WRITTEN TESTIMONY OF
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MEDICINE MOON INITIATIVE PROJECT DIRECTOR
NATIVE AMERICAN TRAINING INSTITUTE
AUGUST 15, 2008

Chairman Boucher and members of the Tribal and State Relations Committee, my name is Deborah Painte, and the current Project Director for the "Medicine Moon Initiative to Improve Tribal Child Welfare Outcomes Through System of Care" administered through the Native American Training Institute, the training arm of the ND Tribal Child Welfare agencies. I have been in this position since October 2003, prior to that I was the Project Director for the United Tribes Technical College Sacred Child Project from 1997 – Sept. 2003. This was a children's mental health project that was in operation on all of the four reservations in ND. Previous to that I served as the ND Indian Affairs Commission director from 1992-1997. For the past sixteen years I have committed a large part of my professional efforts to addressing the socio-economic issues faced by Native children, youth and families in North Dakota.

I will not spend a lot of time addressing the status and needs of tribal communities since you have probably received much of this information from other sources as well as heard many of them identified through your many meetings of the Tribal and State Relations Committee. However, I would like to share with you my thoughts and recommendations on what I believe would be a step in the right direction for alleviating some of the needs of Native American families in ND.

Recommendations:

1.) Focus on strengthening and supporting Native families and youth before they are in the deep end of services or are in residential or correctional facilities regardless of whether they live on or off the reservation. All of them are all citizens of North Dakota, and whether it happens in White Shield, Cannonball, Fort Totten, Belcourt, Devils Lake, Minot, Fargo or Bismarck, it eventually impacts us all as Residents of this state. There are a number of services and supports that I am personally aware of that have dramatically improved the lives of ND Native children & families which can be supported by hard data and improved the functioning of these youth in several areas. The first is the Sacred Child Project, which was federally funded from 1997 – 2003 which was a System of Care Children's Mental Health initiative. (Attached are supporting data)

The success stories of this initiative are amazing and there are numerous anecdotal stories that could be shared as well as numerous written literature by the Center for Mental Health Services, National Center for Children in Poverty and University of South Florida Children's Mental Health Dept. that has documented the promise of this approach. The main point, is the ability to work with complex needs communities and complex needs individuals and families on a collaborative level both on the systems and individual level was facilitated using a System of Care (SOC) approach and operationalizing that SOC through the use of the wraparound process. There is only one ND tribal community today, which is the Turtle Mountain Sacred Child Project that has been able to sustain their project through Medicaid reimbursements. However, it has been a struggle to constantly rely solely on the Medicaid reimbursements, with little room to breath. It takes a toll on the staff morale when there is a constant chase of the Medicaid dollars from one month to the next. Therefore, to enhance the ability of the TM Sacred Child Project to sustain themselves and to re-start the other ND reservations, I would propose to the Tribal and State Committee to **strongly consider introducing a bill that would provide a state general revenue fund for a *"North Dakota Native American Youth & Family Wellness Act"* that would provide funds for direct mental/behavioral health services for prevention and early intervention.**

This **fund would provide $75,000 per annum to each ND Tribal Reservation x (4) for two years to address Native Youth and Family Wellness using the wraparound process,** a holistic way of meeting the variety of needs of youth and families in a coordinated and culturally-competent way, while facilitating self-empowerment and independence. It would also enable some of the suicide prevention efforts that have been underway on the ND Indian reservations to continue beyond their suicide prevention grant funding from federal Garrett Lee Smith Youth Suicide Prevention funds. This would be **$600,000 well spent in preventing further escalation of these families into deep end treatment or restrictive environments,** e.g. juvenile and adult corrections, psychiatric treatment, foster care, which is much more costly in terms of lives and fiscal considerations. Back in the early to mid 90's, the state provided $500,000 in funds per bi-ennium for the "Native American Youth Alcohol & Drug Education" program that was formerly administered by the ND Indian Affairs Commission. It was later transferred to the Dept. of Human Services Substance Abuse Division. To this day, I do not know what happened to program, but it did set precedence for the State of ND to provide prevention dollars to ND tribal communities. I would like to see this type of initiative legislatively updated, funded and

What happened? :
The SACRED CHILD PROJECT

STRENGTHS:

Tribal-State Relationship

- Inter-tribal Relationships
- Native American Training Institute (NATI)
- Natural Supports & Cultural Values of Participating Tribes

What happened?

1st ND Tribal System of Care (SOC) initiative, the SACRED CHILD PROJECT

- Oct. 1997 – Sept. 2003
- Center for Mental Health Services, 6 yrs.
- Graduated Service Site, Sept. 2003

2nd ND Tribal SOC initiative, the MEDICINE MOON INITIATIVE

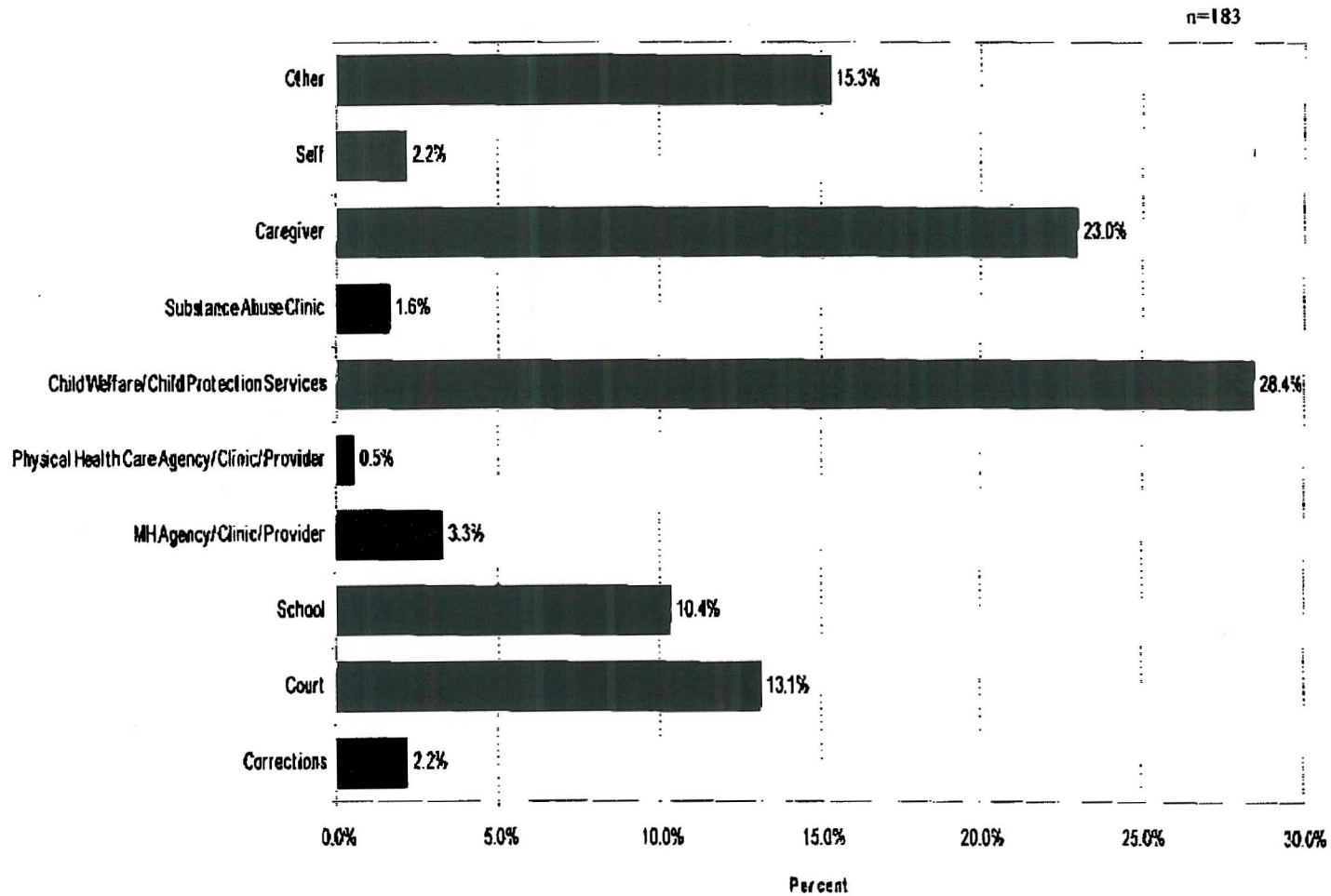
- Oct. 2003 – Sept. 2008
- Children's Bureau, 5 yrs.
- Currently, starting 3rd yr. Oct. 05

What happened? : (SCP cont.)

Enrollment Criteria:

- Multi-agency need (child in 2 or more systems)
- Child/youth was in imminent risk of removal from home and/or community.
- Child/youth was transitioning back into community
- Child had a formal SED diagnosis or had behaviors present for more than (1) year and was diagnosable according to the DSM-IV

Intake Referral* Information



*Referral Information is from respondent reports.

Data are from the CMHS National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program

Report is based on data submitted (Date Submitted)

Aggregate Data Profile Report 8/2003

What happened? : (SCP cont.)

NATIONAL EVALUATION - Descriptive

- Total SCP Youth – 217 served
- (193) youth & families participated in National Evaluation Descriptive Study
- Average Age of children/youth – 13.8 yrs. Old
- 100% Native American – 68% male, 32% female
- Nearly 3/4th (73%) youth were below poverty level (family of 4 w/income less than $18,000)
- Forty-one percent (41%) in single mother households, three percent living with single father households.
- Twenty-nine percent (29%) were involved with Child Welfare, 23% referred by Caregiver, 13% referred by Courts

What happened? : (SCP cont.)

NATIONAL EVALUATION – Descriptive

- Upon enrolling in SCP, less than one-third (30%) had received some form of outpatient and/or school based services
- Almost 39% of enrolled youth had a history of substance abuse.
- Sixty-eight percent (68%) of SCP families had history of substance abuse, with only 51% having received treatment for substance abuse.
- Forty-Eight percent (48%)of enrolled SCP families experienced family violence

What happened? : (SCP cont.)

NATIONAL EVALUATION – Outcome Study:

- Sixty percent or (131) children and their families participated in the Longitudinal Outcome Study.
- Of the (131) or 61% of children participating, 8% participated from intake to 18 mos.
- Over 50% of the children participating from intake to 18 months had improved school performance.
- Between intake and 18 months, SCP enrolled youth showed a drop in school detention rates from 39% to 28%
- Between intake & 18 months, School suspension rates went from 33% to 22%

What happened? : (SCP cont.)

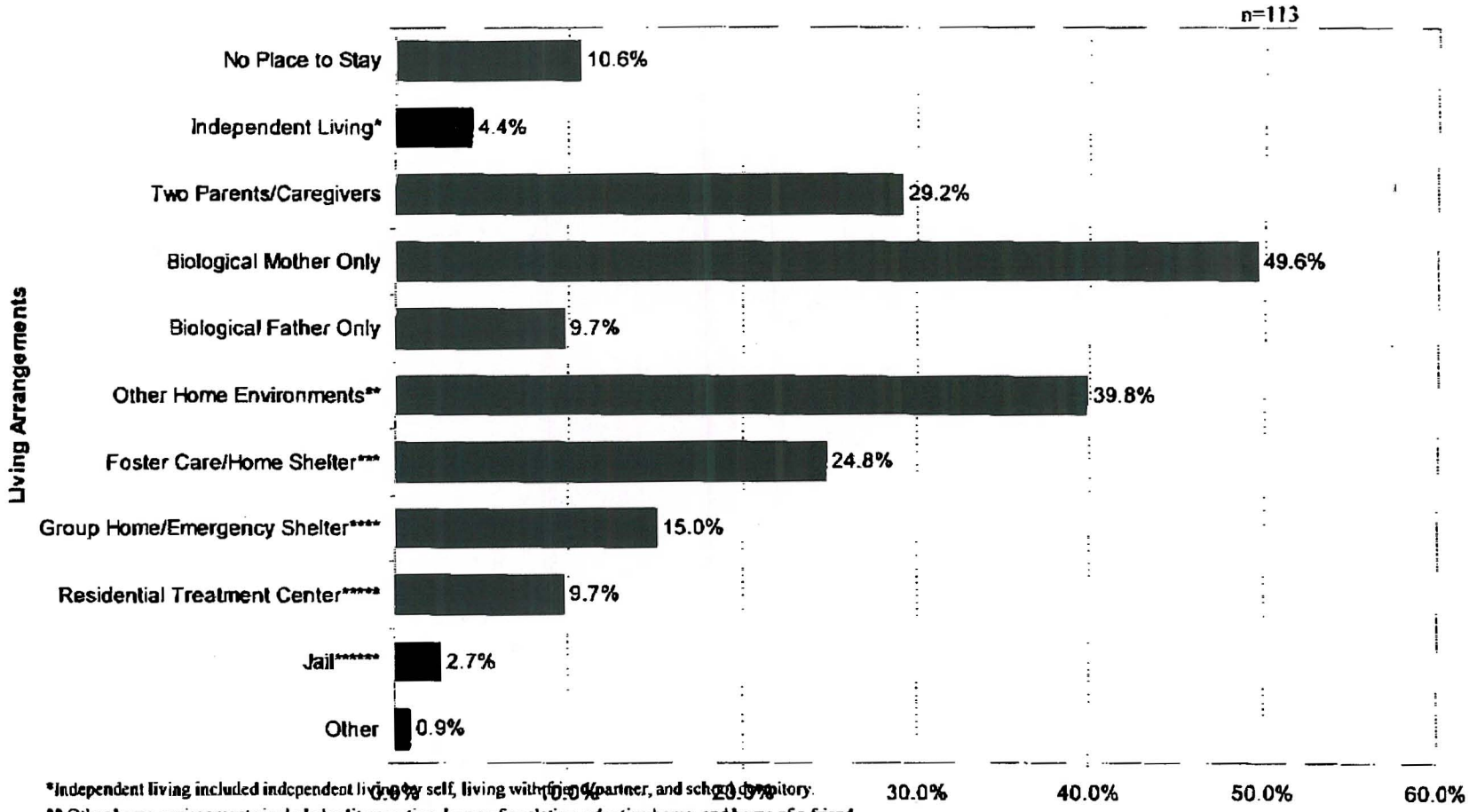
- Of the (11) youth who answered questions about substance abuse between intake and 18 mos.
  - Increase in alcohol use from 37% to 74%
  - Increase in cigarette use from 64% to 91%.
  - No change in marijuana use which remained at 37%

  (Increase in substance abuse may be attributable to youth who begin to experiment as they got older, lack of adolescent treatment centers on reservation & complexity of needs.)

- Of the youth who participated from intake to 12 mos.,
  - Decrease in juvenile detention from 28% to 17%
  - Decrease in convictions rates from 22% to 17%.

- Of the youth who participated from intake to 12 mos.
  - Dramatic improvement in living arrangements from 42% who had one living arrangement at intake compared to 71% in living arrangement 12 mos.
  - Multiple living arrangements drecreased from 58% to 30% between intake and 12 mos. Later.

Living Arrangements at Intake



*Independent living included independent living by self, living with friend/partner, and school dormitory.

** Other home environments included split parenting, home of a relative, adoptive home, and home of a friend.

*** Foster care included camp, supervised independent living, foster care, therapeutic foster care, specialized foster care, and individual home emergency shelter.

**** Group home/emergency shelter included group emergency shelter, group home, and residential job corp, and vocational center.

***** Residential treatment center included non-drug/alcohol-residential treatment center, drug/alcohol residential treatment centers, medical hospital (non-psychiatric), and psychiatric hospital.

****** Jail included jail, prison, youth correctional center, and juvenile detention center.

Data are from the CMHS National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program

Report is based on data submitted March 2003.

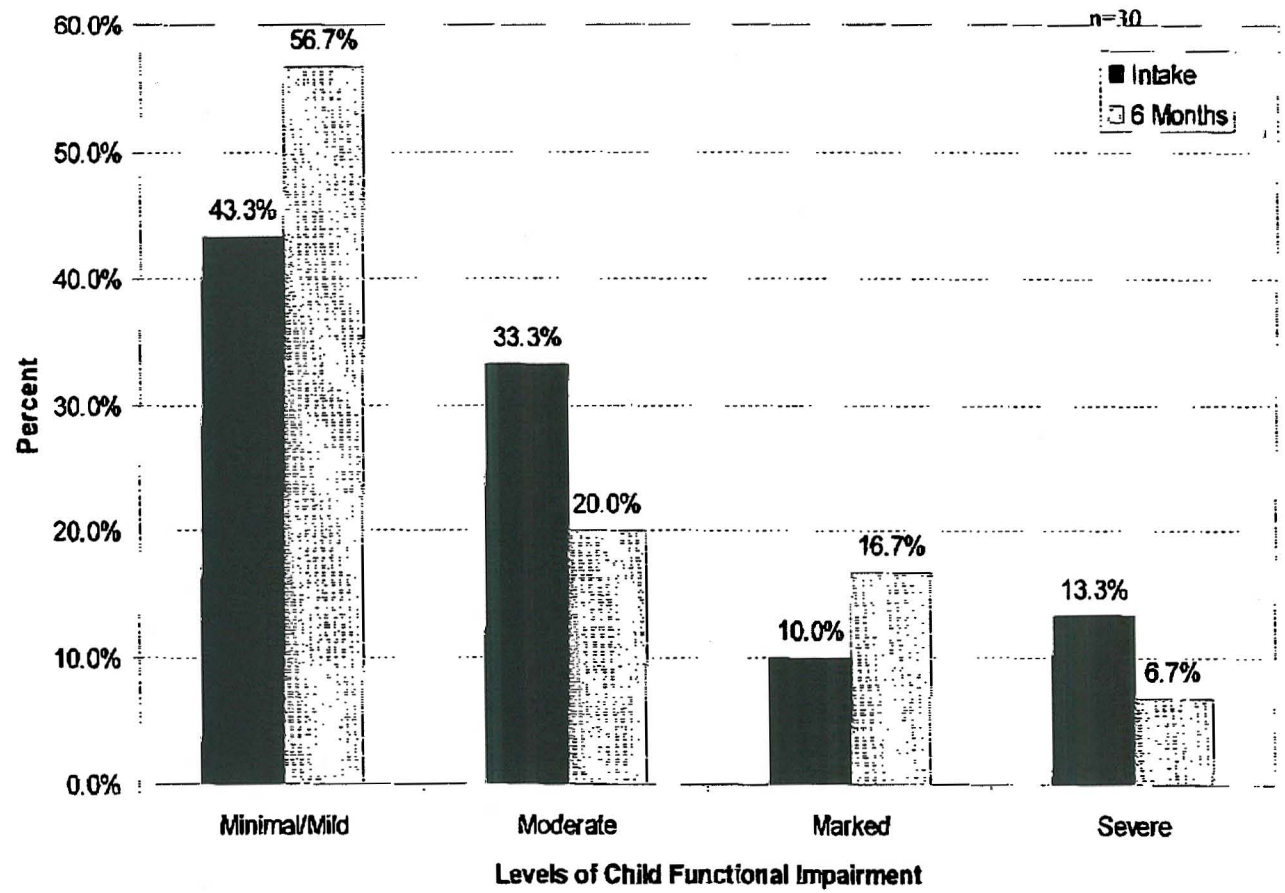
What happened? : (SCP cont.)

NATIONAL EVAL: Child & Adolescent Functional Assessment Scale (CAFAS)

(CAFAS assesses degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.)

- Between intake & 12 mos. SCP participants had a marked increase in functioning. (n=23)
- Increase in Minimal/no impairment levels from 39% to 65%
- Decrease in mild impairment from 26% to 17%
- Decrease in moderate impairment from 17% to 4%
- Slight decrease in severe impairment from 17% to 13%.

Level of Child Functional Impairment* at Intake and 6 Months



*Child functional impairment was measured by the CAFAS (Child and Adolescent Functional Assessment Scale).

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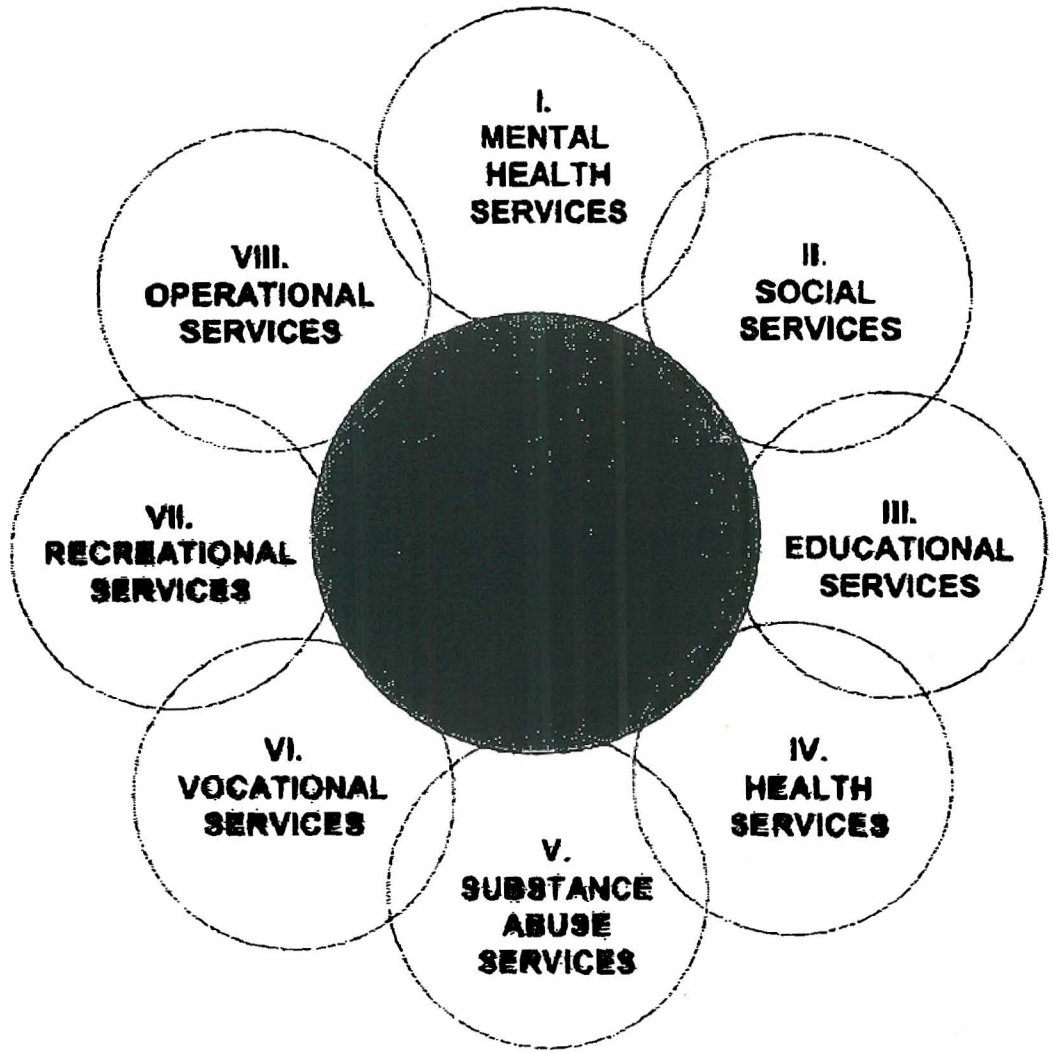
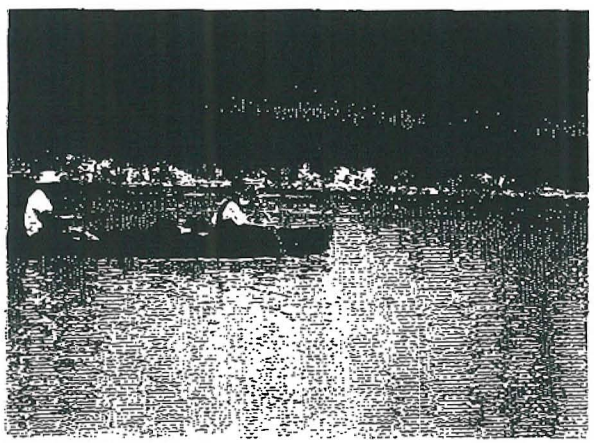
System of Care Framework



WHY SOC?

- Addresses Challenges of Rural Communities
- Culturally-compatible with Native American Cultures of ND
- Enhances collaboration among area service providers
- Maximize resources

Characteristics of Systems of Care include:



- individualized care practices
- culturally competent services and supports
- child and family involvement in all aspects of the system and measures of accountability
- Interagency collaboration.

GUIDING PRINCIPLES

- *Comprehensive array of services and supports that address the child and family's physical, emotional, social, cultural and educational needs.*
- *Individualized services and supports in accordance with the unique needs and potential of each child and family.*
- *Services and supports will be provided to children and families within the least restrictive, most normative environment that is clinically and culturally appropriate.*
- *Families and surrogate families should be full participants in all aspects of the planning and delivery of services.*
- *Children and families should receive services and supports that are integrated, with linkages between child and family-serving agencies and programs and mechanisms for planning, developing, and coordinating services.*
- *Children and families should be provided with case management or similar mechanisms to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and can move through the System of Care (SOC) in accordance with their changing needs.*

PRINCIPLES (cont.)

- *Early identification and intervention for children and families should be promoted by the System of Care (SOC) in order to enhance the likelihood of positive outcomes.*
- *Children & youth involved with the System of Care (SOC) should be ensured smooth transitions to the adult service systems as they reach maturity.*
- *The rights of children and families should be protected, and effective advocacy efforts for children and families involved with the System of Care should be promoted.*
- *Children and families should receive non-discriminatory services and services should be sensitive and responsive to the cultural differences and special needs.*