

**Legislative Testimony  
Budget Committee on Healthcare  
Wednesday, July 27, 2005**

Thank you Chairman Krauter and members of the committee for giving me the opportunity to testify this morning. My name is Garth Kruger and I am a project director at the Center for Rural Health located within the School of Medicine and Health Sciences at the University of North Dakota in Grand Forks. For this particular discussion, it may be relevant for you to know I am a master's prepared clinical psychologist with a specialization in rural issues. I've been working in, for, and with rural communities for 7 years and have been with the Center for Rural Health for just under three. I'm a third generation farmer and live in a rural community 40 miles north of Grand Forks.

The Center for Rural Health was established in 1980 and our mission is to strengthen and sustain health care services for rural communities. One of the many activities currently underway at the Center that is part of this mission is a project entitled The North Dakota State and Tribal Health Policy Forums. These are series of forums focusing on state and tribal priority health concerns affecting North Dakota. These forums are funded by a foundation to support the development of objective issue briefs and forums reflecting high priority health topics. Our hope is that these efforts are helpful to state legislators and tribal leaders as they consider complex health issues.

Thus far, we have held three such forums; one targeting state policy makers focusing on the uninsured and uncompensated care, one targeting tribal policy makers focusing on the Indian health services reauthorization act and the third and most recent forum engaged both state and tribal policy makers together, focusing on suicide --a topic important to both reservation and non-reservation communities. Over 120 people attended this joint forum, representing tribal

leaders, state health officials, mental health practitioners, and legislative members among others. The remainder of my testimony will focus on highlights gleaned from the suicide prevention forum and provide you with statistical highlights on suicide in North Dakota.

Imagine for a moment a small town in North Dakota of about 800 people. That is the number of lives that were lost in North Dakota over the past ten years to suicide --the equivalent of losing a small town. More specifically, the chart located on the first handout shows that, from 1994-2003 there were 797 deaths recorded as suicides. 700 were white, and 89 were Native American. Eight were from other ethnic groups. In terms of statistics by race, suicide disproportionately impacts Native American Communities. Depending on the reservation, Native Americans experience anywhere from two to ten times higher rates of suicide than the rest of the state. As you can see by the suicide numbers, 11% of suicides were Native American but census bureau statistics indicate that they represent only 5% of the state population.

On the following handout, there is a chart depicting a breakdown of those suicides by age in North Dakota. It is noteworthy to know that during the 1994-2003 time period, --North Dakota exceeded the national average for suicide rates in every age category depicted on this chart below age 64 years. The graph you're looking at is not age adjusted so it appears that the number of deaths in the age category of age 45-64 is much higher than other age categories. However because these categories are not age adjusted, it does not reflect the fact that there is a larger number of people in the 45-64 year old age group and less people in others. So, while I'm providing you with the actual numbers, the information as its depicted could be misinterpreted. I've also displayed on handout three, information about youth in North Dakota. More specifically suicide data for youth ages 10-19, from the Centers for Disease Control and Prevention indicating that North Dakota is among the 75<sup>th</sup> percentile for suicide rates. We know

that isolation and lack of resources are two of the factors known to contribute to the elevated rates in the regions where suicide rates are highest.

In addition to looking at suicide statistics by age and tribal vs. non tribal breakdowns, we can also look at suicides at the county level as shown on handout 4. According to North Dakota vital statistics, during the 5 year period 1997-2001, Billings and Sioux counties had the highest rates of suicide in North Dakota. Numbers are not reported on this map but rather rates based on 10,000 people. This allows us to compare numbers of suicides across both large and small population areas. On a numbers basis alone, Cass, Burleigh and Grand Forks counties would have the most deaths, because that is where the population centers of the state are. And, I have those numbers by county if you're interested. However, more meaningful for detecting trouble spots is to use the rate of suicide against a constant population size. In this case, per 10,000 people. The national rate of suicide is .82 (or just a little less than one person who commits suicide per 10,000 people). On the North Dakota map, that means that any county in the dark green, blue, or dark blue are counties that exceed the national average suicide rate. Those in the light green are around or near the national average, and those in yellow are below the national average.

One of the issues that research indicates is related to suicide is lack of access to mental health services. The US Department of Health and Human Services (HHS) indicates that 95% of North Dakota is designated as a Mental Health Professional Shortage Area meaning residents have mental health needs going un-met or are being under-served. Handout number 5 shows you North Dakota's federally designated Mental Health Professional Shortage Areas. As you can see, geographically it is a large area of the state. By comparison, 20% of the national population lives in a Mental Health Professional Shortage area whereas 28% of the ND population lives in one.

Often, instead of accessing mental health services appropriately individuals may end up in emergency care settings, or not receive services at all. For example, the North Dakota Suicide Prevention Task Force estimates that approximately half of the teens and young adults who make a suicide attempt serious enough to need emergency medical care receive no mental health services two weeks after the incident. Without the formal professional resources to draw upon, these communities must draw upon local grass root support networks to address situations as they arise creating unique training and legal issues.

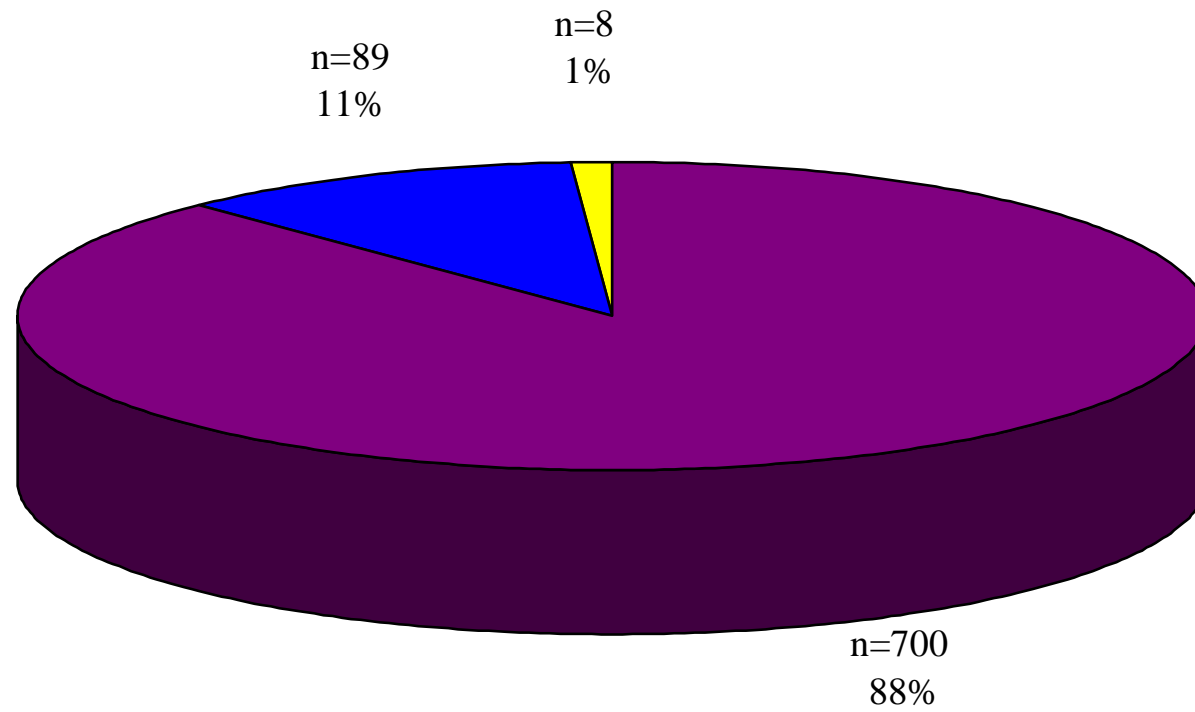
These figures I've shared give you a bit of a picture about where suicide occurs in the state, and some of the related statistics. Now I'd like to take a moment to share with you some of the factors that are often related to suicide, as shown on the final page in your handouts. The CDC indicates that there are a number of factors, including beliefs and stigmas that people often have about seeking help. Harassment and bullying as well as barriers to accessing services have also been found to be related to suicide. You will also see on the bottom of the list, specific mental illnesses associated with suicide. It's important to note that not all people who commit suicide have one of these or other mental health diagnosis. This may be for a couple of reasons. First, as I mentioned, there are a number of contributing factors, and mental illness has been diagnosed in just some of those cases. However, lack of a diagnosis may also indicate that those patients may not have had access to mental health care providers who could have appropriately diagnosed them and given them the services they needed. Anecdotal evidence suggests it may be more related to accessing services. I say this because one of the things we heard repeatedly during our suicide prevention forum is that many communities across North Dakota don't even have the most basic infrastructure to provide mental health services or address the kinds of problems identified in the CDC's list. Another illustration of this point from what we heard at the

forum relating to the issue of access was the lack of awareness by front line mental health staff of the statewide 211 suicide and crisis hotline. Finally, our forum also revealed that there's a need to get a better handle on current activities offered by state and local agencies in order that policy makers and others can get a clearer picture of where the gaps in services are occurring and where improvements can be made.

The information that I've presented clearly indicates that suicide is serious problem in ND, and the potential solutions to addressing this problem are complex. We are in the process of preparing an issue brief on this topic for state and tribal policy makers. The issue brief will provide more detail about the nature of the problem, a summary of the issues raised at our forums, and relevant programs and policies that exist at the state, tribal, and federal levels.

I appreciate this opportunity to provide you with an overview of the extent of this problem and would be pleased to answer any questions.

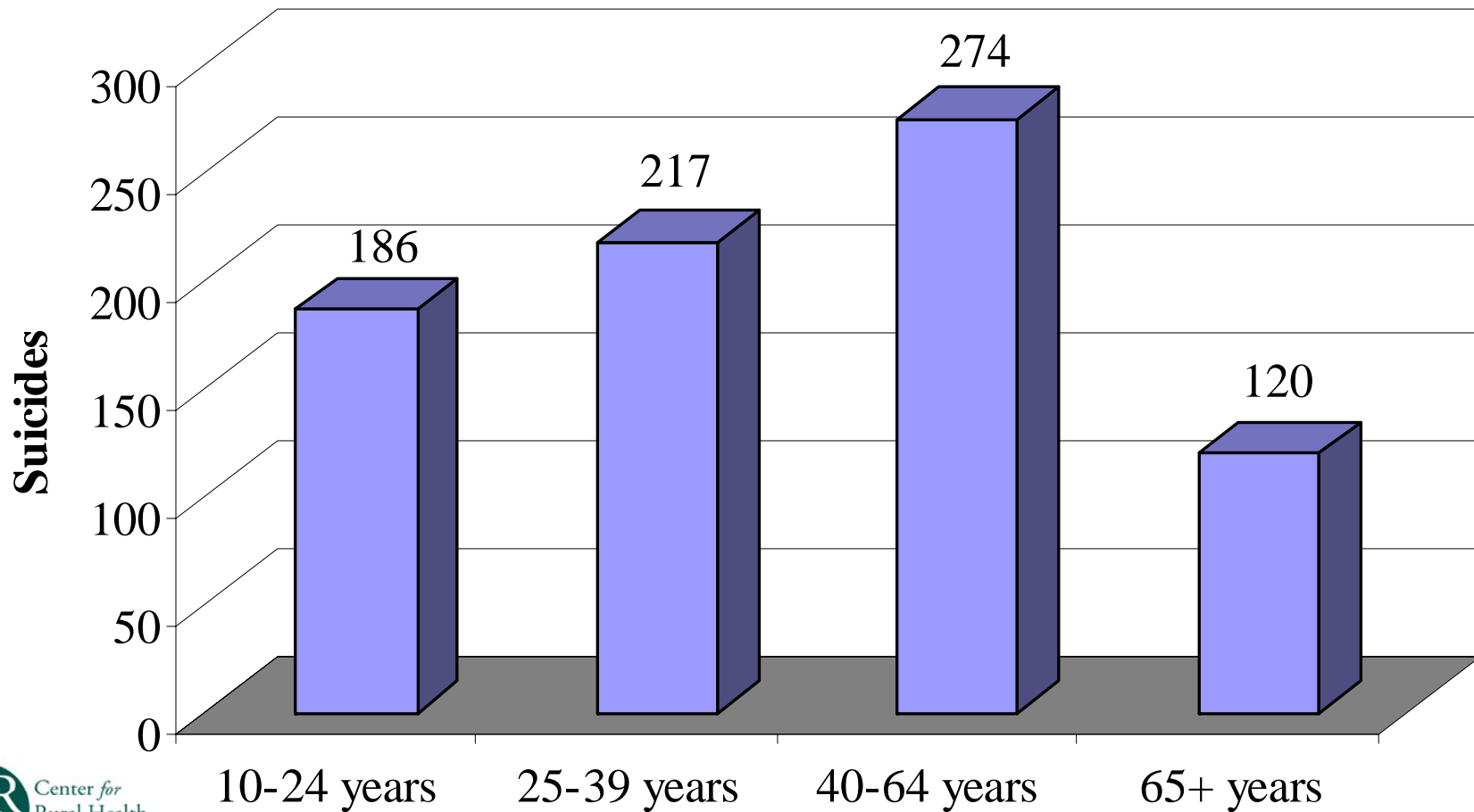
# North Dakota Suicide Numbers 1994-2003



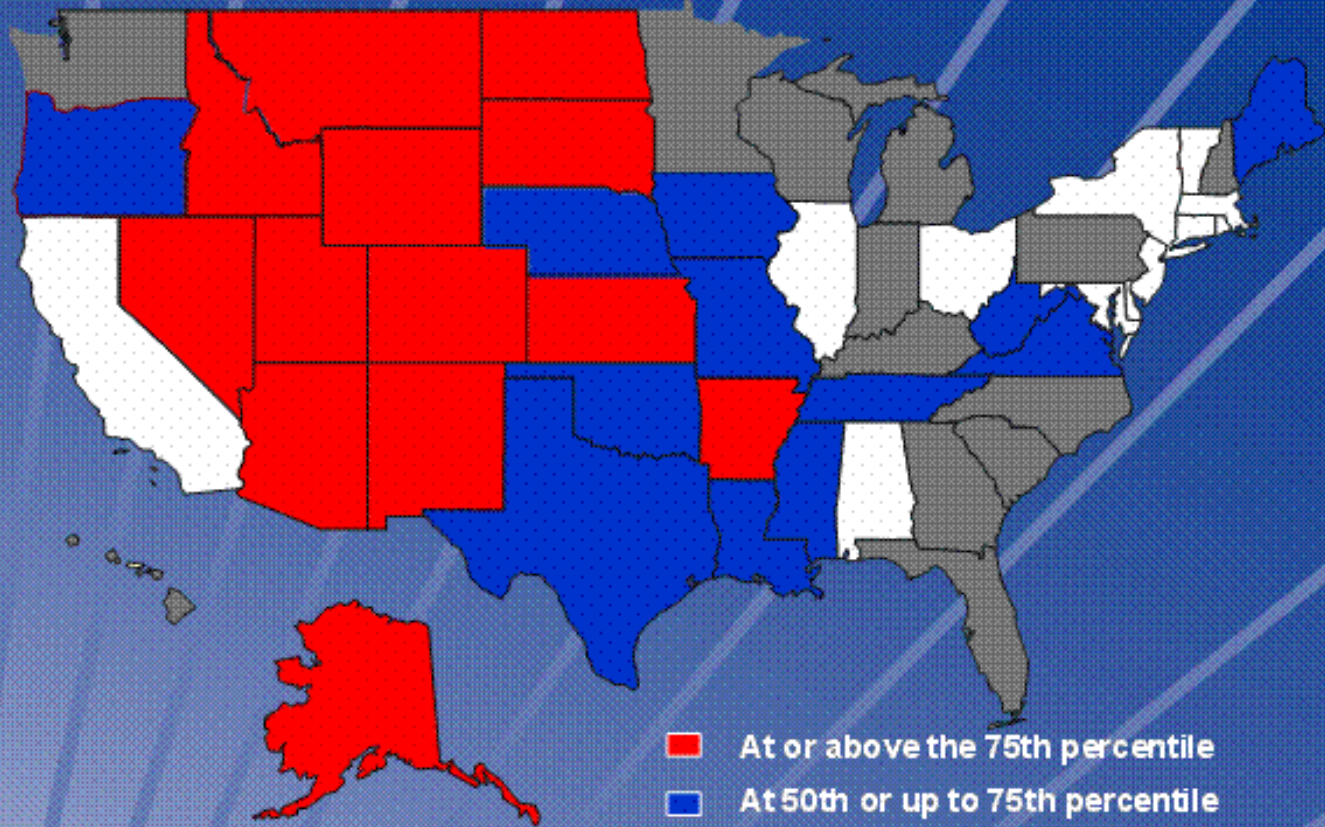
■ Caucasian ■ Native American ■ Other Ethnicity

n=797

# Number of Suicides by Age Category (1994-2003)

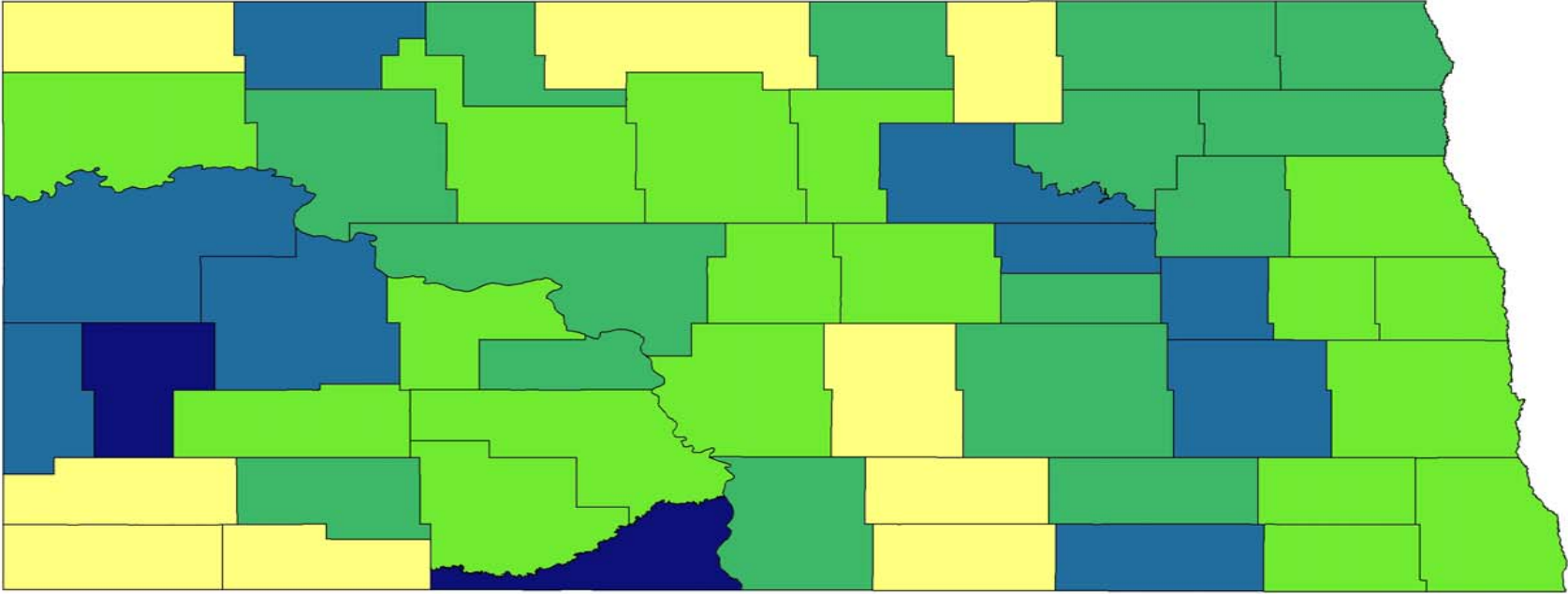


# Youth Suicide Rates, Ages 10-19, US, 1996-1998

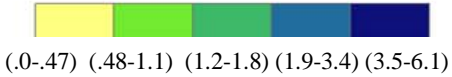


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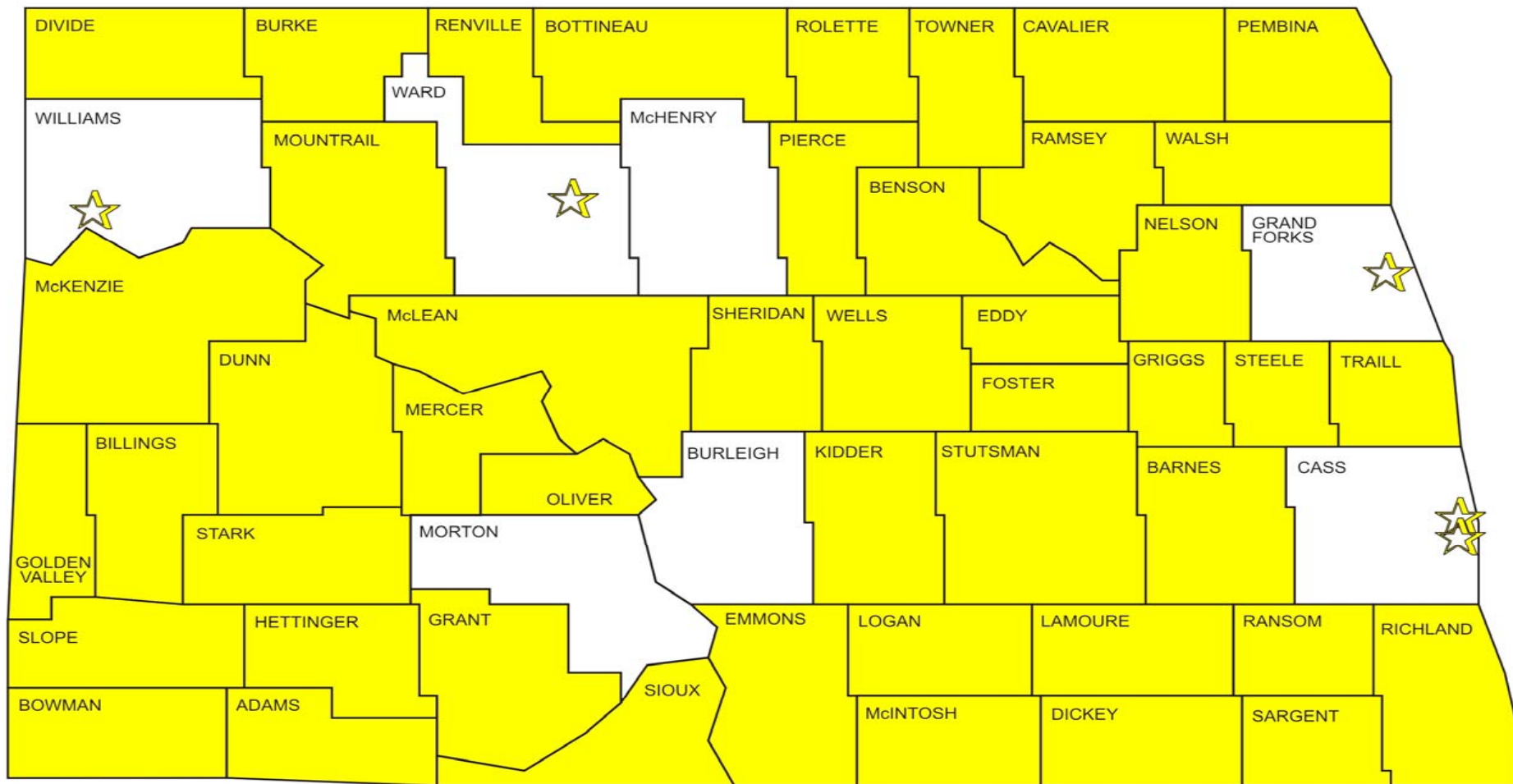
# North Dakota Suicides by County 1997-2001



**Legend:** Age adjusted Suicide Rates  
per 10,000



# North Dakota Mental Health Professional Shortage Areas



- Mental Health Professional Shortage Area
- ☆
 Mental Health HPSA Facility

# Key Risk Factors

- + Loneliness and isolation
- + Hopelessness
- + Beliefs and stigmas about help seeking
- + Barriers to getting help/lack of access to services
- + Experiencing violence, child abuse, sexual abuse
- + Harassment & bullying
- + Access to lethal means
- + Community acceptance/tolerance of suicide
- + Alcohol & other drug abuse
- + Historical trauma and cultural “numbing”
- + *Depression and post-traumatic stress disorder*
- + *Schizophrenia, Bipolar Disorder, Panic disorder*



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