and females, ages 10 to 24, of any racial group (Indian Health Service [IHS], 2008a).

This crisis is about more than numbers. It's about people, wonderful young people with everything ahead of them, who take their own lives. It's also about the traumatized and grief-stricken families and the communities left behind. Too often, Native young people simply

fall through the cracks of a broken medical system that does not detect their mental health problems and, when they are detected, often fails to adequately treat them.

Jami Rose Jetty, a beautiful 14-year-old girl from the Spirit Lake Nation in my home state of North Dakota, was one who met that fate. In November 2008, she felt hopeless and took her own life. Her older sister, Dana Lee Jetty, who found her sister hanging in her bedroom, testified before a hearing of the Senate Committee on Indian Affairs which I called early last year to examine this crisis. She said her Mom "did all the right things." Jami's mom noticed that Jami seemed to be troubled. "She took her to the doctor. She talked to counselors, and she even had her evaluated by mental health professionals from the Indian Health Service. Those mental health providers dismissed my Mom's concerns and diagnosed my sister as being a 'typical teenager,'" Dana told us. "I know my Mom is angry that these professional people did not provide the help when she needed it." Sadly, Jami's story is one we hear too often in Indian Country.

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Youth Suicide Data

The rate of suicide among Native American youth, ages 15 to 24, is the highest of any racial or age group in the United States (Centers for

Disease Control and Prevention [CDC], 2008). Suicide is the second leading cause of death for Native Americans between the ages of 10 and 34 years (CDC, 2005). The Native youth have an average suicide rate 2.2 times higher than the national average for their adolescent peers of other races (CDC, 2005).

Native American suicide rates are highest among the 15 to 19 year-old age group (IHS, 2008a). Males account for up to five times more suicides than females in Native American youth. The rate of suicide among American Indian and Alaska Native 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. However, studies have shown female youths may be attempting suicide more often. Regardless, suicide rates for both sexes of Native American youth are higher in comparison to adolescents of any other race in the U.S. (CDC, 2007; Patel, Wallace, & Paulozzi, 2005).

In the Great Plains, the area west of the Mississippi River and east of the Rocky Mountains which includes the states of South Dakota, Wyoming, Montana, Nebraska, Colorado, Kansas, New Mexico, Oklahoma, Texas, and my state of North Dakota, the youth suicide rate has reached epidemic proportions. On certain reservations, the incidence of youth suicide has been documented at 10 times the national average. For example, in North Dakota during 2004, there was an average of six suicide attempts and one completion for every five days. Of these suicides, up to five times more occurred on Indian reservations than on nontribal land (CDC, 2008).

Risk Factors for Native American Youth Suicide

There are several important risk behaviors for suicide, and unfortunately, many of these factors are more prevalent in Indian Country (National Youth Violence Prevention Resource Center, 2007). Specifically, the CDC lists the following risk factors for youth suicide: history of previous suicide attempts, family history of suicide, symptoms of depression or other mental illness, alcohol or drug abuse, stressful life event or loss, easy access to lethal methods, exposure to the suicidal behavior of others and incarceration (CDC, 2008). This list of risk fac-

tors is descriptive of many health and socioeconomic disparities we see in Indian Country. For many Native Americans, living on an isolated reservation in rural America only makes these risk factors even more of a danger.

Drug use and crime rates are known to be higher on reservations than in other communities. For example, methamphetamine use is more prevalent in Indian Country than nontribal communities in the United States. Native Americans account for ~1% of the United States' youth, but between 2 to 3% of youth arrests. A 2008 report of the Federal Bureau of Prison stated that of the youth in custody, 79% are Native American (Cross, 2008). Additionally, studies have shown that more Native American youth are victimized each year than any other ethnic group (U.S. Department of Justice, 2000). Sexual assault rates are 2.5 times higher for Native American women than the general population. The high prevalence of alcohol and drug abuse, lack of law enforcement, and low socioeconomic status undoubtedly contribute to the despairingly high rate of mental illness in Native communities.

In recent years, during hearings before the Senate Committee on Indian Affairs, a connection between youth suicide and increased crime activity in Indian Country has been exposed. For example, suicide pacts have been discovered within Tribal gangs in the Great Plains. When Operation Dakota Peacekeeper was dispatched to the Standing Rock Sioux Reservation, which increased the number of law enforcement officers on the Reservation, there was a decrease in gang activity and subsequent decrease in youth suicide. The overall environment, safety and lifestyle play a role in the mental health and risk of suicide for Native American youth.

Historically, of the 12 Indian Health Service Areas, Alaska, Aberdeen (that includes the States of North Dakota, South Dakota, Iowa, and Nebraska), Billings (Montana and Wyoming) and Tucson (southern Arizona) have had the highest suicide rates. However, it should be noted that for the most part, IHS is only able to track suicide completions, and data on suicide attempts is difficult to obtain and document. In these specific IHS Areas, youth suicide rates were as much as eight times greater than those of the general population (CDC, 2005). The trends suggest that Native Americans residing

on reservations in the most rural areas are most at risk. Isolation and limited mental health services have been shown to correlate with increased rates of suicide. Health disparities and environmental conditions are linked to the mental health and incidence of youth suicide.

United States Government, Indian Tribes, and Health Care

The federal government has a special responsibility to address the tragic number of youth suicides and other urgent health problems in Indian Country. In exchange for land, through many negotiated treaties between the federal government and sovereign Indian nations, as well as statutes and Supreme Court decisions, the United States promised to provide health care to Native Americans. We have a trust obligation to keep that promise.

The federal government also has a moral responsibility to provide health care to Native Americans. Throughout its history, the U.S. government has adopted policies (establishment of the reservation system, allotment of land, forcing of Indian children into boarding schools, and termination of tribal communities for relocation to urban areas) which have contributed to a cycle of deteriorating health conditions.

The IHS was established within the Public Health Service (PHS) in 1955 to carry out the federal government's responsibility to provide health care to Native Americans. Previously, this responsibility rested with the Bureau of Indian Affairs (BIA) within the Department of Interior. Currently, IHS provides health care to 564 federally recognized tribes in 35 states (IHS, 2008).

However, history shows IHS health programs for years have been chronically underfunded. IHS estimates that annual Congressional appropriations have commonly only met 52% of the health care needs of Native Americans. Mental health, alcoholism, and substance abuse services, all of which relate to suicide prevention, account for about one third of health care needs (IHS, 2008b).

The result of such underfunding is a health care delivery fact that is widely known on most Indian reservations in America—full-scale rationing of critical health services, including mental health care services.

Youth Suicide Prevention Efforts in Indian Country

As youth suicide in Indian Country has drawn more attention, Congress has addressed the issue in legislation. Government agencies have developed programs aimed at reducing the incidence of youth suicides. Indian tribes have focused on prevention endeavors and advocates (like Dana Lee Jetty and her family) who have joined forces and are working to prevent suicide epidemics. Most notably, IHS and Substance Abuse and Mental Health Services Administration (SAMHSA) have created targeted prevention efforts that have achieved some success.

In 2003, the IHS began a Suicide Prevention Initiative, which developed a strategic plan for implementing prevention and guidelines for suicide response. As a part of the Initiative, the agency maintains a website providing resources and information on youth suicide. In each of the 12 Area Offices, IHS also provides suicide assessment and prevention education at regional substance abuse treatment centers for youth and data collection through the tribal epidemiology centers. IHS collaborates with advocacy groups and assists in broad spectrum programmatic efforts. The goal is to provide extensive resources to Indian Country to prevent and respond to such high incidences of youth suicide. However, resource constraints often restrict the availability and scope of IHS programs.

SAMHSA has also been integrally involved with suicide prevention in Indian Country. Through an Interagency Agency Agreement for technical assistance, SAMHSA, along with the Centers for Medicare and Medicaid Services (CMS), provided the original funding of \$200,000 to assist IHS in the response to youth suicide clusters in 2004 and 2005. These same funds supported the foundation of the suicide prevention initiative at IHS. Furthermore, SAMHSA provides Garrett Lee Smith grants to states and tribes. The grants are awarded to programs aimed at preventing suicide within high risk populations. SAMHSA continues to fund various programs throughout the country that support mental health services with a focus on suicide prevention, resource centers and suicide prevention advocacy organizations.

Over the last decade, legislative efforts have been made to address youth suicide, specifically in Indian Country. For example, during the 110th

Congress, the Senate passed the Indian Health Care Improvement Act, No Child Left Behind Act of 2001, Juvenile Justice and Delinquency Prevention Act, and Garrett Lee Smith Memorial Act; all of which have provisions addressing youth suicide in Indian Country.

However, the hard fact remains that there has been no substantial decline in the youth suicide rate in Indian communities. It is evident that the current mental health services and suicide prevention efforts in Indian Country are inadequate to the substantial task at hand.

Barriers to Addressing Youth Suicide in Indian Country

The data available regarding the mental health of tribal communities and Native American youth in Indian Country are sparse and incomplete. As a result of complex, intricate systems of tribal and U.S. government-operated health services, there is often no centralized data collection. Tribes that operate their own programs may choose to not report their data to the IHS or State Departments of Health, resulting in deficient data. Much of the data available is not specific to Indian Country and includes only snippets of tribal data. This lack of data presents a serious barrier to understanding the depth of the youth suicide issue in Indian Country and hampers the development of promising solutions (Middlebrook, LeMaster, Beals, Ovens, & Manson, 2001).

In addition to the complex relationship between the federal government and Indian tribes, there are serious cultural barriers in addressing youth suicide. For many Indian tribes, spiritual and cultural sensitivities prevent open dialogue. Communication is a crucial part of the effort to prevent and educate people about youth suicide. Not only must a tribal community be willing to admit that a problem exists, but the population must be willing to discuss openly the devastating trends in youth suicide among Native Americans.

Along the same lines, youth suicide rates vary dramatically between Indian tribes, owing to the unique nature of individual tribes and diverse levels of available services. Therefore, prevention and intervention efforts cannot be uniform for Indian Country but must be carefully developed and culturally sensitive to the needs of different tribes.

Another barrier to addressing youth suicide is the rural nature of the Indian communities. The population base is often hundreds of miles from an urban area, making adequate care and outreach to Native American youth problematic. Additionally, it is difficult to recruit sufficient mental health professionals to Indian reservations. Transportation to and from rural areas is expensive, making emergency ambulance services especially difficult. In addition, the lack of access to transportation makes it more difficult for health care providers to make long-term commitments to service tribal communities.

The above mentioned barriers to addressing youth suicide are made worse by IHS funding constraints. It is not uncommon for mental health services to be cut first when Indian tribes are faced with budget shortfalls. Developing and implementing a wide array of mental health care services, unique to each Indian tribe in rural areas, is costly. Recruiting and retaining mental health clinicians to Indian reservations, like other underserved areas, requires complex policies, like government scholarship loan repayment, which have high upfront costs. Using contract-temporary doctors, called locum tenens, can cost two to three times as much as a permanent clinician. In Indian communities there are significant barriers and widespread health disparities and thus suicide prevention does not get the attention it so urgently needs.

What Must Be Done

Decreasing the incidence of Native American teens taking their own life requires more than new legislation, new initiatives, and additional funding; although, all three are surely needed. The complexity and enormity of teen suicides in Indian Country means that there is no simple solution. No one sector can solve this tragic problem on its own. The U.S. federal government, Indian tribes and mental health professionals are all going to have to work together and develop stronger, more effective approaches to this crisis.

Indian Country needs targeted suicide prevention programs, with strong leadership, collaborative efforts and dedicated mental health professionals. Education programs must be a crucial component to any plan to address teen suicide. For example, Native American communities are in need of education on mental health

illnesses, accessible services, and suicide risk factors.

Native American teens need to know help is available and that they are not alone in their struggles. We need training for teachers, mentors and any person who comes in contact with teens in schools, health care facilities, or after-school activities like Boys & Girls Club. Mental health advocacy groups have developed the idea of mental health checkups and screening tools for doctors and nurses to use to address the mental health of their patients. We need tools like this in Indian Country. They will help save the lives of young teens like Jami Rose Jetty. In fact, during the Indian Affairs Committee hearing, Dana Lee Jetty told us the one thing she thinks would save the lives of teens like her sister are well-trained, dedicated mental health workers in Indian Country.

In addition, new programs like the Methamphetamine and Suicide Initiative at IHS, the Garrett Lee Smith Grants at SAMHSA and the National Suicide Network partnership within the Department of Health and Human Services need continued attention and dedication from the Agencies. Funding for youth suicide prevention must be a priority for both Congress and the Indian Health Service. I believe suicide prevention initiatives should be given a separate line item in the budgets so that the suicide programs do not compete with other health care services for funding.

Additionally, lawmakers must remember the issue of teen suicide in Indian Country when legislation comes up that could improve the health disparities, mental health, education or economic development for Native Americans. That means additional funding.

It also means addressing the fact that IHS is in desperate need of reform. IHS has been seriously dysfunctional with severe management problems for far too long—we need to correct that. We cannot afford to let this affect the mental health and ultimately, the very lives of Native American teens.

Lawmakers must support health care reform efforts that will improve the health care delivery system in Indian Country. For example, recent Congressional efforts to secure funding for telemental health programs will hopefully lead to expanded mental health resources for at-risk Native American teens. Policymakers should monitor the progress of these programs, and if

performance meets the promise, be ready to expand them quickly.

Conclusion

The incidence of youth suicide has reached catastrophic levels in Indian Country. There is an urgent need for increased access to quality mental health care services and suicide prevention for Native American youth.

To begin to combat these trends, the federal government must fulfill its trust responsibilities to provide federally recognized tribes with health care by fully funding IHS programs and making prevention efforts and mental health programs a priority. In turn, all of us—policymakers, clinicians, researchers, and Indian communities must collaborate. A successful effort to prevent youth suicide in Indian Country requires a comprehensive view of the numerous disparities and contributing factors. We must develop innovative solutions and outreach efforts to overcome the immense barriers of a troubled history, rural settings, limited resources, and many other barriers, which hinder access to appropriate mental health care for Indian youth.

The lack of preventive efforts and the rationing of health care we provide to Native Americans are simply unacceptable. Native Americans deserve much better. Native youth are particularly at risk. Meeting their mental health needs must become an urgent priority for everyone.

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