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YOUTH SUICIDE PREVENTION

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

ON

OVERSIGHT HEARING ON THE CONCERNS OF TEEN SUICIDE AMONG AMERICAN INDIAN YOUTHS

JUNE 15, 2005
WASHINGTON, DC

PART 2

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YOUTH SUICIDE PREVENTION

WEDNESDAY, JUNE 15, 2005

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m. in room 485 Senate Russell Building, Hon. Byron Dorgan (vice chairman of the committee) presiding.

Present: Senators McCain, Dorgan, Smith, and Johnson.

STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator DORGAN. We will begin the hearing today.

This is a hearing of the Senate Committee on Indian Affairs. My name is Senator Dorgan. I am joined by the chairman of the committee who has asked that I convene the hearing and appreciate very much your being here today and appreciate the leadership of Senator McCain. We have had the opportunity to work together for a long while and we have worked together on a lot of very important issues.

The hearing this morning is for the purpose of discussing an issue that is very important and very sensitive. When I talked to Senator McCain about holding this hearing, he was very interested in having us do that. He has asked me to chair this hearing and I appreciate very much his graciousness in doing it.

This is a hearing in many ways that all of us wish we were not attending, to discuss a subject that perhaps we would wish that we had not had to discuss, but we do. It is the issue of teen suicides. I do not want to imply that teen suicides represent only a problem on Indian reservations, but I do want to recognize that the problem is more acute there than in other areas.

We know that suicide is the second leading cause of death of American Indians, Native Americans, aged 15 to 24, 2½ times the national average. Native American children under the age of 15 are 5 times more likely to take their own life than the population, the same age population generally. In the northern Great Plains, the rate is 10 times higher for teenage children on reservations taking their own life than other children of the same age in this country.

There is in some areas an epidemic of teenage suicide. It would be more comfortable perhaps not to talk about it publicly, but it would be the wrong thing to continue watching this happen, seeing the broken hearts and deciding to do nothing about it.

The Standing Rock Reservation in North Dakota and South Dakota which covers both States has had 12 suicides in the last 6 months. I have spoken on the floor of the Senate. I have spoken on the floor of the Senate maybe four or five times about a young woman named Avis Little Wind, a 7th-grader, and I have used her name with the permission of her family, a young woman who felt that life was so hopeless that she took her life, this 7th-grader took her life. Her sister had taken her life 2 years previous to that. She lay in a bed for 90 days, missed 90 days of school.

Mental treatment was not readily available. I went to that reservation and talked about this young 7th-grade girl, talked to her classmates in school, talked to the school officials, talked to the mental health officials, talked to the tribal officials, just to try to understand what has happened, not just in this situation, but in others.

Because in this same situation on the same reservation, I held a hearing in Bismarck, ND and a young woman who on that reservation came to testify at the hearing broke down and began sobbing during the testimony. She said, you know, I just have to beg to try and find a car to see if I can help give a kid a ride to a clinic someplace. She said, I have a stack of allegations of child abuse on the floor in my office that have never been investigated because I have no resources.

And then she said, I do not even have the vehicle to drive a troubled kid to get some help. And then she began sobbing. She quit her job about 1 month after that hearing.

The point is we have very serious problems. Dr. Grim testified at a hearing I held in Bismarck, ND, again with the permission of the chairman of the committee, for which I am grateful. Dr. Grim, I think, made the point, and it is a really important point, he said, suicide is not a single problem. It is a single response to multiple problems. Neither is it a strictly clinical or individual problem, but one that affects and is affected by entire communities.

Some families of children who had taken their lives came to see me after the last hearing, and some children who were friends of children who had taken their lives came to see me. One of the things that I remember about the classmates was they said, you know, so-and-so, naming one of their friends, really did not mean to die. He just wanted some attention to the things that he was going through, the problems he was facing in his life. He wanted some attention to those problems. We do not think that he wanted really to die.

So look, we have some serious issues that we are facing on this committee. We are trying to reauthorize the Indian Health Care Improvement Act and we are going to do that this year. My hope is, and I believe the hope of the chairman, is that perhaps as we do that a portion of that, a piece of that might also begin to address this issue as we learn more about it and determine how we can try to apply some more attention and some more resources to this issue, and say to those young children who are too often now thinking about taking their lives, that you are not alone. This is not hopeless. You are not helpless. We are here and we want to do something to address this very difficult and very sensitive issue.

So again, let me thank all of you for being here. I recognize that in calling this hearing we are dealing with a difficult topic, but I think it is time, long past the time for us to discuss it publicly and evaluate what we can do to reach out to these children.

Senator McCain.

STATEMENT OF HON. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. Thank you very much, Senator Dorgan. And thank you for your leadership and the commitment you have made on this issue.

There is very little I can say which would add to your very compelling opening comments, so I will not, except to say that I am pleased that Vice Admiral Richard Carmona, the Surgeon General of the United States, could be here today. Admiral Carmona, I know you have faced numerous challenges in your career as a professor, a health professional, a deputy sheriff, and even a SWAT team leader. Throughout your career, you have demonstrated exceptional leadership, particularly in addressing psychological and mental trauma in communities. I am encouraged that you are taking a leadership role in addressing Indian youth suicide.

I thank you again, Senator Dorgan, and I appreciate your very compelling and strong leadership on this issue. Thank you.

Senator DORGAN. Senator McCain, thank you very much.

I might point out that we will have a vote in the Senate probably somewhere between 10 a.m. and 10:30 a.m., we expect, so at that point I will recess the hearing just for 15 minutes to go and vote.

In the meantime, we have two panels of witnesses. The first panel is Dr. Carmona. Senator McCain has described in some detail, Dr. Carmona, your very interesting background. We appreciate your public service. You are accompanied by Charles Grim. Dr. Carmona is the Surgeon General of the United States. Dr. Grim is the Director of the Indian Health Service. Dr. Grim testified at a previous hearing on this subject. We held a hearing in Bismarck, ND.

We appreciate both of you being here. Dr. Carmona, we will include your full statement as a part of the record, and you may proceed orally.

STATEMENT OF RICHARD CARMONA, M.D., SURGEON GENERAL OF THE UNITED STATES, ACCOMPANIED BY CHARLES GRIM, DIRECTOR, INDIAN HEALTH SERVICE

Mr. CARMONA. Thank you, sir. Senator McCain and Senator Dorgan, thank you for the privilege of being with you today and allowing me to address this very important issue.

My name is Rich Carmona. I am the Surgeon General. I certainly do appreciate this opportunity. I am joined today by my colleague Rear Admiral Charles Grim, also Assistant Surgeon General and Director of the Indian Health Service.

As you know, the mental health of our Nation is a critical component of our Nation's public health. Suicide is one of the most tragic events that a family can endure. Suicide costs us more than 30,000 lives a year. That is almost 1 person every 15 minutes. Once every 45 seconds, someone engages in suicidal behavior.

Even if the life is spared, the heartache and pain are so severe that the spirit may never fully heal. The science tells us that the suicide rates in Indian country are generally higher and are characterized by younger people engaging in fatal and nonfatal suicidal behavior at much higher rates than the overall U.S. population.

For 5 to 15 year-olds, the suicide rate is more than twice the average of the national average and there is an even greater disparity in the later teenage years and into young adulthood. The suicide rate for American Indian and Alaska Native youth aged 15 to 24 is more than 3 times higher than the national average. In fact, young people aged 15 to 24 make up 40 percent of all suicides in Indian country.

The reality is that in many of our tribal communities, suicide is not just an individual clinical condition, but also a community condition. To address it appropriately requires public health and community interventions, as much as clinical interventions. It also requires resources to understand and support the interventions. The Administration's 2006 budget request for IHS includes $59 million for mental health. That is a $4-million increase over 2005.

This leads me to the next critical question: What are we doing to prevent suicide in Indian country? My predecessor, Surgeon General David Satcher, shined a bright light on the too often darkened pain of suicide. In 1999, he issued the Surgeon's General Call to Action to Prevent Suicide. It brought the best science together with the best experience on the subject of suicide prevention. Dr. Satcher was also instrumental in developing the national strategy for suicide prevention. The strategy is the national blueprint for action for suicide prevention.

Today, it is an ongoing joint effort of SAMHSA, the CDC, NIH, PHSA and in Indian country, the Indian Health Service. I am proud to report that for the general population, the long-term trend in the United States has been toward a decline in the suicide rate. However, suicide in Indian country is not declining.

One of Dr. Grim's first acts as Interim Director of the IHS in 2002 was to convene a tribal consultation on behavioral health. Representing over 200 tribal organizations, the consultation provided recommendations for long-term goals to revitalize and promote behavioral health in Indian country. In the past 3 years, every one of those goals has been addressed.

But this marks only the beginning of a much longer process to bring leadership programs and resources to this ongoing crisis. For example, the Jicarilla Apache of Northern New Mexico have engaged in a successful effort to develop a community-based intervention strategy. It brought together tribal leadership, community members, youth, as well as university and IHS clinicians and researchers to design and implement the program.

The result is that over the past decade, suicidal activity has fallen by approximately 60 percent among the Apaches and has been maintained at that level. This success is more evidence that effective programs require clinical, educational, community, interagency, and intergovernmental input.

Work like this is ongoing, led from the top by President Bush and Secretary Leavitt, our bosses. We are working to address the risks for suicide. The first international meeting of the Indian

Health Service Director's National Behavioral Health Initiative will be coming up this fall, led by Rear Admiral Grim. The charge is to provide strategic leadership and implement ongoing work groups for action.

As I mentioned, the National Strategy for Suicide Prevention is being implemented across the Nation, including Indian country. Of course, the funds available made under the Garrett Lee Smith Memorial Act that President Bush signed in October 2004 will help enable States, Indian tribes, colleges and universities to develop suicide prevention and intervention programs.

In closing, there are many positives that can result from discussions like the one we are having today. By talking about suicide and suicidal behavior, we take it out of the darkness, shine a light on it. It should always be okay to talk about being depressed or about having suicidal thoughts. Young people should be able to go to their parents, teachers and other caring adults for help with depression and even anger, without feeling like they will be labeled weak or bad or broken.

Paramedics and emergency room doctors are often heralded as life-saving heroes. Each of them deserves praise, that is true. But so does everyone who has ever held out a hand, given a hug, or spoken words of encouragement when a person considering suicide needs it most. Everyone has an important role in this cause and we must all band together for hope.

With that, I will end my testimony. I would ask to be able to submit my entire written statement into the record. Thank you. I look forward to our discussion this morning.

[Prepared statement of Dr. Carmona appears in appendix.]

Senator DORGAN. Dr. Carmona, thank you very much.

We have been joined by our fellow Senator from Oregon. Let me say that all of us understand that his family has been visited by this tragedy and has been a catalyst for him to lead the U.S. Senate and the Congress in a very constructive direction to address these issues. I am very proud of the work that he has done, as are all of my colleagues. Let me see if he would like to make an opening statement.

STATEMENT OF HON. GORDON SMITH, U.S. SENATOR FROM OREGON

Senator SMITH. Senator Dorgan and Mr. Chairman, thank you for holding this hearing. I have an opening statement, but I do not think I can get through it. So let me ask that it be included in the record. Let me also thank you for helping to highlight this issue.

When President Bush signed this into law, the Garrett Lee Smith Memorial Act, which the Senate unanimously passed, the substantial piece of legislation designed to help young people in college, in high school, in Indian tribes specifically, to get the help they need so that they can cope with an illness which is just as lethal as physical illness.

President Bush signed this on a day in the midst of a very difficult political campaign. He did it quietly. He did it quietly because of the sensitivity of the issue and the desire on my wife's and my part that it not be in any way politicized. There were present on that occasion some of the President's political opponents, but not

his enemies, specifically Senator Kennedy among them. But by doing it quietly, perhaps there was one disadvantage. That is that many people do not know about what the Federal Government is now trying to do.

So again, Mr. Chairman, thank you for having this hearing, with this clarion call saying to tribes and to States and universities, apply for these funds; develop suicide intervention programs because this is a problem that can be addressed and successfully if done in a timely way.

There is nothing worse in life than life without hope. Some people of our citizenry are unable to find hope in living because of the makeup of their brains, of their chemistry and there is help that can be found to help them to do that.

So I think my only message this morning, Mr. Chairman, is, I think Senator Dorgan is on the Appropriations Committee, the Garrett Lee Smith Memorial Act authorized $82 million for 3 years. The first $10 million was appropriated in the last Congress, and $27 million is what is required to stay on course. I would just simply ask all of our appropriators to make sure we get $27 million.

If we are truly serious about being pro-life, I can think of few appropriations that could do more to help our Native American children and all of America's children who suffer from bipolar afflictions, manic-depression, schizophrenia or whatever the cause, to find the way to get the help they need to contribute to our great Nation the way that they can, even with mental disorders.

So with that, Mr. Chairman, I will just include my statement in the record.

[Prepared Statement of Senator Smith appears in appendix.]

Senator DORGAN. Senator, thank you very much. Certainly as one appropriator, I am pledging to do everything we can to fully fund this requirement. It seems to me you cannot understand this problem and decide to do less than is humanly possible to deal with it. I hope our colleagues will agree on the Appropriations Committee.

Dr. Carmona, I quoted Dr. Grim that this does not arise from one cause. I mentioned, for example, the one young woman who was dealing with these children's issues on one reservation who broke down and sobbed because she just had no resources. With the resources that are available at this point, do you have some confidence that ultimately on these reservations there will be adequate mental health services staffing for the psychologists, social workers, psychiatrists and others to be able to respond to these needs?

Mr. CARMONA. Sir; I am happy to address that. My answer maybe predates me being Surgeon General because I have had the privilege and opportunity to live and work in Indian country for a couple of decades in Arizona, and have gained a great appreciation and fondness for the culture, for the people, for their passion and also for the deficiencies in the communities.

I think we are on the right road to remedy this very longstanding situation, which as you mentioned and as my colleague Admiral Grim has mentioned, is multi-factorial. It is people who have been robbed of their culture. It is people who are living a different life

than their ancestors are used to. It is being disconnected from their families. It is being disconnected from mainstream America.

It is so many variables, but we understand many of the variables because many of our people in the Public Health Service live among Indian country. Many of the programs that are in place now and growing based on funding that you have mentioned and the National Strategy for Suicide Prevention are working in the right direction.

It is not all about clinicians. It is really about improving health literacy; that the people understand the genesis, the cause of the problems; that we who have the privilege to serve them understand the uniqueness of the culture; that we work hand in hand with our Indian partners to develop strategies that will address many of the issues.

And not just in response to, but to prevent, to change culture, to change environments so that people do not feel that despondent in the environment; that they see hope where there was otherwise despair. That is not just psychologists or psychiatrists, but it is community health workers. It is faith healers within the community and so on.

So I think we are developing robust programs. We are heading down the right path, but we should not forget that it has taken us, well, a couple of centuries to get where we are today. We are working as quickly as we can with great passion to remedy this problem. I do not think there is a better leader for the Indian Health Service than Admiral Grim, who I do not think a week goes by that we are not discussing ways to move these strategies forward for the general public health, as well as mental health in Indian communities.

Senator DORGAN. Dr. Carmona, I have some additional questions, but my colleague, Senator Johnson, has just arrived. It is my understanding that he has to leave for another committee. He shares in his State a portion of the Standing Rock Reservation which I described earlier. Let me call on Senator Johnson for his comments.

STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Thank you, Senator Dorgan and Senator McCain for holding what I think is a critically important hearing on just a tragic, tragic issue that affects young people in general, but particularly impacts Native American young people.

I do have another obligation that I am going to have to leave soon to attend, but I do want to acknowledge that participating in the hearing today and making just enormously positive contributions to our circumstances in South Dakota are Julie Garreau, who is Director of the Main. She will be sharing her thoughts on what is going on in the Cheyenne River Reservation relative to activities for young people and how they are trying to address that terrible issue there.

Twila Rough Surface of the Standing Rock Sioux Tribe is here as well. She has been very much involved in these issues. Betsy Mitchell is President of the Cheyenne River Sioux Youth Project. We also have with us representatives from the Project's partner organization, Running Strong for American Indian Youth.

The South Dakota Health Department's statistics on suicide for 2004 list suicide as the second-leading cause of death for South Dakotans aged 15 to 24. On average in our small State, 750,000 people, we lose 23 young people in that age group to suicide each year, a rate of one almost every 2 weeks. The suicide rate among Native American males in particular runs two to three times higher than the general rate in the United States as a whole.

There are many factors that go into this tragic circumstance, but it is important that we on this Committee and in Congress in general provide the resources that those who are in the front line of combating this awful circumstance need to have. I know that Senator McCain, Senator Dorgan and the members of this Committee, Senator Smith as well, take this issue very much to heart. I look forward to working in a bipartisan fashion with the IHS and with our tribal leadership in our respective States to address this issue.

Thank you.

Senator DORGAN. Senator Johnson, thank you very much.

Dr. Carmona, I mentioned that in the Northern Great Plains the rate of teen suicide on reservations is 10 times, according to the statistics we have seen, 10 times the national average. We also find clusters. I mentioned that on the Standing Rock Reservation, there have been 12 suicides in the last 6 months. Can you or Dr. Grim tell me, when you begin to identify a cluster of teen suicides, do you have teams that are sent out? What kinds of teams? What are those resources?

Mr. CARMONA. I would be happy to start, then I will pass it to my colleague, Admiral Grim.

We do. U.S. Public Health Service officers, our Commissioned Corps readiness force, can be deployed at a moment's notice to any unmet health need, and not just mental health. We do it all over the world, but we are especially sensitive to the needs of the Indian Health Service and the tribal leadership who are experiencing these problems.

One of the things that we really want to do is, rather than just always respond to clusters, but be able to build capacity within the tribal leadership and leadership within any tribe to be able to look forward and be able to have some predictive ability when they see children who may be developing that type of ideation.

Certainly, we need to respond to these tragedies, but we feel it is much better to develop capacitance within the tribal leadership to be able to identify those risk factors and be able to prevent those things from happening. So we are looking at both sides, but certainly prevention, we want to spend a lot of time on, too.

I will ask Admiral Grim to please comment.

Mr. GRIM. I would just say that the Surgeon General adequately described the ability of the Commissioned Corps of the Public Health Service to respond. We have called on the readiness force on multiple occasions when we have had suicide clusters within Indian communities. We bring in mental health professionals, social services professionals, logistics folks to help get all the people in and out.

We work with tribal leadership. We wait until they ask. It is not something we thrust upon them. We work closely with tribal leadership and their councils. We work closely with them as they try

to overcome those issues. Whenever we feel that we have addressed the immediate surge capacity need that that community has, we step out with the larger number of people.

We try to leave some capacity there as well. When that many mental health and social services people have come in, they oftentimes bring in new programs, new sorts of treatments that perhaps the community did not have before. They help the local staff there in the local Indian Health Service or tribal program to just raise the capacity at that time.

After the surge capacity leaves, we continue to keep an eye on that. We have developed a behavioral health management information system over the last several years that we have begun to deploy that now allows us to spot suicide clusters at a much earlier stage as we look at ideations and attempts.

Senator DORGAN. Let me ask both of you, if you would, to submit for us following this hearing any evaluation you might have of what we might contribute to the Indian Health Care Improvement Act as we reauthorize it that might address this issue, recognizing we passed legislation previously on the issue of suicide prevention. But if there are things that you think we could do, particularly addressing the Indian issue, but not exclusively that, we would appreciate it.

The fact is, most of us have in some way or another become acquainted with this issue. It is always a tragedy. When I was in my twenties, I walked into a room and found a friend who had taken his life. It took me a long while to just get over that, the tragedy of it. But when I see and hear about these young children who take their lives, it just breaks your heart. I think there must be ways for us to devote more time, more attention, more resources to try to intervene and intervene at the right time to be helpful.

I think Senator Smith said it right. We tend to take a look at people who have an acute medical problem such as something that you can see, a huge wound bleeding, broken limbs. That is obvious, and we will immediately bring all of our medical resources to address something that is obvious and visual. But there are many in this country who live with afflictions that are not quite so visual and not quite so obvious. We spend less attention, less time trying to heal them.

So at any rate, I appreciate very much your being here. I am going to call on my colleagues for questions as well.

Senator McCain.

The CHAIRMAN. Thank you very much, Senator Dorgan.

Dr. Carmona, Senator Dorgan just mentioned that the suicide rate on Indian reservations is 10 times that of the non–Indian population. Do you accept that?

Mr. CARMONA. Senator, depending on which reservation you are speaking of, but certainly it is multiples of the U.S. incidence, depending on where you are looking.

The CHAIRMAN. In the Northern Plains, as Senator Dorgan pointed out. As you mentioned in response to a previous question by Senator Dorgan, there are multiple reasons which you listed. What I do not understand, and you as the Surgeon General of the United States may have a view of this, is that I understand all those conditions that exist which lead to this terrible crisis that we are dis-

cussing, but don't those conditions also prevail, say, in inner-cities in America? Don't they prevail in other parts of America where there are pockets of poverty, crime, et cetera, and yet you do not see that level of teen suicide?

How do you rationalize that? What is the difference that would make this such a serious problem in one area of poverty, deprivation, breakdown of families, et cetera, and not prevail in other areas of similar conditions?

Mr. CARMONA. Senator, it is a great question and one that confounds all of us. We have a good deal of information about urban problems, and where we see suicide clusters or suicide ideation in youngsters because of despondency, because of economics, because of social status, because of being ostracized from their communities.

We do not have enough information yet, and we require more research on the uniqueness of Indian country and the tribal problems, because they are unique. Geographically they are unique. Culturally they are unique. The history is quite unique because it goes back centuries where they have been disenfranchised in some cases from their own cultures. It is a struggle every day for these young men and women growing up in a bicultural or multi-cultural society where elders may be attempting to retain their own culture.

So my colleagues who are quite expert in this recognize that there are variables that are very unique to Indian country that need to be studied further before we could actually answer definitively your question.

However, we are able to say that the rates are higher, the situation is much more complex, and because of that we have put more resources into research through CDC tracking with epidemiologists and surveillance programs; through our NIH and SAMHSA doing basic science and clinical research in those areas; working with tribal leadership to ferret out the specific variables, risk factors that are unique to Indian country.

Admiral Grim.

Mr. GRIM. I would just add, too, that one of the three primary things that we are working on is to expand and enrich the data research around Indian country, not only the risk factors, but the protective factors, why some tribal communities do not have this problem and why others do. We are working with SAMHSA. We are working with NIMH. We are also working with Canada and their indigenous population and their professionals.

The conference that the Surgeon General mentioned that is scheduled to occur in September in New Mexico is going to bring together people from all these organizations to start to develop a research agenda for the indigenous population of our country. We hope with a long-term approach to it and putting money into it immediately that we are going to start better understanding.

We know the things that you can just state about it. It occurs in younger people. It occurs with some impulsivity instead of planning. We know things like that, but we do not know a lot of the multi-factorial causes that are both risks and protections.

I want to publicly thank Senator Smith for getting a bill through in the Senate, for unanimously passing it to make more money available for this particular thing that particularly affects Indian

country. I think, Senator Dorgan, at a hearing that you held in Bismarck, it was very telling when you asked how many people have been touched by suicide. It was in a room much larger than this that was also filled almost to capacity, and you asked how many people have been touched by suicide, either someone you knew or a family member, and almost every single person in that room raised their hand.

So it is one of our three major focus areas to expand that research base to be able to answer those questions, Senator McCain.

The CHAIRMAN. I hesitate to speculate, but if you have conditions, say, in an inner-city in America, of poverty, despair, alcohol, drugs, et cetera, and the American reservation has the same conditions, and yet the suicide rate on the reservation is far higher than that of the inner-city, I do not know how you can draw any other conclusion that it has something to do with the history of Native Americans and their exploitation and placement in American society which leads to greater despair.

I do not indulge in psycho-babble here, but it seems to me that the only real difference is the history of Native Americans in America. Does that make any sense, Dr. Carmona?

Mr. CARMONA. Senator, it definitely does make sense. There is no question that there has been marginalization. There has been discrimination. There has been tribal America that has been ostracized. That manifests itself in a number of different ways.

We today, the leadership today are feeling the burden of centuries of these problems that are now being clinically manifest in one manner with the suicides and suicide clusters in youth. So we are desperately seeking to identify scientifically the specific variables.

I agree with the intuitive approach. I feel the same way from my experience living among and working with my colleagues in Indian country. But yet we have to take it to a higher level and actually put the scientific scrutiny to it to be able to specifically identify variables that we can then address to be able to develop programs that we can actually measure success with over time.

So I am absolutely in agreement with you and share the same sentiments intuitively.

The CHAIRMAN. Thank you very much, Senator Dorgan.

I thank the witnesses.

Senator DORGAN. Senator Smith.

Senator SMITH. I think Senator McCain has really hit on the real dilemma we have. Is suicide nature or nurture? I think the point I was making earlier is that many mental illnesses are clearly nature. I think Senator McCain's point is it is possible, maybe even probable, that the rate is higher among Native Americans because of the environmental factors in which they live.

I would be surprised if mental illnesses are any more prevalent among Native Americans than other Americans, unless you have evidence to the contrary. In other words, a Caucasian or an African American child is probably numbered in the same percentages that would have bipolar illnesses or manic-depression. Does the evidence suggest that?

Mr. CARMONA. I think the point you made, Senator, regarding nature and nurture is appropriate. I know of no evidence that

would suggest that there is inherently a difference of incidence, bipolar, schizophrenia or any others. However, again, we all understand that the environment has huge ramifications in this problem and we are trying to identify the specific environmental factors that lead to this dysfunction, to this psychological instability in our tribal America.

Senator SMITH. I suppose my point is, to Senator McCain's, is that in addition to the medical intervention, the testing, the programs of interdiction, we have the added responsibility of making sure they have decent schools; that they have the potential for upward mobility; that they have an environment in which to live in which hope abounds instead of the depressive kinds of circumstances that many Native Americans feel.

That is our challenge as a Nation to do better here, because this is a shameful thing in our country, that this rate is higher among Native Americans than other Americans.

Mr. CARMONA. Senator, I truly thank you for bringing out what to us is the obvious. I would say you are preaching to the choir because we see that every day. There is no question that these youngsters as you go through the reservation, where the high school dropout rates are terrible, the disease burden is astronomical even at a young age, alcoholism, drugs. Life expectancy is much less. Opportunity is much less. When they look out on the horizon of life, it should not be surprising that what they see is despair and not hope.

I appreciate your pointing out that what we really need to do, as Admiral Grim and President Bush have directed, that we approach this in a multi-factorial way. We have to appreciate the environment. We have to appreciate the schools, the homes, the family situation, access to care. All of those things contribute ultimately to the health and growth and development of our youngsters on the reservation.

Senator SMITH. I think obviously these are larger issues we need to work on. But isn't it also true that suicide is higher in Native American communities because of their access to care? They do not have psychiatrists. They may not have the counselors in place to be helpful early enough.

Mr. CARMONA. Certainly intuitively people have said that. I do not know of any literature that would suggest that there is a link because of that, but those are some of the variables that we need to look into.

We are doing everything we can now to increase the amount of health professionals and paraprofessionals, especially community health workers and healers in the tribal communities working with the tribal leadership, because often the opinion leaders in the community who may not have true medical professional degrees, but yet they have inherent credibility in their own communities. They are a stabilizing factor in those communities, whether it is a faith healer or a medicine man.

But with increased health literacy, knowledge that the problem exists and us helping to give the tools to the leadership to be able to recognize these problems and try and correct them before the problem develops, I think this is where we are spending a lot of our time now, in partnership with the tribal leadership.

Senator SMITH. Doctor, do you know of any research, and in asking this question I think I know the answer because I do not think records were kept, but is there any research or historical evidence that prior to the westward movement of the European peoples into America and the conflicts between them and Native Americans, was their incidence of suicide in any way documented prior to that time among Native Americans?

Mr. CARMONA. I am aware of no such records, sir.

Senator SMITH. Thank you.

Senator DORGAN. Senator Smith, thank you very much.

A vote has just begun in the Senate, so we will take a 15-minute recess. The Committee will reconvene at 10:30 a.m.

Let me thank Dr. Carmona and Dr. Grim. Thank you very much. Would you please submit for the committee your evaluations of things that we might consider for the Indian Health Care Improvement Act dealing with this issue.

Thank you very much. The committee is in recess.

[Recess.]

Senator DORGAN. The committee will come to order.

The second panel of witnesses at today's hearing will be Twila Rough Surface, a member of the Standing Rock Sioux Tribe who lost a family member to suicide and who is also an employee of the tribe's Family Protective Service.

As I call their names, if they would please come forward. We would appreciate their attendance: Joseph B. Stone, a member of the Blackfeet Tribe of Northern Montana, who is a practicing psychologist in Oregon and Washington; Julie Garreau, a member of the Cheyenne River Sioux Tribe and director of the Billy Mills Youth Center, the Main, in Eagle Butte, SD; R. Dale Walker, a Cherokee from Oklahoma and director of One Sky Center, which is a national resource center focusing on mental health prevention and treatment for Indians; and Clark Flatt, president and CEO of The Jason Foundation, named for his son who committed suicide at the age of 16 in 1997, from Hendersonville, TN, which is working with the Bureau of Indian Affairs on suicide education and prevention programs.

Let me say to all of you how appreciative I am of the fact that you are willing to come today and to present public testimony. As I have indicated at the start of this hearing, perhaps for you as well, this is a hearing that you would sooner not attend and a subject you would sooner not discuss, but in many ways you are more qualified and in a better position to discuss publicly these issues with us in order to help develop some responses to them than almost anybody else in the country, so we appreciate your willingness to do that.

We will begin with Twila Rough Surface, a member of the Standing Rock Sioux Tribe. Twila, thank you for traveling to Washington to be with us. We welcome you.

All of the statements will be made part of the permanent record. You may summarize your statements. Second, the hearing record will be kept open for a period of time, 2 weeks following this hearing. If there are those in attendance at the hearing that would wish to submit additional testimony to be a part of the formal hearing record of the Committee on Indian Affairs, I would invite

you to do that and send it to us here in Washington, DC, to the committee. We will make your testimony a part of the permanent record as well.

Again, Ms. Rough Surface, your entire statement will be made a part of the record and you may proceed.

STATEMENT OF TWILA ROUGH SURFACE, REPRESENTING THE STANDING ROCK SIOUX TRIBE

Ms. ROUGH SURFACE. Thank you. Good morning. I would like to thank Senator Dorgan for the invitation to state my concern for the young people of my tribe. My name is Twila Summers Rough Surface. I am an enrolled member of the Standing Rock Sioux Tribe. I have lived on the reservation my entire life. I am a mother, a grandmother, a wife, and I come from a family of 5 brothers, 3 sisters, with 14 nieces and 20 nephews.

I recently lost a niece to suicide on February 2, 2005. She was my sister's third child. The following events, I believe, contributed to the eventual death of my niece. On January 7 of this year, her brother, my nephew, was killed in a car accident. During the grieving period, her mother had nobody to come and talk to her regarding the death of her son. So I can only speculate that my niece saw all the hurt and could not handle the loss, so she decided to take her own life. My sister was overwhelmed by the deaths, and also tried to take her own life.

Senator DORGAN. How old was your niece?

Ms. ROUGH SURFACE. She was 23. And my sister was overwhelmed and she tried to take her own life. After the attempt, my sister related the following, that she thought that the only way to make the hurt go away was to take her life so she would not feel the pain and the hurt. Luckily, a family member found her in time.

The loss of my nephew not only had an impact on our family, but on his friends as well. One of his good friends who had been selected to be a pallbearer at his funeral committed suicide the day my nephew was buried. His other best friend, he missed him very much and he was talking to my brother and he said he missed him a lot. On April 7, he also committed suicide.

The effects of the deaths in my family have touched many and continues to be a concern. I must mention that at no point did any mental health professionals contact our family. I feel that if there had been intervention with grief counseling and support for my sister and her children, my niece may have had a chance to grow to be an elder of the community.

The overall rate of suicide among our youth has increased. The rates remain unacceptably high. Adolescents and young adults often experience stress, confusion and depression from situations occurring in their families, schools, and communities. Such feelings can overwhelm young people and lead them to consider suicide as a solution.

Few schools and communities have suicide prevention plans that include screening, referral, and crisis intervention programs for youth. Programs designed to assist children and families dealing with severe trauma are not readily available on Standing Rock. The families are economically disadvantaged and with a 40- to 75-

mile trip to see counseling, it is virtually impossible to access these options.

Transportation and access to a telephone is essential to regular therapy. However, this is not a luxury the majority of our families have. In our IHS Great Plains office, through the Indian Health Service, we only have one psychologist and he takes on about 3,000-some cases just for him. He travels to the South Dakota site and he only has 2 hours to spend down there. He cannot see as many people there either, to help.

We do have two workers that have bachelor's degrees, but they are not trained to do assessments and things like that, so it is very hard for our tribe to get these resources. We do not have effective clinical care for the mental, physical and substance abuse disorders, and easy access to a variety of clinical interventions and support for help-seeking. We do not have support from ongoing medical and mental health care relationships, and we do not have grief counseling, and not enough police.

I believe suicide is preventable. Most suicidal individuals desperately want to live. They are just unable to see alternatives to their problems. Most suicidal individuals give definite warnings of their suicide intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.

Surviving family members suffer the trauma of losing a loved one to suicide and are at higher risk for suicide and emotional problems. We as a Nation need to be aware to learn the warning signs, get involved, become available, show interest and support, be willing to listen, be non-judgmental, offer empathy, offer hope that alternatives are available and outreach services, take action, remove means, and get help from individuals or agencies specializing in crisis intervention and suicide prevention.

In conclusion, I would like to thank you for listening and request immediate assistance for the Standing Rock Sioux Tribe.

[Prepared statement of Ms. Rough Surface appears in appendix.]

Senator DORGAN. Ms. Rough Surface, thank you very much for being with us today and for your testimony. I will have some questions, but we will hear from the other panelists.

Dr. Joseph Stone, a member of the Blackfeet Tribe of Northern Montana, is a practicing psychologist in Oregon and Washington. Dr. Stone, thank you for being with us.

STATEMENT OF JOSEPH B. STONE, REPRESENTING THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. STONE. Thank you, sir.

I would like to thank the chairman, Ranking Member Dorgan and members of the committee for the opportunity to address this hearing today.

I am Joseph Stone. I am an enrolled member of the Blackfeet Tribe of Northern Montana, and descendant of the Turtle Mountain Chippewa of North Dakota and the Lakota of South Dakota. I am an honorably discharged veteran of the U.S. Navy. My professional credentials include licensures as a psychologist in Washington State and Oregon; licensures as a mental health professional in Washington; and certification at level III as a chemical dependency professional.

On behalf of the tribal members of the Confederated Tribes of Grand Ronde for whom I serve as the behavioral health program manager and clinical supervisor, the tribal council sends their greetings to the committee and thanks the committee for their attention and provision of resources to the issue of youth suicide prevention in native communities. The members and tribal council of the Confederated Tribes of Grand Ronde are committed to the health and well being of their youth and other native youth. They encourage the work of this committee.

We have talked a lot about the statistical profile of what is occurring in the tribal communities, so I am not going to belabor that point too much. What I would like to do is speak briefly to some of the issues that were raised by the committee just a few moments ago.

What we see is the outcome of a historical context, a context of historical trauma and what we have begun to consider post-colonial stress. Research in this area is new, but it is beginning to occur. Post-colonial stress it seems to have to do with the capacity of children to regulate their arousal and the ability of families and family members impacted by the chronic stress over the course of generations to help those children regulate their arousal.

If a child grows up and they cannot regulate their arousal because their parents have been too impacted by chronic stress and thus too busy surviving, then that child has a compromised behavioral immunity or vulnerability then to further psychological or emotional or physical developmental insult, and therefore a lack of resilience to issues like suicide and other mental health disorders.

In working with the tribal communities as a psychologist, I would like to present about 8 days worth of work that occurred at a tribe I worked at a few years ago. On Sunday evening, we had suicide number one, a male tribal member age 21 jumped off a bridge. He was never referred to my waiting list. I had 40 active clients, 20 to 25 counseling sessions a week, and no time for community outreach to help reduce the stigma of seeking mental health services. He was not willing to seek referral to the community mental health center. The family perceived a lack of adequate culturally appropriate sensitivity and skill on that staff.

He was not willing to discuss his issues with the medical providers because of the sense of shame and stigma that he felt. He reported to family members suicidal ideation, despondency, anxiety over fiscal matters, a severely depressed mood, ongoing suicidal ideation and substance abuse issues. He had recently been trained as a diver and had a chance to make some money. What happened is he stopped his car, went to the bridge, mounted the bridge as though is were the transom of a boat, and flipped over backwards as though a diver was going into the water to dive for sea cucumbers. We do not know if it was a genuine attempt to kill himself or if he was simply acting out of a substance abuse-induced haze. That does not matter.

What happened then was by Wednesday, a second male tribal member in Canada had killed himself by self-inflicted hanging. This was hundreds of miles away, but he had heard about it. There was a lack of professional service for him, no community outreach, and the family did not know how to seek help or referral. They re-

ported he was despondent and anxious over finances and over a failed romance. He had depressed mood. When he found out about the first suicide of his relative, he said he had found a way out of his pain.

The psychological effects reverberated in our tribal community. There was fear, grief, a sense of foreboding. Who would be next? Feelings of powerlessness and helplessness. During that period of time, several of my regular clients reported increased suicidal ideation and intention. I had increased phone contact from community providers, tribal police and other tribal professionals about their concerns; monitored increased professional self-doubt about our capacity to help; sought outside intervention and support.

We had a serious suicide attempt number three 1 day and 1 week after the first suicide, a 17-year-old pregnant female, a close friend of the first tribal member killed herself with a massive overdose of Tylenol and other pills. She did not succeed; lost her child; killed most of her liver. During that week, I had three other attempts.

No. 1, was a 17-year-old tribal member. He had issues of depression and substance abuse. He was arrested and reported to the county that he was suicidal. He attempted to kill himself by running into the wall at the jail and breaking his neck. There was no assessment or treatment through the community.

No. 2, a 12-year-old tribal male had trouble at the school, hit his teacher, tore up his classroom. He came and saw me at my office. He said he was suicidal. I said, how would you kill yourself? He said, I would jump off a bridge. My words not his, the same bridge the first man had jumped off of. He had crossed it on a daily basis. No intervention from the community mental health program. I had him and his grandmother call me on an hourly basis.

No. 3, 1 week and 3 days following the first suicide, I am going home from work. I get to a corner. There is a 9-year-old kid 40 feet up a tree. A police officer on duty and myself climbed into the lower branches of the tree so we could attempt to break his fall in case he actually jumped. We managed to talk him down. We did not have training to do that, but we just kept at it until he came down.

What I would like to recommend is that we look very strongly at designating suicide prevention as the top preventive focus for the Indian Health Service; dedicated funding to support urban American Indian mental health and suicide prevention; establishing a national center of excellence for suicide prevention in tribal communities, operated and managed by Native American and American Indian experts and professionals; develop school-based mental health services to promote a positive school environment and help prevent youth suicide.

Professional mental health providers should be able to make direct services to residential treatment for native children. We need to increase the collaboration between the county and the State system gatekeepers and tribal mental health providers to ensure adequate access. Exclusion of Native American clients who are suicidal from the system by State and county gatekeepers must be examined and that process must be changed.

We need to increase the number of qualified mental health professionals in the field to a number proportionate in the general population. Funding for the American Indians in the psychology program should be doubled, with at least two additional university sites. We need to increase funding for training social workers and counselors.

We need to provide an additional $170 million as recommended by the Friends of Indian Health to IHS to address the level of need for health and mental health care. We need to benchmark the funds available to the Indian Health Service versus those funds available to other publicly funded health care systems; ensure the number of IHS mental health providers meets the ratio of mental health and care providers for the general population and that each IHS area can subsequently ensure that there exists community-based mental health and suicide prevention programs.

Thank you.

[The prepared statement of Mr. Stone appears in appendix.]

Senator DORGAN. Dr. Stone, thank you very much for your testimony.

Next, we will hear from Julie Garreau, and I hope I am pronouncing your name correctly, Julie, a member of the Cheyenne River Sioux Tribe and director of the Billy Mills Youth Center, the Main, in Eagle Butte, SD. Welcome, and you may begin.

STATEMENT OF JULIE GARREAU, EXECUTIVE DIRECTOR OF THE CHEYENNE RIVER YOUTH PROJECT, CHEYENNE RIVER SIOUX TRIBE

Ms. GARREAU. Thank you. Good morning, Senator Dorgan and members of the committee. My name is Julie Garreau. I am a member of the Cheyenne River Sioux Tribe and executive director of the Cheyenne River Youth Project.

On behalf of the Cheyenne River Youth Project and the young people of Cheyenne River, I would like to thank you for holding this series of hearings about youth suicide prevention in Indian country. We certainly appreciate the opportunity to share our thoughts and to participate.

In addition, I would like to thank Senator Johnson, who helped to secure Federal funding for our teen center which is currently under construction.

I understand that I was invited to participate in this hearing because the Cheyenne River Youth Project has an inspiring story to tell, a story that spans the course of 17 years; that involves success, joy and heartbreak. But I was not sure what part of that story to tell because it has truly been an incredible journey. I have many stories that I can share with you, all of which are very personal, in fact so personal that I often become very emotional, especially when I think about those young people who have lost all hope and felt they had no other option but suicide.

In 2002 and 2003, on Cheyenne River we lost 17 of our young people to suicide. In a community as small as ours, it is all very personal because they are our neighbors, our relatives. We know their mothers, their fathers, their grandmas and their grandpas. They are my nieces and my nephews.

It truly is an indictment against all of us, our families, our communities and our tribes, when we lose our children to suicide and other tragedies. We are failing our children, but it does not have to be that way if we can make a combined effort to combine our resources and partners to make a difference.

I believe the Cheyenne River Youth Project is an example of what a grassroots organization can do for its community. The key to preparing our kids to confront the challenges of youth lies within local initiatives. We all know the history of the reservation, when we were told what to wear, what to eat, how to dress, how to think, and even how and when to pray. Although that history is tragic, it is that reservation system that may now be our salvation because we are remotely located and come from close, small, close-knit communities.

Our story is only inspiring because it is about people taking care of themselves, a local initiative, a personal solution. This is the story of a small group of people doing everything possible in their community to make a difference for their children. Once we had done all we could through our own resources, we sought partnerships with community organizations and eventually outside support.

I would rather try to take it on ourselves, and we tried, but because we live in an impoverished economic condition and due to our rural location, we understand that it is impossible. In our history, we have encountered stumbling blocks, but instead of expending our energies deciding where to place the blame, we are finding solutions. We have succeeded because we have not deviated from our mission, which is to love and support the children and families of Cheyenne River. Quite honestly, I would rather not be here today. I would rather not leave my community to testify or to fund-raise, but the reality of our situation is that we need help. Our children need your help.

I truly love my home, my work, and most of all the children and families that we are privileged to work with. I think the greatest example I can give you about why the Cheyenne River Youth Project is a success is the teen center we are currently constructing. The teen center is a reflection of listening to the children and building upon those ideas. When we decided that it was time to move forward in our plans to design and construct a teen center, we understood from years of experience that we needed to consult our teenagers. From that consultation, we have incorporated an internet cafe, a library, a computer lab, art and dance studio, and a counselor's office into the plan, because our children told us what they needed.

We have made listening to our community an artwork. A teen center is not the only answer, nor is it the solution for every community. There are so many other needs, drug and alcohol counseling, better foster care and juvenile justice systems, and more mental health counselors. Nevertheless, our teenagers are excited about this new youth center. We have seen it in their faces and heard it in their voices. Even before it is built, it is giving them what they need most, which is hope. Now, when they look on the horizon of Cheyenne River, they see a teen center, which again represents hope.

I thank you very much for your interest in our organization's efforts. I think that we are truly doing some amazing things on Cheyenne River and I think we are part of a really great future for our kids.

Thank you.

[Prepared statement of Ms. Garreau appears in appendix.]

Senator DORGAN. Ms. Garreau, thank you very much for your testimony.

Ms. GARREAU. You are welcome.

Senator DORGAN. We appreciate your work and your inspiring story. I will have some questions as well.

Dr. Dale Walker is the director of One Sky Center. He is a Professor of Psychiatry and Public Health and Preventive Medicine, and director of the Center for American Indian Education and Research and Oregon Health and Sciences University. We very much appreciate your willingness to be with us, Dr. Walker, and you may proceed.

STATEMENT OF R. DALE WALKER, DIRECTOR, ONE SKY CENTER, OREGON HEALTH AND SCIENCES UNIVERSITY

Mr. WALKER. Senator, thank you very much.

I want to also add that your comments to open the meeting were remarkable. They were personal and we can tell you have been there. That is much appreciated. Sometimes we who testify have to do that work to make those voices heard. Your efforts to help bring this to the attention of the public is vital and greatly appreciated.

I would add also that Senator Smith's opening conversation about suicide and difficulties of families in this country are landmark in importance.

I am so happy and humbled to be here with you. I want to tell you a little bit about who we are and what we have done, and what we have found out about, and then some recommendations.

The One Sky Center is 2 years old. We have been working with SAMHSA as a grant that is uniquely funded, actually, by two centers, both prevention and treatment centers within SAMHSA. It was the vision to have a national resource center to provide information and cultural competence and best practices for all Indian communities across the country. It has been a vision that I have had for my 28 years of work in this area, that we need to have a centralized body to gather this information.

Until now, we have been unable. SAMHSA itself spends between $40 million and $50 million each year on American Indian projects. The ability to collect the information in a way that we learn and gather the data so that it is available to other Indian communities has not been there. We have now put that information in place. A major part of that information and our visits over the last two years, I have been out to over 100 Indian communities to see what is happening, to provide technical assistance, to provide training, and also to explore consultation.

The issues that have happened in the last 6 months are critical and extraordinary. The fact that there are suicide and violence issues in schools in Indian communities is something that we are vulnerable to across this country. All Indian communities have the symptoms and the risk factors that you have heard today and are

vulnerable to the continuation of loss of life, incarceration and continued family and domestic destruction.

There is no doubt in my mind after seeing all of the places that I visited, the intensity, severity and degree of difference in other communities that exists in Indian communities. Earlier today we were talking about why would that be. I think that indeed the historical relationship of 400 years, and over 600 treaties that define access to care and education for Indian people and location of Indian people have been a part of the issues that we should all be concerned about.

In addition, how people receive care has become quite visible, the access to care. I was asked to do a site visit with Standing Rock and provided the community assessment approach to doing that, which is a unique and very important way to do suicide prevention intervention work, where the community has its input and its ideas are forefront in resolving the problems and issues.

If you look at Standing Rock and you see the size of the high schools and junior highs or middle schools and the grade schools, it is important to note some issues. If you just look at the facts for a moment, what you find out is that well over 300 children have attempted suicide in their lifetime, attempted. Where does their treatment go after they have attempted? What access? You just heard that if indeed there was an attempt, what kind of follow-up, what kind of community and family interventions are made to support that attempt?

If you look further and broader, you find out that 40 percent of the children have talked about suicide as an outcome in their life. It is no doubt to me that the access to care is an issue. One of the recommendations that we talk about is strengthening the behavioral health care capacity. It has been said that the Indian Health Service can provide adequately 40 percent of the need. If that is the case, what are we doing with the other 60 percent?

I recommend that we pay attention to full funding for the Indian Health Service, and we also pay attention to full funding for mental health and addictions care within the Indian Health Service. Even at that level, Senator, we need more resources. An interagency collaboration led by Health and Human Services has been a remarkably important next step in cross-agency support. I would think that if we could somehow from your point of view encourage this continued interaction of interagency cooperation, that that would be a vitally important step as well.

I have been a part of that growth and development over these 2 years and think that is one of the most wonderful dedications of Federal services for support for Indian people that I have seen in my 28 years of work.

A demonstration project, as Dr. Stone has suggested, a national center for suicide, is an important step as well. We have been providing the leadership to develop a community interface so that you can go to any of the communities and tribes and urban Indian centers to do this kind of evaluation from their point of view. That is critical, and we have to continue.

We have also provided assistance for Standing Rock to seek funding under emergency funding for their services and if indeed that occurs, the One Sky Center will be there also to provide the care

and the assistance and consultation to get that project moving along.

The issue of a national evaluation of treatment must go hand in hand with any resources. Dr. Stone defined benchmarking of services. We need to get the information out to all 562 recognized tribes and the 34 urban Indian health programs so that they all will be skilled and they will have the monies to support the access to care that is needed.

I would like to thank the Committee and also this panel because it is an honor to be here with all of you as well. Thank you.

[Prepared statement of Dr. Walker appears in appendix.]

Senator DORGAN. Dr. Walker, thank you very much.

Finally, the last witness will be Clark Flatt, president and CEO of the Jason Foundation. Mr. Flatt is the president and CEO of the Jason Foundation, a foundation begun after the suicide death of Mr. Flatt's youngest son Jason, aged 16, in 1997. It has received national recognition for its community assistance resource line, a 24-hour, 7-day-a-week resource line staffed by a clinical specialist in partnership with the foundation.

Mr. Flatt, we appreciate very much your willingness to be here and share your comments with us. You may proceed.

STATEMENT OF CLARK FLATT, PRESIDENT AND CEO, THE JASON FOUNDATION

Mr. FLATT. Thank you, sir.

Mr. Chairman and members of the committee, it is indeed an honor to be here. This is as much a fact-finding experience for me of being able to meet and talk with some of the people on the panel and some of the people in the audience that we have been wanting to talk with. You have really put together a good panel and a good resource here.

My name is Clark Flatt, as you said, president and CEO of the Jason Foundation. I was asked to come here today to share my personal story about our organization, The Jason Foundation, specifically our funding strategy and our current work with the Bureau of Indian Affairs, specifically the Office of Law Enforcement Services, District Five.

One month from tomorrow, July 16, will be the eighth anniversary of the tragic death of my youngest son Jason, to what I have even heard mentioned here, which we have been calling for years a terrible silent epidemic. In the general population, this silent epidemic is now the third leading cause of death for our young people aged 15 to 24. It is also the second leading cause of death for our college-age students.

This silent epidemic as we call it has seen an over 300-percent increase in the last 40 years among the general population of our youth. Even though it has been mentioned and sometimes touted that this trend has now leveled off and started to decline slightly, when we look at it, it is still almost 300 percent from where it was 40 years ago, which is a rate that nobody could say is acceptable in anyone's eyes.

This silent epidemic that took my son's life, of course, is youth suicide. Nationally, the NHSDA reported in 2002 that in a study done in 2000 of the general population, there was an estimated

daily average of over 2,700 suicide attempts each day in our Nation from young people age 12 to 17. From these stats and others that have been mentioned here today, specifically with the Indian nation, it was these types of stats that prompted us, my family and a small group of friends back in 1997 to start The Jason Foundation in Hendersonville, Tennessee.

The Jason Foundation literally began on, as they say, the kitchen table. A few months after my son's death, we decided to get together and brought some friends and some professionals together and decided that this silent epidemic of youth suicide that took my son, that Jason would become a silent statistic. We would begin to talk about how this impacted our family, how it impacted the community, and how it impacts even the extended community beyond just where we live.

Our first mission was very simple. It was to do parent education seminars. I had gone to every seminar that I could go to, the PTO, PTA, community, church, to learn about drugs, HIV, homicide, school violence, anything that can make me a better parent to protect my children. No one in the 16 years of Jason's life ever discussed suicide as a problem that would face my problem and literally take my son's life.

So we started a very, very aggressive local program to educate parents. This grew very quickly. Today, we offer specialized programs which is a school-based program that is to be built within the health and wellness curriculum of a school. It is not an extra program or after-school program. It is actually a curriculum.

We also do staff training seminars which are used a great deal across the Nation in in-service training for educators for continuing education credits. Also, we still do the parent seminars, which is a big part.

Our budget in 1997 was for two months, $2,700, which was a really aggressive thing for us at that time. Our budget for this year in 2005 is $9.7 million, so we have grown quite a bit over the last 7½ years. We now have a corporate office that from the kitchen table has grown to a little over 4,000 square feet in Hendersonville, TN. We have 25 regional offices across the Nation. We have contracted to open 24 more offices before the summer of 2006, covering 28 States that will have a Jason Foundation office literally within their States and serving a great deal more.

One thing that as we talked and I was sharing with some of the people that we talked about was how we did some of these things. We very much believe in collaboration. Collaboration is the key. We have a national clinical affiliate which is one of the things that makes our program different, which is Psychiatric Solutions, Incorporated, out of Franklin, TN. They are now the largest provider of in-patient health care in the Nation. They have served as our national clinical affiliate and give us the basis for our programs that helps us in our development across the Nation.

We also have the AFCA, which is the American Football Coaches Association. One of the things that was mentioned earlier is the stigma. When we decided to come out and talk about Jason, people did not talk about suicides that are happening. It was a personal tragedy and you went on. I have talked with Senator Smith about his. The situation to break this out, we needed to have a voice out

there. The American Football Coaches Association has provided that voice. We have over 50 coaches across the Nation that do PSAs for us and help us as ambassadors across the Nation in opening doors and getting our programs presented to the right people in the States.

Also, the USA Wrestling Organization does the same thing with their network. They have one of the best middle school and high school networks in the Nation. We then went on to have a national corporate affiliate which are proud to announce is Wal-Mart, which is doing a tremendous effort with us in awareness across the Nation. We also work with 31 attorneys general.

I was asked today to specifically comment on JFI's funding strategy of how we do this. Of the $9.7 million budget this year, JFI has only one government grant, and that is for $77,500 that is a block grant from the Tennessee Department of Mental Health and Developmental Disabilities. It helps us with a specialized program within Tennessee where we provide our school-based programs and teacher in-service training for over 700 schools. All other funding that we receive for The Jason Foundation is through corporate gifts, in-kind support, private and public grants, fund-raising activities and individual gifts.

When I began The Jason Foundation, we spoke with several successful and some not so successful non-profits. I approached it as a business decision. The one thing that almost ran with every one of the ones that were not so successful, they had a small funding base and almost every one of them were tied entirely to State or Federal funding. They had failed. So we decided on our board of directors not to go that route. We have been able to, as I think JFI has demonstrated, that if corporate America can see a well-defined need and see how their involvement can make a difference, they will invest in an organization that is well run and that can show accomplishments.

Last, I would like to comment on our collaboration which is part of this hearing here with the BIA Office of Law Enforcement Services, specifically with district 5. John Olivera, which is the National Child Abuse director for the BIA, heard me speak in Los Angeles and came up and asked me to consider doing a program in youth suicide prevention, which I discouraged him at that point, until he shared with me some of the stats, where it is 2½ times as bad as what we have shared here about the general population. It is 2½ times that on Indian reservations and in Indian country.

So after talking and much prodding, we decided and signed an agreement of operation in January 2005. We started the basic information gathering by talking to tribal leaders and community workers, specifically in district five. Our plans are to take the JFI programs for the schools and for the teachers and staff training and parent seminars, and to take those and make them more ethnic and responsible to the community, and then provide those to the communities. Again, as we operate throughout the Nation, we never charge for any of our programs in our service areas that we do for schools, churches or youth organizations.

As has been addressed and in closing here, one of the things that we have seen, and I really believe the challenge is not identifying the at-risk youth. That is not a challenge. We have the programs,

not only The Jason Foundation, but other fine programs out there, have the programs that can be put in to and made ethnically responsible that will help identify these at-risk students. My concern is, and it has been echoed here, what do we do once we recognize those at-risk youths?

The services we have seen there at this point are not adequate of being able to respond. Our fear is that if we start recognizing more youth that are at risk and we do not get them help, as was brought forth by Ms. Rough Surface as far as the things not coming in, that we will even make the problem worse.

We are working on two programs, a tele-counseling program which is modeled after, I know you do some work in tele-medicine. We have looked at that and worked with the people doing the cardiac care part. We really believe that even though it is not optimum, that we can do using experts in adolescent psychiatry to help locally train therapists to be able to provide services in these remote areas.

Also mirroring some other programs, the mobile counseling centers, we have already gone to the point of outfitting it where they could go to different points of the reservation 4 days a week and go back to the IHS hospital that we hope to collaborate with, where there would be referral sources and looking more in to the points of what we could do for extended care of some of the families they talk to.

We are very much in the infancy range of all these programs, but we are excited about working with the other fine organizations here and we appreciate the opportunity to testify here. I would in closing say that the key lies, as we said here, I believe with the grassroots organizations throughout the communities. Those are the ones that make the difference. Those are the ones that are in tune with the communities. And those are the ones that we need to center upon.

Thank you for this opportunity.

[Prepared statement of Mr. Flatt appears in appendix.]

Senator DORGAN. Mr. Flatt, thank you very much. I appreciate your testimony and your work on behalf of the memory of your son in ways that we hope will, and are convinced will save other lives.

Dr. Walker, you used a term of 45 percent. I think you were talking about the Indian Health Service. Describe that term to me again.

Mr. WALKER. Yes; several years ago when the Indian Health Service was trying to develop its budget and projections, they tried to look at the need in the community. They went through an assessment process on all of the regions. If you collectively looked at it in an additive way, 45 percent of the services they were able to provide. It is not defendable, if you will. It really tells the problem in being true.

If I could say an example of that I think is if you look at Standing Rock. Those kids that are in the schools, when the counselors are told that the kids are feeling suicidal, they are referred over to mental health for evaluation. There are only two mental health people, one in North Dakota and one in South Dakota, who line up the support and services. It is a 4-month waiting list. Two people are not enough. So the services and the ability to get the number

of people there is not adequate. The people who are doing the work are excellent.

Senator DORGAN. Mr. Flatt described, once you have identified the person, a young person at risk, then what do you do with him. In the case of Standing Rock, for example, with the waiting list you have described, the inadequate services that Ms. Rough Surface described, to the extent that some child is sent someplace to get some help, in most cases they are sent to a hospital to a psychiatric unit about 70 miles or 80 miles away. Testimony from that tribe indicates that most of these children are back home within 1 day or two, with a little bit of medicine and no follow-up.

So that describes the problem, Mr. Flatt, that you have alluded to, that if you have identified someone at risk, then you have to have the mental health services, the general health services available to treat it and deal with it.

Ms. Rough Surface, you described the tragedy in your family. You said that there just are not enough mental health services, one psychiatrist, 3,000 cases. Did you mean 3,000 people and one psychiatrist? At any rate, you just indicated that there is not the ability to have professional help because the help is not available.

I think one of the other things that you had in your testimony, I think it was yours, just for example the lack of telephone service in a number of homes. A home that does not have a telephone is not a home that can easily reach out and go track somebody down. Can you describe that?

Ms. ROUGH SURFACE. Yes; IHS is the primary mental health provider for the majority of families on the reservation. Accessing other services requires a drive of up to 75 miles or more. Families have little choice but to depend on the limited services of the IHS. There are several discrepancies of services in the area of mental health. One such gap includes the absence of an on-call mental health liaison mechanism to assist families during emergency situations involving a suicide episode. The lack of support services compounds the event with additional trauma to family members. The majority of incidents which require intervention occur after working hours.

Dr. Kevin Furst at Standing Rock IHS, gives the following explanation for the policy that there are not enough qualified mental health providers to provide adequate coverage. We only have one doctoral-level professional. Dr. Furst also reports here on Standing Rock that there is one psychologist for every 3,740 mentally ill persons.

Senator DORGAN. Okay. That is the statistic I was looking for.

Ms. ROUGH SURFACE. Yes; they have two bachelor-level staff, but they are not qualified to do suicide assessments, although they have done them in the past.

Senator DORGAN. Thank you.

Dr. Stone, you mentioned the need for school-based mental health services. What is the effectiveness of the school-based mental health services and how prevalent is that service?

Mr. STONE. The prevalence rates I could not quote directly to you, but I will look that information up and get it and submit it to you.

I think the critical element of school-based services, as Mr. Flatt had reported, accessing children in the schools is very important, but the critical element is not necessarily just school-based services, but collaborative school-based services, so that the school is collaborating.

Senator DORGAN. Collaborative with what?

Mr. STONE. Collaborating with the Indian Health Service, and then further collaborating with other agencies that have responsibility for the mental health care of tribal people. That would include counties and State agencies also.

So we really have to have a robust collaboration among professionals and an educational effort among professionals to understand the issue of suicide, to recognize the factors of suicide, to help identify the kids who are possibly suicidal, and also to provide preventive activities to those kids and families that may help them to deal with issues of alienation, with issues of self-esteem, with issues of depression, possibly before they get into the acting-out phase.

So I think it is clear that interagency collaboration is very important.

Senator DORGAN. All right. Thank you very much.

Ms. Garreau, with respect to the Cheyenne River Youth Project, you are now building a teen center, but you have had the Cheyenne River Youth Project in operation for some while. Is that correct?

Ms. GARREAU. Yes; it has.

Senator DORGAN. Have you seen a diminishment of suicide attempts? Tell me the impact that you have been able to see or experience with respect to youth as a result of this project.

Ms. GARREAU. Our organization was established in 1988. In 1994, we created a suicide crisis referral hotline, which we operated from 1994 through 2000. At that point, we lost funding and so we were not able to do it anymore. In working with the tribal psychologist, within the first year he had estimated that we had affected the number of completions and attempts by 38 percent.

So we know that, and I think it worked because they were local people who manned the hotline. We had close connections to community organizations and agencies. We worked with the psychologist to where we could actually schedule somebody when they needed it. When they would call on the hotline, we had times when we could schedule them to go in and see a psychologist.

So we did see an effect almost immediately. I think as far as the teen center, I think what we provide is a support system for our kids. I do not have any definitive numbers, but what I do know because I have been there since the beginning, actually being the founder of the organization, I can tell you how many kids that we have affected positively who have gone on to become, and most of our kids are at risk. All of them come from family situations where they struggle getting to school every day, focusing on their homework, where their meals are going to come from.

What we try to do is we are a support system. So if they need help with homework, we are there for them. If they just need to talk, we are there for them. We provide them social opportunities. We also provide tutoring. With the new teen center, we have had a youth center for kids ages four to twelve, but we did not have

a place for them to transition into. So hopefully in the spring of 2006 we will have the grand opening for our teen center so that our children will have, once they outgrow our first youth center, they will be able to move into the teen center and continue to have that positive influence.

Senator DORGAN. Thank you for your work.

Mr. Flatt, you heard Dr. Walker talk about 45 percent. I think this describes that when you look at the universe of health care need, 45 percent of it is covered with existing funding and 55 percent is not covered. That obviously means that people with all kinds of problems are not getting the health care, in some cases mental health care they need.

Now, you have been enormously successful raising private sector funds for your foundation, and I commend you for that. I know how hard that must be. You have obviously reached out and found a network of private sector funding. Yet what you are doing is really important. I am really pleased you are connecting to Indian Health and so on.

We still need full funding and we need to move toward full funding for the needs in the Indian Health Service. Dr. Grim, a man for whom I have great admiration, he has testified here a number of times and testified at the Bismarck meeting. He cannot answer the questions I ask, and I understand why he can't. He works for the Administration. I asked the question, Dr. Grim, how much money did the Indian Health Service ask for? Tell me what your request was of the Office of Management and Budget? That is the eye of the needle through which funding requests go. It goes from the Indian Health Service to the Office of Management and Budget, which is part of the White House, and then into the President's budget and back.

So we know what the President's budget asks for with respect to the Indian Health Service, but Dr. Grim cannot answer the question: How much did you request? And so, because he works for them, and to do so would undercut the President's budget. So I formally asked him for it, but I do not ever expect to get it.

The question is, however, do you agree that notwithstanding all the private sector initiatives, and especially yours, which I am so proud of what you have done, we really do need to focus on better funding through the Indian Health Service for a wide range of things, especially mental health.

Mr. FLATT. Yes, sir; definitely. I think that it needs to be both. I think that you need to tie the private sector funding, which I am a big champion of. I believe that is the moneys that will be if it is built in a correct way, will be there year after year. It breaks my heart when I hear stories like she said of starting a program that is successful and because, especially on State levels where budgets are here today and gone tomorrow, where a great program is working and showing results has to shut down because their only funding source was that governmental source.

The best scenario would be to have the private sector and the governmental funding together. Just with the money, I can tell in the short 6 or 7 months we have been working with BIA, the IHS could use a lot more money than they are asking for and still would have a lot to go. They are doing a noble job with the moneys

that they are getting, but yes sir, it cannot be done on the private sector at that large scale.

But I do think that they should be a collaboration. I agree with several of the people who talked here, and that is what we were talking with Dr. Perez earlier. We have been trying to get together for a couple of months now, of trying to get the private sector to work with IHS and to share together resources and to share together different things that we can do together.

So yes, sir, I wholeheartedly, and we work very hard with the Garrett Lee Smith Memorial. In fact, Congressman Bart Gordon from Tennessee was the one who championed that on the House side, which we had spoken with him about getting involved. We are so proud that he was that member to do that.

So yes, we need that funding. We need more than that funding. But I would like to see, so that we do not have stories like this, that we bring in the private sector, sell them on the idea of getting involved, especially on the local areas. There is a lot of the clinical support that can be done and would love to be done by local affiliates. And then you get a buy-in that goes on and on and on beyond possibly just a governmental grant.

Senator DORGAN. Dr. Walker talked about access to care and location. I think you were describing, as we know especially in North Dakota, but in most parts of the country, the location in many cases of where Native Americans live is far from the hospitals, the primary centers of care.

So because of that, we have in one reservation, for example, a dentist who performs dentistry out of a trailer house for 5,000 people. Well, is that dental health? Well, whoever is there is doing I am sure the best job they can, but the resources are not sufficient and the location of the reservation is often far from these other facilities. That, too, is a very significant problem. That is why the Indian Health Service has to be better funded.

If we are only meeting one-half the need, and I do not know these statistics. I just asked our staff to dig into that some. But if we are only meeting one-half the need that exists, that means the other one-half are suffering, perhaps mental health issues; perhaps resulting in suicide; perhaps cardiac problems. The list is endless.

So we just have to do better, in my judgment. Dr. Walker, you might want to expand on the access issue. I think that even if we have the will here, you have to have the will to identify, the will to understand who is at risk. You have to have access on an emergency basis when you need it, regular access to the services you need.

Mr. WALKER. I could not agree with you more. The issue of access and understanding how you get access are quite important in Indian communities. One level is to try to support the funding process to its requested level.

I understand "requested by whom" is maybe a part of that question, but need has to be served. That is a treaty obligation. If it is not being served, I would question the treaty.

The other part of that may be my more optimistic side, is that there are multiple agencies that do provide services, both State and Federal, that are not within the IHS, but could be potential resources. One of those is Medicaid and Medicaid reimbursement for

care. We know that the rates and the ability to get access to care in the two States of North and South Dakota are different from one another in the way that they do their services, even in the timing that they have their services available.

Wouldn't it be nice if we could encourage agencies that do provide social services and support, housing, criminal justice support, at multiple State levels and Federal level to begin to work on these problems and get together to provide a service of care.

You know well, Senator, that there are different points of view and different very misunderstandings of Indian needs. Many States will say that is a Federal problem; we do not do that. There are 35 States that have Indian communities, Indian reservations. All of those States have to have an equal and balanced understanding of how they get access to care.

Now, you are right in the isolation. Standing Rock is an interesting area because there are eight communities somewhat distant from one another in an area the size of one-half of New Jersey. You are trying to provide geographic care and assistance to eight communities. Somehow when you set up appointments in one area and you expect the patient to be there, but they are unable to communicate that they cannot be there. There are many broken-down appointments and follow-up just based upon the geography, as you say.

I would add, though, that is actually true in the urban settings, too. We have a lot to learn in that area.

If I might, I want to add one other extra point. That is that we have these emergencies of Standing Rock and Red Lake. If you look at think about over the year, there might be 10 of those a year that are extra-emergent; that stand up and say do something. The One Sky Center has tried to be the on-call center to be there. It is a commitment beyond what we were originally funded to do, but it is a moral commitment that we have to make to be there.

We have worked closely with the Indian Health Service and SAMHSA to provide as much support as we can, but if we really want to develop a demonstration project to develop emergent care, and why would one want to do that? The example would be both at Standing Rock and Red Lake. When your health care providers are members of the community, it is their families who are committing suicide and suffering from homicide. It is not the time for them to be therapists. It is the time for them to be grieving family members.

We have to provide a backup system and support to help that emergent care. While it is not a huge issue from point of view of happening every day, we cannot visit Standing Rock, do our evaluation, shake hands with them, and wish them well. We have a committed partnership and that lasting relationship has to be supported.

Senator DORGAN. Dr. Walker, thank you very much.

I want to thank all of the witnesses who have come from some distances to be with us today.

Let me thank also Senator McCain. He had another hearing this morning, but I thank him for his cooperation and his work and his attention to this issue as well.

I think that, as I said when I started, this is a very sensitive topic. There are some who have counseled me privately not to have public hearings on this because it diminishes some in the eyes of others. That is not my intent at all. I think that when asked what is the most important thing in your life, if you do not answer "your children," there is something fundamentally wrong with you. I think everyone in this country answers "their children." They will do anything for their children. We all want life better for our children. Whatever is in second place is a long ways behind. It is about our children.

You have, Mr. Flatt and others, I, too, have lost a wonderful daughter to heart disease, not to suicide, but I can only imagine the added horror of having a child not only gone, but having a child that has taken his or her own life.

In terms of responding to the needs of our children, I think the passion that has been demonstrated by the testimony today is really important. We are going to get this done, make progress. We are going to try to reach some goals here if people pull together and understand there is an urgency.

I do not mean to suggest somehow that there is something different about Indian country. These are the first Americans. These are the people who greeted the immigrants. And yet in many cases, they live in third world conditions on too many reservations with full-blown crises in housing, health care and education, and with circumstances where those who are afflicted with problems cry out for help and do not find it.

It seems to me you start with building blocks deciding the first thing we are going to do is make sure that we reach out to our children. When you find areas of the country where you have 2½ or 3 times the rate of teen suicides, or in the Northern Plains 10 times the rate of teen suicides of the rest of the country, there is an urgency and a crisis for us to understand what is happening and to begin to mobilize efforts to do something about it.

All of you in your way are doing that and your travel to Washington, DC is important. I hope in the long term we will save lives of children in this country.

I would encourage you to do the same as I did the previous panel, the Surgeon General. If you have some suggestions for Senator McCain and I of what you think we might add to the Indian Health Care Improvement Act as we consider introducing that and moving it forward now in this Congress, we are determined to get this done and get it signed by the President, please send us your recommendations as well following this hearing.

In the meantime, I want to thank all of you for some very important testimony and I appreciate your participation.

This hearing is adjourned.

[Whereupon, at 11:40 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. GORDON SMITH, U.S. SENATOR FROM OREGON

Mr. Chairman, I'd like to begin by thanking you for recognizing the serious problem of youth suicide among our Native American population, and for convening today's hearing to call attention to this issue and the steps that can be taken to prevent it from happening.

Suicide is the second leading cause of death among Native American youth aged 10–24. And according to CDC, in 2002 there were 106 suicides in this age group, 80 percent of whom were male. In my home State of Oregon, 63 young people in this age group died by suicide in 2002, 5 percent of whom were young Native Americans. Mr. Chairman, it is time for the Federal Government to respond to this alarming trend, as we cannot afford to wait any longer.

Fortunately, there is hope. On October 21, 2004, President Bush signed the Nation's first youth suicide prevention bill into law—the Garrett Lee Smith Memorial Act, named in memory of my son who died by suicide in September 2003. Garrett's law recognizes that youth suicide is a public health crisis linked to underlying mental health problems, and specifically targeted funds to help enable Native American tribes to develop suicide prevention and early intervention programs.

Garrett's law authorized $82 million dollars over the next 3 years for youth suicide prevention and early intervention programs including voluntary, confidential screening programs like TeenScreen, a program my wife Sharon and I have been enthusiastic supporters of in our hometown of Pendleton, OR.

The Federal Substance Abuse and Mental Health Services Administration [SAMHSA] is charged with implementing Garrett's law and will be awarding grants shortly. These grants will be used to develop and implement State-sponsored statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems and other child and youth support organizations.

Of the $10 million we appropriated for fiscal year 2005, $5.5 million will find State and tribal youth suicide prevention efforts. According to SAMHSA, this money is expected to fund 14 awards, with a maximum award of $400,000 and at least one grant will be made to a Native American tribal organization. I'm pleased to report the first grant awards will be announced at the end of the summer.

For fiscal year 2006, the Garrett Lee Smith Memorial Act is authorized to receive $27 million, as advocated by the suicide prevention community. Securing full funding through the appropriations process will be a major step forward in helping States and tribes make real progress in preventing youth suicides.

However, enactment and securing full funding of the Garrett Lee Smith Memorial Act is just the beginning, a first step down a long road toward developing our Nation's mental health infrastructure.

Mr. Chairman, mental illness is a treatable disease, especially if detected at an early stage. Full funding for Garrett's Law will improve early identification of young Americans with mental illness and help facilitate their access to treatment, espe-

cially among our Native American youths who are at particularly high risk. I am confident the Garrett Lee Smith Memorial Act will help save Native American children and families from experiencing the pain of suicide.

I sincerely appreciate the efforts you and this committee are undertaking on behalf of our Native American population to highlight the importance of this issue, and we are fortunate to have such a distinguished group of witnesses with us today.

I am especially pleased to welcome Joseph Stone, who is a member of the Black Feet Tribe and provides mental health services to tribes in Oregon; and Dale Walker, director of One Sky Center at the Oregon Health and Science University in Portland, OR, which helps tribes develop effective mental health and substance abuse treatment programs. It is a pleasure to have both of you here and I truly appreciate your sharing your experiences with us today.

Mr. Chairman, in closing I would like to leave you and my colleagues with this final thought: Today, while we are discussing the broad spectrum of the possible approaches that can be taken to proactively help prevent these tragedies among our Nation's young people, we must not forget that mental illness and suicide are indiscriminate killers. Mental illness doesn't care if you're rich or poor, from a loving family or a broken home. The only thing that matters is diagnosing the problem early and getting treatment to those who need it in time to make a difference. This is an area I'm sure all my colleagues can agree upon, and I look forward to working with you Mr. Chairman to help young Native Americans and their families combat this terrible problem.

Thank you.

PREPARED STATEMENT OF TERRANCE BOOTH, SR., METLAKATLA INDIAN COMMUNITY, METLKATLA, AK

I am a former tribal council member, Metlakatia Indian Community, Metlakatia, Alaska. I served on the tribal council for 8 ½ years and during my time served we in our community had youth suicide take place. More attention needs to be given to the Native American Youth. Primarily, poverty reductions steps need to be in place for all of the American Indian Reservations. Each year as the new USA Census report comes out one does not see the elimination of poverty among American Indians it remains about the same each time Census Report is issued. Eliminating poverty and improving the social and economic conditions of American Indians will greatly improve their tribal settings. As it is now with such poor state of tribal settings it is no wonder thoughts of suicide prevail among our youth.

Terrance H. Booth, Sr. (Tsimshian Tribe)

PREPARED STATEMENT OF TWILA ROUGH SURFACE, STANDING ROCK SIOUX TRIBE

Good Morning, I would like to thank Senator Dorgan for the invitation to state my concern for the young people of my tribe.

My name is Twila (Summers) Rough Surface, I am an enrolled member of the Standing Rock Sioux Tribe and lived on the reservation my entire life. I am a mother and a grandmother and come from a family of 5 brothers, 3 sisters with 14 nieces and 20 nephews.

I recently lost a niece to suicide on February 2, 2005. She was my sisters' third child. The following events, I believe contributed to the eventual death of my niece. January 7, 2005, her brother was killed in a car accident. During the grieving period, her mother had nobody to come and talk to her regarding the death of her son. I can only speculate that my niece saw all the hurt and couldn't handle the loss, so she decided to take her own life. My sister was overwhelmed by the deaths and also tried to take her own life. After the attempt my sister relayed the following "She thought the only way to make the hurt go away was to take her life so she would not feel the hurt and pain." Luckily a family member found her in time.

The loss of my nephew had a great impact on his friends. One of his friends who had been selected to be a pallbearer at his funeral committed suicide on the day my nephew was buried. His best friend also said he missed him very much and on April 7, 2005 he committed suicide The effect of the deaths in my family has touched many and continues to be a concern. I must mention that at no point did any mental health professionals contact our family. I feel if there had been intervention with grief counseling and support for my sister and her children, my niece may have had a chance to grow to be an elder of the community.

The overall rate of suicide among our youth has increased. Rates remain unacceptably high. Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools and communities.

Such feelings can overwhelm young people and lead them to consider suicide as a "solution." Few schools and communities have suicide prevention plans that include screening, referral, and crisis intervention programs for youth. Programs designed to assist children and families dealing with sever trauma are not readily available on Standing Rock.

Families are economically disadvantaged and with the 40–75-mile trip to seek counseling it is virtually impossible to access these options. Transportation and access to a telephone is essential to regular therapy, however this is not a luxury the majority of our families have.

We do not have:

- Effective clinical care for the mental, physical, and substance abuse disorders.
- Easy access to a variety of clinical interventions and support for help seeking.
- Family and community support.
- Support from ongoing medical and mental health care relationships.
- Grievance counseling.
- Not enough police.

Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. Surviving family members, suffer the trauma of losing a loved one to suicide, and are at higher risk for suicide and emotional problems. We as a nation need to be aware:

- Learn the warning signs.
- Get involved.
- Become available.
- Show interest and support.
- Be willing to listen.
- Be non-judgmental.
- Offer empathy.
- Offer hope that alternatives are available.
- Out reach services.

Take action, Remove means and get help from individuals or agencies specializing in crisis intervention and suicide prevention.

In conclusion, I would like to thank you for listening and request immediate assistance for the Standing Rock Sioux Tribe.

Testimony
Before the Indian Affairs Committee
United States Senate

Suicide Prevention Among Native American Youth

Statement of
Richard H. Carmona, M.D., M.P.H., F.A.C.S.
Surgeon General
U.S. Public Health Service
Office of Public Health and Science
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 9:30 AM
Wednesday, June 15, 2005

Good morning Mr. Chairman and distinguished members of the Committee. My name is Vice Admiral Richard Carmona, and I am the Surgeon General of the U.S. Public Health Service.

I have had the honor of working with many of you, and I look forward to strengthening our partnerships to improve the health and well being of American Indian and Alaska Native communities, as well as all communities across our great nation.

I appreciate this opportunity to represent the U.S. Department of Health and Human Services (HHS) to discuss suicide and suicide prevention activities in Indian Country.

Suicide is one of the most tragic events that a family can endure. The heartache of families' grief cannot be underestimated or ignored. We must continue to ensure that we are a nation that takes the necessary steps to prevent suicide.

I believe — as I know you do — that the mental health of our nation is a critical component of our nation's public health.

Suicide costs us more than 30,000 lives each year. That's almost one person every 15 minutes. And once every 45 seconds someone engages in suicidal behavior. Even if the life is spared, the heartache and pain is so severe that the spirit may never fully heal.

On May 2, 2005, in Bismarck, North Dakota, Senator Byron Dorgan and Representative Earl Pomeroy heard testimony from my colleague Rear Admiral Charles Grim, Director of the Indian Health Service (IHS), Ulonda Shamwell of the Substance Abuse and Mental Health Services Administration (SAMHSA), and tribal and community representatives from across the country. They described in detail the significance of the suicide problem, as well as some of the efforts to address it. For the benefit of the full Committee, I will review some of the information shared at that hearing and provide supporting detail on some of the specific responses to the situation. I will also focus on specific leadership tasks for all of us to undertake — including federal, tribal, state, and community members — to successfully address the suicide problem and promote the health and well being of tribal communities.

Background

The suicide rates in Indian Country are generally higher, and are characterized by younger people engaging in fatal and nonfatal suicidal behavior at much higher rates than the overall U.S. population.

- Based upon the most recent data from the Indian Health Service (*Trends in Indian Health, 2000-2001*, published in 2004), the suicide rates for American Indians and Alaska Natives are many times the national average for other population groups. For 5- to 14- year-olds, the suicide rate is 2.6 times higher than the national average. And there is an even

greater disparity in the later teenage years and into young adulthood. The suicide rate for American Indian / Alaska Native youth aged 15 to 24 is 3.3 times higher than the national average.

- In fact, young people aged 15-24 make up 40 percent of all suicides in Indian Country.

- Suicides are just the tip of the pyramid in examining suicidal behavior among American Indian youth. There are many more nonfatal injuries due to suicidal behavior than there are suicides. It is estimated that there are 13 nonfatal events for every fatality.

The patterns of completions suggest these young people act more impulsively than planned, are usually responding more to external stimuli (including significant family or interpersonal problems), have been using alcohol and/or other substances, and they tend not to have been previously seen in any behavioral health clinical setting.

In addition, suicide and suicidal behavior are becoming more prevalent in many of our smaller tribal communities.

We have some indications and areas to further explore in the small, but growing, literature on suicide among American Indians / Alaska Natives, but we have nothing close to the more robust literature and science that are available about

the general population. And what the available literature does tell us is that suicide in Indian Country is different from the overall population — including some of the ways I've just mentioned — and requires different approaches to prevention. In many of our tribal communities, suicide is not just an individual clinical condition, but also a community condition.

Suicide is not a single problem; rather it is a single response to multiple problems.

The reality is that we have not adequately explored either the problems or the necessary responses. We know that some of the underlying social, educational, and cultural issues related to suicide include poverty, lack of economic opportunity, limited educational alternatives, community breakdown, familial disruption, and stigma; and we need to better understand the role of social risk and protective factors. These social issues are every bit as important to understand and address as are clinical factors such as substance abuse and mental health. We know that these factors are all critical to promoting long-term health and minimizing potential suicidal behavior. We can guide and evaluate programs to reduce suicidal behavior by what we learn about social, educational, cultural, and clinical factors.

In sum, we know enough to know there are differences, and we can identify some of the more critical differences, but we do not yet have as complete an understanding as we should to guide suicide treatment or prevention.

This is particularly true in Indian Country. To address it appropriately requires public health and community interventions as much as clinical interventions. It also requires resources sufficient to understand and support the interventions. The Administration's FY 2006 budget request for IHS includes a total of $59 million for mental health, an increase of $4.3 million, or 8 percent, over FY 2005.

We also know enough to take active steps to respond, which leads me to the next critical question: What are we doing to prevent suicide in Indian Country?

My predecessor, Surgeon General David Satcher, shined a bright light on the too-often darkened pain of suicide. He said that we need to work to prevent suicide and suicidal tendencies before they manifest.

In 1999, he issued *The Surgeon General's Call to Action to Prevent Suicide.* It is the product of an effort that brought the best science together with the best experience on the subject of suicide prevention, and was organized around three central themes of Awareness, Intervention, and Methodology. In addition, Dr. Satcher was instrumental in developing the *National Strategy for Suicide Prevention.* It details 11 national goals and 68 specific objectives to reduce suicide in the United States.

The Strategy was and remains the national blueprint for action to prevent suicide. Promoting awareness, supporting treatment, enhancing research, and fostering

collaborations among public and private organizations as endorsed by the goals have been very successful. I am proud to report that for the general population, the long-term trend in the United States has been toward a decline in the suicide rate. I am troubled by the fact, however, that suicide in Indian Country is not declining.

Because of this fact, one of Dr. Grim's first acts as Interim Director of the IHS in 2002 was to convene a tribal consultation on behavioral health. Representing over 200 tribes and tribal organizations, the consultation provided recommendations for long-term goals to revitalize and promote behavioral health in Indian Country. In the past three years, every one of those goals has been addressed, with substantial progress noted in all of them. This has been a collaborative process between HHS, the Department of the Interior, and other federal agencies, tribes, states, and communities. Collaboration is the hallmark of this new behavioral health approach. But it marks only the beginning of a much longer process in which we are currently engaged to bring leadership, programs, and resources to what is, by any reasonable judgment, an ongoing crisis.

In the short term, a federal crisis response capability was developed to intervene quickly, collaboratively, and effectively in tribal communities. This federal response capability includes the IHS, the Office of Force Readiness and Deployment of the U.S. Public Health Service, SAMHSA, and the Department of the Interior. It provides emergency short-term and intermediate-term direct

services, training, and infrastructure support to communities in crisis. The teams have been deployed to tribal communities twice in the past two years and were highly effective in both cases. In fact, these deployments now serve as models for intervention, not only in Indian Country, but for any small or isolated community in need.

Various models of care have also been developed and are currently in use. For reservation-based programs, there are highly innovative approaches that show great efficacy and could be used as models for other tribal communities. For example, the Jicarilla Apache of Northern New Mexico, in the span of approximately 10 years, addressed one of the highest rates of suicidal activity in the United States by developing a community-based intervention strategy that remains a model for tribally run programs. The strategy brought together tribal leadership, community members, youth, clinicians, researchers from the University of New Mexico, and IHS personnel to design and implement the program. The program involves the entire community, from tribal government, to schools, to social service and law enforcement agencies. The result is that over the past decade, suicidal activity has fallen by approximately 60 percent among the Jicarilla Apache of Northern New Mexico — and has been maintained at that level.

Another success story, and a landmark best practice, goes back to the year 2000, when the Phoenix Indian Medical Center, the second-largest Indian Medical Center in the country, responded to patient waiting lists of sometimes up

to six months by performing a data-based analysis of patient needs, services, and flow, and then completely overhauling its behavioral health care delivery system. The Center instituted what it calls the "Open Access Model of Care." What this means is that instead of making appointments and having to wait for weeks and sometimes months to see a mental health professional, a patient can walk in to the behavioral health department between 8 a.m. and 2 p.m. and see a licensed clinician that same day. In the 5 years it has been in operation, there has not been a suicide completion noted among active patients in the service. This is particularly impressive because the Center sees, on average, over 18,000 patients per year. Let me stop here and point out that this is a remarkable achievement for any organized health care anywhere.

Finally, from the largest to the smallest: In Alaska the Behavioral Health Aid program trains community member paraprofessionals to screen and intervene in the smallest villages in the vast territory of Alaska. Specific training in screening, crisis intervention, referral, and consultation techniques are combined with external supervision and culturally specific traditional sensibilities to create behavioral health first responders for communities too small and too isolated to be able to otherwise access behavioral health professionals. The program is in its infancy but shows substantial promise for long-term success and the possibility of replication across Indian Country.

The longer term is also being addressed by the Indian Health Service Director's National Behavioral Health Initiative. As Dr. Grim described in his previous

testimony, this initiative brings together various federal agencies, including SAMHSA, the National Institute of Mental Health of the National Institutes of Health (NIH), IHS, the U.S. Public Health Service Commissioned Corps, American Indian / Alaska Native communities and programs, and other public and private organizations to provide strategic direction and concrete action.

Indian Country has adopted the planned approach of the *Surgeon General's Call to Action to Prevent Suicide* and is taking active steps to implement it. To that end, IHS, NIMH, SAMHSA, the U.S. Public Health Service Commissioned Corps, the Department of the Interior, and other federal agencies are working together with tribal governments and American Indian/Alaska Native communities to collaboratively extend the service and science base to the community level.

Within the past year, it already established surveillance, training, and prevention programming for American Indian/Alaska Native communities nationally, but its major work is only just beginning for long-term, sustainable system change. It will support clinical and community program development in Indian Country, as well as basic and program research. Work has been ongoing for the past two years to develop and implement approaches, as well as bring together representatives from across the United States, Canada, the Americas, and Circumpolar North to continue that work. The first international meeting of the National Behavioral Health Initiative will be held this fall. The charge is to provide strategic leadership and implement ongoing work groups to turn that leadership into concrete action.

The issue of suicide in Indian Country will take years, not months, to address, and just as suicide among American Indian/Alaska Native populations is a multifactorial phenomena, the response must also be multifaceted. We know that effective programs are dependent on clinical, educational, familial, community, interagency, and intergovernmental responsibilities being carried out. I commit my support to you and all those represented here today. I also commit the U.S. Public Health Service Commissioned Corps to continue providing leadership and personnel to support tribes and tribal programs to reduce suicide and suicidal behavior among all our tribal communities.

Led from the top by President Bush and Secretary Leavitt, we are working day and night to address the risks for suicide. The President signed the Garrett Lee Smith Memorial Act in October 2004. The $11 million dollars made available under this Act will help enable states, Indian tribes, colleges, and universities to develop suicide prevention and intervention programs. SAMHSA is administering this grant program, and accepted applications through June 1 for a variety of youth suicide prevention efforts. In addition, the National Strategy for Suicide Prevention is a joint effort of SAMHSA, the Centers for Disease Control and Prevention, NIH, the Health Resources and Services Administration, and IHS.

For those looking for more information on what we are doing at HHS and ways that you can help prevent suicide, I recommend www.mentalhealth.org/suicideprevention

Suicide is the most sobering of all death. We can and must do a better job of preventing it. The positives that result from discussions like this include the fact that by talking about suicide and suicidal behavior, we take it out of the darkness, and remove the mystery. It should always be okay to talk about being depressed or about having suicidal thoughts. Young people should be able to go to parents, teachers, and other caring adults for help with depression and even anger without feeling like they will be labeled "weak" or "bad" or "broken." Adults should be able to talk with friends, family, co-workers, neighbors, and professionals who can help prevent suicidal thoughts from becoming suicidal actions.

Paramedics and emergency room doctors like me are the often-heralded lifesaving heroes. Each of them deserves praise, that is true.\ But so does everyone who has ever held out a hand, given a hug, or spoken words of encouragement when a person considering suicide needs it most.

As the Surgeon General, I want to thank you for all of the lives that you've saved. I was a trauma surgeon in Arizona before coming to Washington to be the Surgeon General. Too often, by the time I saw someone on the gurney who had attempted suicide, it was too late for me to help them.

That is why each of you is so important to this national cause. You don't have to be a trauma doctor to save a life. You can be a counselor, a teacher, an organizer, a loved one, a friend or — indeed — an elected leader.

Thank you for caring and for taking action.

I think we are engaged in a battle for hope. For those young people who see only poverty, social and physical isolation, lack of opportunity, or familial dissolution, hope can be lost and self-destructive behavior can be a consequence. The programs I have described are some methods and means to restore that hope and engage youth and their communities to sustain and nurture it. They are not sufficient, in and of themselves, to significantly change many peoples' living conditions. However, if we can act together, across tribal governments, states, and communities, I believe there is hope that the tide can be turned and hope restored. I commit to work with you and anyone else in and out of government to bring services and resources to this important effort.

I appreciate the opportunity to discuss with you this health crisis in Indian Country. Thank you, and I look forward to our discussion.

QUESTIONS OF DR. CARMONA, SURGEON GENERAL, AND DR. GRIM, DIRECTOR, INDIAN HEALTH SERVICE

Question: What is the status of fiscal year 2005 funding through SAMHSA for two programs authorized under the Garrett Lee Smith Memorial Act?

Answer: The request for applications for the State-sponsored Youth Suicide Prevention and Early Intervention grants and the Campus Suicide Prevention grants have been received and are currently undergoing peer review. SAMESA expects to make awards for these programs by September 30.

Question: In September, 2003, Dr. Grim created a National Suicide Initiative at IHS to provide national leadership on this tragic issue. One of the major areas of this initiative involves research. What is the status and results of this initiative with respect to data collection?

Answer: Surveillance, data collection and data analysis are integral to data based research efforts, but just as importantly they are components to a comprehensive community or public health response to suicide. In support of data collection and analysis, and under the direction of the Indian Health Service Division of Behavioral Health (DBH), the Office of Information Technology (OIT) released a suicide surveillance tool in the Resource and Patient Management System (RPMS) Behavioral Health System (BHS) v3.0. This suicide surveillance tool, a 21–item form, allows behavioral health providers to record suicide events. The suicide reporting form is also available in the graphical user interface to BHS v3.0, Patient Chart, which supports direct provider entry of clinical information. Direct provider entry of clinical information enhances both the accuracy and privacy of clinical data—two very important factors in the collection of suicide data.

It is believed to be the most comprehensive tool and surveillance undertaking for suicide anywhere.

Also, under the direction of the DBH, the Indian Health Performance Evaluation System (IHPES) Program developed a corresponding web-based suicide reporting form. The web-based suicide surveillance tool replicates the functionality and content of the RPMS-based tool. The web-based form allows non-RPMS users to: (1) access the tool via the DBH website; (2) complete documentation and data entry activities for suicide related events; and (3) submit the completed suicide activity to a central data base located at National Programs.

DBH/OIT will release the RPMS suicide reporting form in the IHS Electronic Health Record by the end of fiscal year 2005. Deploying the form in the EHR will allow primary care providers to also record suicide events. This will provide more comprehensive data and facilitate baseline fiscal year 2006 suicide data for American Indian/Alaska Native patients receiving care at IHS direct, tribal and urban facilities Suicide data (including data entered via the RPMS-or web-based reporting tools) will be available via the DBH website. I/T/U behavioral health program managers will be able to view data specific to their Area (rates per 100,000) as well as data from other areas. All data will be in aggregate form and will not contain any patient identifiers. The system will contain three layers of security including: (1) IHS firewall and network security; (2) user id and password protection; and (3) Secure Socket Layer (SSL) security. SSL security is the same security used by financial institutions to allow "on-line" banking activities. There are currently 250 sites using the current BH applications.

Question: What sorts of partnerships have IHS and BIA formed to address the youth suicide issue on reservations? What kind of partnerships do you think would be useful?

Answer: At the national level, IHS Division of Behavioral Health (DBH) representatives are collaborating with the BIA Office of Law Enforcement Services (OLES) representatives to develop a Memorandum of Understanding (MOU) to improve access to health and mental health care for American Indian and Alaska Natives (AI/AN) who are incarcerated in BIA and tribally contracted/compacted adult jails and juvenile detention centers. The intent of the MOU is to promote the establishment of local IHS, BIA and Tribal interagency agreements to coordinate services and establish Indian Country policy regarding screening (e.g., for suicide ideation), intake, assessment, medication management, and other health and mental health procedures (e.g., protocols for actively suicidal inmates) for incarcerated individuals. One issue in AI/AN communities is that tribal or IHS clinics are usually open 8–5, and an individual who is actively suicidal may need to be transported hundreds of miles to a regional hospital. In situations where local secure safe room are not available a suicidal youth may end up being incarcerated in the local adult jail for protection (which is against BIA OLES policy). Better IHS/BIA collaboration should create additional secure space for individuals who are actively suicidal.

IHS Headquarters Office of Clinical and Preventive Services (OCPS) has established a multi-disciplinary School Health Committee, which is obtaining information concerning school health issues in Bureau of Indian Affairs Schools, Tribal Contracted/Compacted schools, and those State public schools whose student population is predominately American Indian. The overall goal is to assist those schools to promote healthy lifestyles for AI/AN students (e.g., reducing risk factors relating to suicide ideation) and to effectively provide an environment that is conducive to learning and encourages students to achieve. In the Billings Area, the IHS, BIA, tribal representatives and the Jason Foundation are collaborating to provide a culturally appropriate suicide prevention curriculum for school administrators and staff to recognize signs and symptoms of suicide and other suicide prevention services. This type of collaboration could be easily duplicated in other parts of Indian country. Another area that IHS and BIA partnerships could be developed is providing suicide prevention e.g., peer mentoring and life skills education in schools including Youth Regional Treatment Centers. Better collaboration at the local level would also lead to improved follow-up care plans and policies for suicidal individuals who have been hospitalized in State, regional, or private hospitals.

Also, some of the IHS Area Offices behavioral health staff are involved in establishing an Area-wide suicide surveillance and prevention system in collaboration with the Bureau of Indian Affairs (BIA) and States.

Question: At the committee's May 2 field hearing in Bismarck, Dr. Grim spoke of his experience at Red Lake High School. He told us that he saw the Red Lake Community drawing strength from not only mental health professionals but also tribal spiritual leaders. Please comment on the role of traditional health care practices in prevention and treatment of suicide and related mental health issues.

Answer: It is the policy of the Indian Health Service [IHS] to facilitate the rights of American Indian and Alaska Native people to their beliefs and health practices as defined by the tribe's or village's traditional culture. The current IHS policy is meant to complement and support previously stated IHS policy for implementing the American Indian Religious Freedom Act of 1978 (Public Law 95–341, as amended). The IHS recognizes the value of traditional beliefs, ceremonies, and practices in the healing of body, mind, and spirit. The IHS encourages a climate of respect and acceptance in which traditional beliefs are honored as a healing and harmonizing force within individual lives, a vital support for purposeful living, and an integral component of the healing process.

According the World Health Organization (WHO), the term "traditional medicine" refers to ways of protecting and restoring health that existed before the arrival of modem medicine. In practice, the term "traditional medicine" refers to a number of components including mental healers and herbal medicines. A majority of native populations depend on traditional medicine for primary health care. The work force represented by practitioners of traditional medicine is a potentially important resource for the delivery of health care and medicinal plants are of great importance to the health of individuals and communities.

The Director's Traditional Medicine Initiative emphasizes the alliance of traditional and western medicine practices between community traditional healers and IHS health care providers. Through this initiative, the agency seeks to foster formal relationships between local service units and traditional healers so that cultural values, beliefs, and traditional healing practices are respected and affirmed by the IHS as an integral component of the healing process.

During 1995, 1996, and 2001, discussion circles were held in Indian Country to seek advice from traditional healers and tribal leaders on how to address traditional medicine. In response to concerns identified in the discussion circles, decisions regarding traditional healers are to be based upon what the local community considers appropriate. The IHS will honor the preferences of local communities in identifying traditional healers and determining how and if they should be incorporated into the medical model. It is the local community's responsibility to approach and orient local health care providers about tribal and/or community culture and traditions.

Question: Please discuss IHS's efforts with SAMHSA to conduct training for tribal communities in suicide prevention and response.

Answer: The IHS and the Center for Mental Health Services (CMHS/SAMESA) Inter-Agency Agreement supports programming and service contracts, technical assistance and related services for suicide cluster response and suicide prevention for American Indian and Alaska Native tribal and urban populations. The Agreement involves two areas: (1) the development of a community suicide prevention "tool kit" website. The tool kit will include culturally appropriate information on suicide prevention, education, screening, intervention, and community mobilization which could be readily available in American Indian and Alaska Native communities via web

and other digitally based media for "off the shelf" use and further development throughout the country. And, (2) The training and deploying of a network of at least 12 behavioral health personnel (Tribal and/or Federal), one from each IHS Area, to serve in the CMHS/IHS national Suicide Prevention Network (NSPN). These individuals will be trained to provide onsite visits to communities in need of suicide prevention and/or intervention assistance. To date, prevention/intervention tools have been developed and a focus group was convened to review the materials at the annual IHS/SAMHSA Behavioral Health Conference in San Diego on June 28, 2005. Feedback from this meeting will aid in the refinement of the tool kit materials. It is the intention of the IHS to implement the toolkit in all their area offices by the end of the summer.

In Albuquerque, NM, on June 13–17, 2005, a 5-day training was held to prepare over 20 participants to deliver onsite assistance to communities in crisis; those that are experiencing suicide clusters or need suicide prevention assistance. The training included: (1) Youth Suicide Prevention Initiative, which is based on the Center for Substance Abuse Prevention's (CSAP) Gathering of Native Americans (GONA) Model Program and also involved concepts of peer mentoring, facilitator training, and team and trust building; (2) Critical Incident Stress Management (CISM), which included concepts of defusing and debriefing; (3) QPR (Question, Persuade, and Refer)—a suicide prevention basic skills train the trainer technique; and (4) presentations on traditional healing ceremonies and resiliency. A second Youth Suicide Prevention Initiative training will be held in Billings, MT, on August 1–3, 2005, and will provide participants an opportunity to engage their facilitation skills in delivering suicide prevention models/processes to approximately 60 youth, with an estimated 8 adolescents attending from Standing Rock and Red Lake communities. IHS is collaborating with BIA at the local level to coordinate this training.

Another suicide prevention effort that IHS and SAMHSA are collaborating on is the development of a Suicide Prevention Scan. The Indian Health Service and First Nations and Inuit Health Branch of Health Canada (FNM/HC) Memorandum Of Understanding (MOU) Suicide Prevention Working Group was developed to address concerns and share solutions regarding the disparity of suicide rates among the indigenous people of North America. It was a direct result of the MOU between the HHS and Health Canada, signed in Geneva, Switzerland, in 2002. The purpose of this MOU is to "share knowledge through an agreed upon annual schedule of work which may include the exchange of information and personnel, the conducting of workshops, conferences, seminars and meetings." The Scan (a comprehensive directory) of promising and best suicide prevention practices, or programs, is currently being developed by One Sky (on behalf of the U.S. and funded by CMHS) in collaboration with FNIHB, Assembly of First Nations (AFN) and the Inuit Tapariit Kanataini (ITK) organizations.

One area that IHS, SAMHSA, and BIA could collaborate on is the incorporation of suicide prevention programs (e.g., life skills education or peer mentoring programs) in schools with high AI/AN populations.

Testimony
Before the Committee on Indian Affairs
United States Senate
June 15, 2005

The Jason Foundation, Inc
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Youth Suicide Among American Indians and Alaska Native Youth

Statement of:

Clark Flatt, President / CEO

Working with:
Bureau of Indian Affairs'
Office of Law Enforcement Services, District V

Statement of The Jason Foundation, Inc.
Hearing on
Youth Suicide Among American Indian Youth

Mr. Chairman and members of the Committee, good morning. I am Clark Flatt, President / CEO of The Jason Foundation and I am proud to be Jason's Dad. Thank you for this opportunity to share with you about The Jason Foundation and specifically our work with the Bureau of Indian Affairs' Office of Law Enforcement Services (BIA-OLES), District V in addressing the tragedy of youth suicide within the Native American and Alaska Native youth.

I have been asked to share with you my personal story, about the program we have begun nationally to address youth suicide, and specifically about our work with the BIA-OLES District V.

On July 16, 1997, my world as a parent changed drastically forever. I lost my youngest son, Jason – age 16, to a terrible *"Silent Epidemic"* in our nation today. This "Silent Epidemic" is the **THIRD** leading cause of death for our youth ages 15-24 in our nation and the **SECOND** leading cause of death for our college-age youth. We lose an estimated (including a percentage for mis-reported suicides) average of **100+** young people **EACH WEEK** in our nation to this "Silent Epidemic" – that is **ONE HUNDRED** families each week – dads, moms, brothers, sisters, grandparents, uncles and aunts – devastated by the loss of a youth to this "Silent Epidemic". This "Silent Epidemic" is youth suicide. To add to the staggering statistics surrounding youth suicide, the NHSDA reported in the year 2000 there were an average of over **2,700** suicide attempts **each day** by young people ages 12-17.

Although the tragic impact of youth suicide on our young people and families is obvious, you will probably not see a telethon to raise money for prevention or an "A" list celebrity making it their cause. We still have many hurdles in the forms of myths, half-truths, and stigma to over come. But as in the case of a national program of awareness and prevention of HIV-AIDS, it can be done effectively by public education.

As a parent, I attended as many PTO/PTA, community seminars, and church programs that I could to help me be a better informed parent on safety for my sons (I have an older son, John, who is a physician currently completing a Pediatric Neurology residency at Vanderbilt Children's Hospital). I learned about the dangers of drugs, alcohol, school violence, homicide, AIDS and sexual diseases, and even a section on bullying – but the **THIRD** most likely cause of death – suicide – was never mentioned let alone discussed about how to identify at-risk behavior / warning signs.

My family and a small group of friends decided that Jason's tragic death to this "Silent Epidemic" would not become just another "Silent Statistic" of youth suicide. A big part of youth suicide's danger is its "Silent" nature of taking a youth from a family / community and it not being talked about or addressed professionally.

In October 1997, we started The Jason Foundation, Inc. (JFI) a non-profit 501 (c)(3) organization with the mission to address this "Silent Epidemic" of youth suicide through education. Our initial program was to educate parents about the National Health problem of youth suicide in a professional manner. This educational seminar not only brought awareness of the problem, but introduced information concerning "warning signs", at-risk behavior, elevated risk-factors, and local resources available to help a parent with a son or daughter who may be struggling with suicidal ideation. However, it soon became obvious from requests by educators, youth workers, and youth themselves that a more comprehensive approach was necessary. JFI developed the "Triangle of Prevention" approach which provided programs for youth (they see the changes in their friends before anyone else), educators / youth workers, and parents. These programs and seminars provide awareness concerning the problem of youth suicide, information concerning "warning signs" / at-risk behavior / elevated risk factors, and local resources for assistance if needed. More information can be found about each program on our website – www.jasonfoundation.com. Today, our programs are in use in forty-eight states and five foreign countries. Our corporate office is in Hendersonville, Tennessee.

I was asked to comment on JFI's organizational structure, JFI's funding philosophy (especially use of non-federal funding), and our current work with the BIA on developing a youth suicide prevention model for Indian Country. I want to begin by commenting briefly on our organizational structure because it is the foundation for our funding success as well as our current project with BIA.

JFI has built (and is building) a support system of national and local affiliations that work together sharing resources and talents for the awareness and prevention of youth suicide. It is this "affiliated network" that has enabled JFI to be successful – collaboration. Due to our National Clinical Affiliation with Psychiatric Solutions, Inc (PSI – Franklin, TN), JFI is quickly growing to provide our clinical based / supported programs nationally. We currently have twenty-six regional / state affiliate offices which provides all of JFI's programs and services to the service area – all of our programs and services are provided at no-cost to the school, church, youth organization, or community in those service areas due in large to our affiliation with PSI. We will have over fifty affiliated offices across the nation by summer 2006 which will enable us to reach even more youth and communities with our programs and services. This does not include our project with BIA which is growing rapidly. We also utilize regional clinical affiliates such as Vanderbilt Psychiatric Hospital, Lakeside Behavioral Health, Frontier Health, and Centennial / Parthenon Pavilion Psychiatric Hospital to support our programs and assist in research and development of programs.

As noted earlier, "Awareness" of the National Health Problem of youth suicide (as declared in 1999 by Surgeon General David Satcher) is the foundation / building block for an effective prevention program. JFI has enlisted three National Awareness Affiliates and a group of "individual" affiliates to help bring such awareness to youth suicide.

- **American Football Coaches Association (AFCA) – Waco, Texas:** Two years ago the AFCA announced a National Affiliation with The Jason Foundation to address the national health problem of youth suicide. This brought over 10,000 high school, college, and NFL coaches to the JFI / AFCA team to take on youth suicide. Today, we utilize over fifty high profile College and NFL coaches as "Ambassadors" for JFI / AFCA efforts in youth suicide awareness and prevention. These Ambassadors help through Public Service Announcements used to educate the public (print, TV, and radio), personal contacts, role models, and in "opening doors" to key individuals / corporations.
- **USA Wrestling (USAW):** USAW works with JFI as a National Awareness Affiliate through their membership and network of over 140,000 members nationwide. USAW is recognized as the governing body for all middle, high school, college, and Olympic wrestling in the nation. JFI and the USAW work closely in building awareness and expanding JFI's programs through its network of schools across the nation.
- **Wal-Mart, Inc.:** Wal-Mart signed as our National Corporate Affiliate in 2004. JFI is working with Wal-Mart to provide resources / educational materials to its 1.6 million associates and their families. We are also working on plans that will utilize Wal-Mart's 4,000+ locations across the nation to help educate and provide JFI materials to the communities they serve.
- **"Individual Affiliates" Group:** We are working with (and expanding) State Attorneys General in our programs. Currently, we have thirty-one AG's working with JFI in their states. Of the members of the Committee on Indian Affairs, we have eight AG's that have committed to working with JFI (New Mexico, Wyoming, Alaska, South Dakota, Idaho, North Carolina, Oklahoma, and Washington). In fact, our Chairperson for our Board of Directors is the Attorney General for the State of Tennessee, General Paul Summers. These AG's are very important in helping introduce JFI to the key people within their states and some have prevention programs in their divisions that work directly with JFI's programs and resources.

JFI believes that collaboration is not only the right thing, but is necessary for success in today's complex society. We are proud of our National Affiliates and all they do to help JFI with our mission. A big part of our success can also be found through our local / regional affiliations (clinical mentioned earlier). Local / regional affiliations such as with crisis intervention centers, Mental Health Associations, NAMI, state American Academy of Pediatrics, and many local mental health organizations have a huge part in the success and implementation of a youth suicide prevention plan.

Funding:

When JFI started, we spoke with many of non-profits about their funding strategies (both successful organizations and those who failed). We found many of those who failed had tied their funding to a few funding sources and that the majority of that funding

many times came from state and/or federal funding which at best can be uncertain due to budget cut backs and changes in priorities by government agencies. Our Board of Directors decided early on not to rely on government funding for the success of our programs, but to raise funds through public and private means.

Our first budget (for only two months in 1997) was $2,700 – all program expense. Our 2005 budget is $9.7 million and we are projecting our 2006 budget in excess of $13 million. Our revenue sources, cash and in-kind support, are 99.9% from corporate support / gifts, grants from private / public foundations, JFI fund-raisers, and individual gifts. We have only one governmental grant, a State grant from Tennessee for $77,500 to help with a special project with the Tennessee Department of Mental Health and Developmental Disabilities.

It is my belief that Corporate America and individuals will invest in an organization that is well run, frugal, and makes accomplishments. Our Administration Expense is less than 5% of our budget – 95% programs.

Our Recent Affiliation with BIA-OLES District V:

The national statistics on youth suicide are staggering. As tragic as those statistics / numbers are to the youth and families of our general population, when we look at the Native American and Alaska Native youth population, we see a rate **2.5 times higher** than the general population (which is staggering within itself). American Indians and Alaska Native youth have the highest suicide rates of all ethnic groups in the United States. Suicide is the **SECOND** (compared to third in general population) leading cause of death for youth in the Indian Nation. In Alaska, where the majority of tribes are located and Alaska Natives make up a significant part of the population, a 2001 Department of Health report showed suicide as the **#1** leading cause of death for ages 10-64. The report also reported that in Alaska, suicide attempts were the **SECOND** leading cause for non-fatal hospitalization for ages 10-14 (in front of sport, bicycle, and traffic accidents) and suicide attempts were **FIRST** for hospitalizations for ages 14-34.

In a recent study on American Indian youth living on a reservation or in a nearby associated town, it was found that 30% had serious thoughts about suicide – this compared to a national general population rate of 16.9%. As youth suicide has been portrayed as a "Silent Epidemic" in the youth general population – It is double its impact on American Native and Alaska Native youth.

Following a presentation about youth suicide that I presented in Los Angeles, I was approached by John Olivera, National Child Abuse Coordinator – BIA, about working together to develop a suicide prevention model for Indian Country. It seemed a good fit because of our successful collaborations with State Attorney Generals whose main purpose, like that of the BIA, is the protection of citizens within their areas. After some discussion and "brainstorming sessions" JFI and BIA-OLES District V signed an agreement to develop such a youth suicide prevention model first for District V and then to be shared with any BIA region wishing to participate.

In preparation, the first segment was to collect information both by the BIA and JFI about the problem of youth suicide from the communities it impacts. I visited the Crow

reservation in Billings, Montana. During my visit, I spoke with tribal leaders, youth workers, and Native American youth themselves. I was also able to visit with the local

IHS department. This visit truly opened my eyes beyond "printed statistics" concerning the problem of youth suicide in the Indian Nation and the challenges of resources.

We are proceeding to collect such "grass-roots" information by talking and visiting with local tribes. We will then begin to take JFI programs for schools, staff training Seminars, and parent training Seminars and make them more ethnic responsive for Native Americans and Alaska Native populations while maintaining the clinical based approached.

Before these programs to help identify at-risk youth can be put fully into place, we must address another challenge. I believe developing a program to identify at-risk youth is not a problem. We can do that now. The major challenge for Indian Country is what can be done for the young person once they are identified at-risk for suicide. The challenge is providing professional resources to help in treatment and counseling of these at-risk youth. There is no purpose and in fact may even be detrimental to identify someone who needs help if you cannot help them.

In my brief exposure to Indian Country and health services, IHS has done a noble job in mental health services with the resources provided. But limited resources and a seemingly almost unlimited geographical area to cover – the Crow Reservation I visited was over 2.5 million acres – makes mental health service delivery almost impossible. I was told by a local official that many times if a youth went to counseling at the local IHS facility, it would take almost two hours travel time one-way and including the session would account for six hours or more a day which most of the time was not possible for the family.

JFI and BIA-OLES District V are exploring two options to address the challenge of delivery of professional mental health services to Indian Country. We hope to collaborate with IHS also on this project and Dr. Perez of the IHS has indicated a desire to talk about such collaboration.

Option I: Utilizing a concept that is growing rapidly for rural American delivery of medical services (especially cardiac services) – TeleMedicine. We believe we can build a TeleCounseling Network that will provide professional mental health care to rural areas, especially reservations. It would involve trained local therapist working with a Psychiatrist via web conferencing (patient could be involved directly at times). JFI is currently using this technology to deliver our Staff Training Programs to rural areas and have found it very successful. It enables JFI to maintain quality of programs and the technology provides the service at a cost that is economically smart. This TeleCounseling Center could provide professional mental health services to even the most remote area as long a high speed internet capabilities exist. (We found recently that a remote island in Alaska that has a very high youth suicide rate and is only accessible by plane, had high speed internet due to its satellite connection to the states. I believe we will find this the case in many areas).

Option II: (excluding many areas of Alaska because of terrain issues) We propose having a mobile counseling center – a customized RV – that would on a regular basis

provide counseling services to areas of a reservation. It would be staffed by 1-3 therapists. Our initial plans would be dividing a reservation into four divisions and having the Mobile Counseling Center in each division one day each week for four days. The fifth day, it would be at the local IHS clinical center for updating with the local Psychiatrist and determining referrals as necessary. This would provide mental health services closer to the communities and would be cost effective in the delivery of these services.

This is not as optimal as building a clinic in each division of a reservation, but would be much better than current service availability for remote areas. It would provide initial professional counseling for youth identified as at-risk for suicidal ideation as well as for other mental / emotional issues and could be effective immediately.

We are working on the programs and options of delivery of services and would welcome the help of the Senate Committee on Indian Affairs and IHS / SAMHSA to join in this effort.

In summary:

1. We are working with BIA and all interested parties to develop programs and seminars for youth suicide awareness and prevention for Indian Country. These programs will focus on school-based curriculum, youth seminars, staff training seminars, and parent training seminars.
2. We are exploring two options on solving the problem of delivery of professional mental health counseling services especially to the remote reservations. The options include TeleCounseling utilizing web conferencing technology to provide professional counseling consultation for local therapist and developing a Mobile Counseling Center that would take therapists on a regular basis to areas of reservations. Both of these options will deliver quality professional mental health care and treatment. Clinical backup and provision of services are critical to a successful youth suicide prevention program

Recommendations:

I was asked to comment on if I were on the Senate Committee hearing today, want recommendations I would like to see put forward:

1. I would also like to ask your help in making the availability of government grants more streamlined and easier to apply for funding. Many good local and regional organizations that provide the lion's share of services in many cases cannot make their way through the maze of paperwork that is required and therefore we see the funding funneling to the same organizations who have built a professional grant department. If we are to be successful in addressing youth suicide in the nation and in Indian Country, it will be because of such "grass-root" organizations that are trusted and part of the communities they serve. Funding needs to be more readily attainable and a higher percent actually making it to the populations it was intended to reach and help.
2. To encourage the IHS and BIA to work collaboratively on the issue of youth suicide awareness and prevention in the Indian Nation. Each organization brings with it a unique resource in successfully addressing this tragedy of youth suicide. The IHS is instrumental in the delivery of mental health services. Their current network of hospitals and clinics need to be a major part of the answer for professional counseling assistance for at-risk youth. However, many times they are not brought in a case until a suicide attempt has been made…and this may be

too late for many. The BIA is directly involved in the daily life of the communities they serve. They have a unique opportunity to help identify at-risk youth before a suicide attempt is made because of this community involvement and/or since they investigate all suicide attempts – can be a tremendous referral resource for at-risk youth.

3. This "collaboration" of BIA and IHS partner with developed public / private organizations that provide programs on youth suicide awareness and prevention to "ethnically customize" the programs for Native American and Alaska Native youth, educators / youth worker, and parents. Funds do not need to be spent "re-inventing the wheel" of prevention programs, but in customizing them to meet the ethnic needs of Indian Country.
   JFI hopes to explore through our relationship with BIA copying our National Clinical Affiliation manner of Affiliate Offices to deliver programs with IHS. This would place a functional JFI Affiliate Office for programs with each hospital / clinic serving reservations across the nation. This would tie in directly with mental health services provided by IHS.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to share with you and the committee about my son, The Jason Foundation and our mission, and our work with BIA in addressing youth suicide in Native American and Alaska Native youth. I will be happy to answer any question you may have.

Sincerely,
Clark Flatt
President / CEO
The Jason Foundation
www.jasonfoundation.com

The Jason Foundation

Ambassadors

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Bill Curry	ESPN
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Ken Sparks	Carson-Newman University
Lloyd Carr	University of Michigan
Tommy Tuberville	Auburn University
Bobby Johnson	Vanderbilt University
Houston Nutt	University of Arkansas
Rich Brooks	University of Kentucky
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Sylvester Croom	Mississippi State University
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Ed Orgeron	University of Mississippi
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Ken Hatfield	Rice University
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Rob Ash	Drake University
Bob Stoops	University of Oklahoma
Ron Zook	University of Illinois
Mark Richt	University of Georgia
David Cutcliffe	Notre Dame University
Tyronne Willingham	University of Washington
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Guy Morris	Baylor University
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Dennis Franchione	Texas A&M
Mack Brown	University of Texas
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Les Miles –	LSU
Urban Myer –	Florida
Steve Spurrier –	South Carolina
Mike Gundy-	Oklahoma State University
Dave Wannstedt	University of Pittsburg
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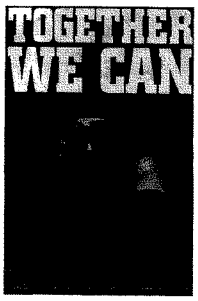
Nick Saban	Miami Dolphins



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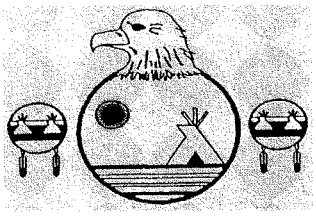

TESTIMONY OF

JULIE GARREAU

EXECUTIVE DIRECTOR,
Cheyenne River Youth Project
THE MAIN YOUTH CENTER

SUBMITTED TO THE
UNITED STATES SENATE INDIAN AFFAIRS COMMITTEE
HEARING ON YOUTH SUICIDE PREVENTION

WASHINGTON, DC
JUNE 15, 2005

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Chairman McCain, Vice-Chairman Dorgan, and members of the Committee I want to thank you for holding these series of hearings on youth suicide prevention in Indian Country. I know our Native Communities in North Dakota appreciated the opportunity to speak with you last month, and we certainly appreciate the opportunity today. Senator Johnson, I would like to share our gratitude to you for your hard work in support of the Main and Teen Center project in Eagle Butte.

My name is Julie Garreau, Executive Director of the Cheyenne River Youth Project. We are a local, grassroots, non-governmental organization, which provides after school activities for young children on the Cheyenne River Reservation, and are in the process of building the only after-school center for teens.

We are heart broken that it may have taken an incident like the school shootings at the Red Lake Reservation in Minnesota to bring national attention to the crisis our children are facing in Indian Country, but are so relieved that someone is finally hearing our voices. Much criticism circulated after the shootings, focused on how people could have missed the "warning signs." We are here today begging that you too do not miss these "warning signs"... our children in Indian Country are in crisis.

THE NATIONAL SUICIDE PROBLEM

Suicide Rate Two to Three Times Higher Than National Average

You have already heard the national statistics; Native youth are 2-3 times more likely than other youths to commit suicide. And in our region of the Northern Plains they are often 5-7 times more likely.

Recent suicide clusters in Standing Rock, Crow Creek and unfortunately Cheyenne River clearly exemplify this trend. Statistics, however, can only tell so much, I would like to share the story of Cheyenne River to help you understand the depth of the heartache our community faces.

SUICIDES ON CHEYENNE RIVER

Suicide Clusters and Pacts

Cheyenne River has seen a heart-wrenching spate of suicides. With class sizes averaging approximately 70, we have lost seventeen teens to suicide. Some of these suicides were young men who had made a suicide pact with one another. They drew numbers, and decided to hang themselves in that order. One by one their families found these boys, often hanging in their homes, as their "number" came up.

In 2001-2002, Law enforcement reported 8 suicides, 48 suicide attempts, 28 suicide threats. In 2002-2003 there were 3 suicide completions, 152 suicide attempts, and 72 suicide threats. In 2003-2004 that trend continued.

Average of 3-7 Attempts Per Week.

Every month, every week, we continue to struggle. It is not just the well-publicized suicide clusters we are struggling with; it is the three to seven suicide attempts we see every week.

And it is not just youth under eighteen that we are losing. The numbers of young people between eighteen and twenty-five, and other adults who suffer from suicide ideation, engage in suicide attempts, and complete, are alarming. Last year alone, not including drug overdoses, the Indian Health Service hospital treated twenty people for suicide attempts resulting in injury requiring emergency medical treatment. This is in a population of approximately 10,000 people.

The Cheyenne River Sioux Tribe Restoring the Balance Project, which was funded by the Department of Health and Human Services Substance Abuse and Mental Health Services Agency, carefully looked at this problem and the scope of mental health service needs for our youth ages birth to twenty-five years of age. The Project concluded after three years of looking at this problem in 1999. Between 1998 and 1999, of all the young people seen by Tribal mental health services, between nineteen (19%) and thirty-nine (39%) per cent were seen for suicide ideation, suicide gestures, or suicide attempts. This is an incredibly high percentage.

The Project also asked youth, adults and service providers what the causes of mental health problems were. Thirty-seven per cent (37%) of youth and twenty-six percent (26%) of adults felt the biggest problem was substance abuse; twenty-seven per cent (27%) of youth and twenty percent (20%) of adults felt that gang activity and violence was the biggest problem; fifteen percent (15%) of youth felt that lack of youth activities was the biggest problem; and fifteen per cent (15%) of youth and sixteen per cent (16%) of adults felt that negative youth behavior was the biggest problem.

SOLUTIONS ON CHEYENNE RIVER

Unfortunately there is no one magic answer to fix what decades of neglect and hopelessness have caused. But our community is strong and resilient, and we are working hard to address these issues together.

The Restoring the Balance Project asked youth and adults what was needed to solve the problems with youth mental health. Youth felt that increased adult involvement with youth (23% of youth), additional counselors and counseling services (16% of youth), employment (12% of youth) and increased access to recreational activities (12% of youth), were needed to improve youth mental health. Thirty-two percent (32%) of adults felt a recreation center was the most important need to address youth problems, twenty-five percent (25%) felt additional counseling services were most important, and twenty per cent (20%) felt that improved substance abuse counseling and awareness was the most important need to address youth problems.

Many of our solutions on Cheyenne River have not been governmental in nature, but homegrown grass-roots efforts. Our communities know many of the actions that need to be taken, but often do not have the resources to maintain the programs.

Service providers, youth and adults all see a need for basic program funding for mental health services, increased recreational and employment opportunities, and programs that increase adult interaction with youth as key to stopping this continuing crisis. With only one full time licensed counselor for the entire population, the Detention Center unfortunately functions as the gateway to mental health services. Any efforts at intervention with youth at risk must include and work with youth who have had contact with the Detention Center. Even more critical is prevention. Prevention starts with improved positive outlets for youth including recreational opportunities and opportunities for youth to interact with positive adult role models. It is much more difficult to handle depression and suicide ideation after the fact. If we can create a

positive outlook for our youth, and programs that have daily contact with our young people, we will be much better prepared to stop this cycle of loss.

The funding that Congress has provided to our local programs in supporting our self-determination, including our new Teen Center, have been invaluable and for that we offer our sincere gratitude. I strongly encourage continued congressional support for access to youth program funds for Tribes, including Youth build funds from HUD and Department of Justice funding for youth programs, and improved basic funding for mental health programming through the Department of Health and Human Services and Indian Health Service.

The Teen Center

In response to our last spate of suicides we went to the students in our community, we asked them what could be done. The students asked us for a Teen Center. With no mall, no movie theatre, no bowling alley, few jobs and very long winters, there are very few healthy outlets for our teens.

The students asked for a place where they could study, have access to the internet (a rare luxury in our community), take Lakota language and arts classes, and receive counseling. The new Teen Center will have basketball courts, a library, an internet café, and counseling offices.

By getting our teenagers "in the door" with attractions like the basketball court and internet café, we then have them as an audience for other health and wellness activities. We plan to work with other tribal resources to offer help in all wellness areas like the juvenile diabetes program, STD awareness, immunizations, counseling, and to reinitiate our suicide hotline.

Together as a community we have been working hard to raise the funds to provide this safe haven for our teens. I am proud to say that we have finally broken ground on the Teen Center and hope to see it operational by Spring 2006.

A Teen Center is not the only answer, nor is it the solution for every community. There are so many other needs, drug & alcohol counseling, better foster care and juvenile justice systems, and more mental health counselors. Nevertheless, our teenagers are excited about this new center; we have seen it in their faces, and heard it in their voices. Even before it is built, it is giving them what they really need most: hope.

APPENDIX TO ORAL TESTIMONY

BACKGROUND: HISTORY OF "THE MAIN"

Daily life on the reservation can be hard on our youth. We see it in families so ravaged by alcoholism that what money is available is "drunk up" rather than spent on food. We know young children whose "dirty necks" are really symptoms of acanthosis nigricans (an indicator of insulin resistance and type II diabetes). We witness older youth taking over the parenting of their younger siblings. As you know, opportunities are often limited in rural communities, and no one feels it more than teenagers. On the Cheyenne River Sioux Indian Reservation, geographic isolation, a lack of infrastructure and grinding poverty are taking such a toll on our youth that too many have seen suicide as the only option.

The Cheyenne River Youth Project was created to improve the quality of life for Cheyenne River children by offering a safe, alcohol- and drug-free environment. We want our children to be healthy in mind, body and spirit. This philosophy is incorporated in all of our programs, from teaching children how to grow and eat healthy vegetables through our organic gardening program to offering them ample fitness opportunities through our basketball and dance camps, mid-night basketball and outdoor recreation activities. A variety of local resources come in to the Main to teach our kids, whether it is the South Dakota Extension Office's summer classes on safety, good nutrition and hygiene or local elders demonstrating how to harvest and prepare traditional foods.

The Cheyenne River Youth Project: A Record of Success

The Cheyenne River Youth Project began in January 1988 in Eagle Butte, SD after a group of local residents and the Cheyenne River Sioux Tribe decided to turn one of Eagle Butte's most notorious bars into a safe, alcohol- and drug-free environment for our community's children. Open seven days a week and run by a completely volunteer staff, the youth center, called "the Main," thrived and quickly became an essential part of the Cheyenne River community.

Unfortunately, that retrofitted bar soon showed its weaknesses after the blizzard of 1996. Severe cold and water damage buckled cement floors, caused electrical shortages and rendered several doors and windows non-functional. The following year, the Cheyenne River Youth Project and the national nonprofit organization Running Strong for American Indian Youth® partnered to build a new youth center.

The brand new "Main" opened in May 1999, following a successful capital campaign and contributions from several local, state and national foundations. The Main's 4,224 sq. ft. facility includes a recreation room, family room, library, kitchen, staff offices and volunteer quarters. Kids who go to the Main receive healthy meals and snacks; participate in "Main University," which encourages them to think about college by teaching topics like biology, writing, history and culture; have homework help; go camping and participate in other recreational activities; and learn how to grow (and eat!) fresh fruit and vegetables from the center's two acre children's garden. An average of 280-310 different children, ages 5-12, now pass through its doors each month.

Cheyenne River Teenagers: Underserved, and Slipping Through the Cracks

Despite these accomplishments, for some time we have been thinking about Cheyenne River's teenagers – many of who are alumni of our children's services – and how to keep them involved after they outgrew our programs. The connection is still there for many of our alumni but our resources for teenagers are limited.

We have made two forays into helping teenagers already, with great success. Our midnight basketball program, runs for twelve weeks each summer for youth ages 13-18, and has an average of 119 youth participating. Our Chief of Police wrote a letter of support stating officers on the night shift noticed a decline in juvenile delinquency since the program was implemented. Last year, we began hosting a "Passion for Fashion" sleepover for over 20 young women, ages 15 and over, where we provided makeup, hair tips, shoes and dresses for the Prom.

But these programs, it is clear, barely scratch the surface of the need for structure and opportunities for Cheyenne River teens. There is no teen youth center, or for that matter, movie theater or bowling alley, on the reservation. Our teenagers need somewhere to go now more than ever, as has been made clear in recent months.

Cheyenne River: New Teen Center

With the completion of our new youth center for teenagers, these programs will be able to grow and expand, building on the foundation of healthy behaviors taught to our younger children. By getting our teenagers "in the door" with attractions like the basketball court and internet café, we have them as an audience for other health and wellness activities, all in a space where Cheyenne River teens feel comfortable. We plan to work with other tribal resources like the juvenile diabetes program, offering our space for their educational efforts. The nonprofit Volunteers of America already has a STD Awareness Educator working out of our current building; we plan to coordinate similar services once we have the space. The possibilities are endless from our offering immunizations to offering counseling by a local licensed clinical social worker.

And finally, building on that community trust, we plan to reinstitute a suicide prevention hotline. The Cheyenne River community had hosted a suicide prevention hotline for seven years until 2000, when the availability of volunteers, funding and phone lines dwindled. The shock of last year's spate of teen suicides is an unmistakable reminder of our community's need to offer this service.

Revised

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

TESTIMONY

Presented by

JOSEPH B. STONE, PH.D.

PROGRAM MANAGER AND CLINICAL SUPERVISOR

CONFEDERATED TRIBES OF THE GRANDE RONDE BEHAVIORAL HEALTH PROGRAM

GRANDE RONDE, OREGON

On behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Before the

SENATE COMMITTEE ON INDIAN AFFAIRS

On

YOUTH SUICIDE PREVENTION

JUNE 15, 2005

Thank you, Mr. Chairman, Ranking member Dorgan, and members of the Committee for the opportunity to address this hearing today on the tragedy of suicide among American Indian and Alaska Native (AI/AN) youth. I am Joseph B. Stone, an enrolled member of the Blackfeet Nation of Northern Montana and a descendent of the Turtle Mountain Chippewa of North Dakota and Lakota of South Dakota. I am an honorably discharged veteran of the U.S. Navy. My professional credentials include being a licensed psychologist in Oregon and Washington, and an internationally and state-certified addiction counselor and alcohol and drug counselor in Arizona and Oregon, respectively. Currently, I am the Confederated Tribes of Grand Ronde Behavioral Health Program Manager and Clinical Supervisor. On behalf of the Tribal members of the Confederated Tribes of Grand Ronde, the Tribal Council sends their greetings to this committee and thanks the committee for the attention and provision of resources they have given to the issue of native youth suicide prevention. The Members and Tribal Council of the Confederated Tribes of Grand Ronde are committed to the health and well being of their youth and other native youth and to the prevention of native youth suicide and we encourage the work of this Senate committee in addressing this difficult and tremendously important tribal health issue. It is my pleasure to represent the American Psychological Association (APA), of which I have been a member since 1998. The APA represents 150,000 members and affiliates, and works to advance psychology as a science, a profession, and as a means of promoting health and human welfare.

In order to address the issue of youth suicide prevention, I would like to first draw the Committee's attention to some statistics about native youth and suicide:

Economic issues and lack of opportunity: Tribal families live in a crucible of economic oppression and lack of opportunity. The two poorest counties in the country are Shannon County in South Dakota (Oglala Lakota) and Glacier County in Montana (Blackfeet Nation), with most of the tribal residents of these counties living at or below the poverty level. Nationwide, 26 percent of the native population lives in poverty (including 38% of native children) versus 13% of all racial groups (including 18% of the children of all races), and only 8 percent of white Americans. Only 66 percent of native people are high school graduates. AI/AN are twice as likely to be unemployed than whites.

Health care benefits and access: When they are employed, native people typically take low paying work and often do not qualify for or receive benefits. In the general U.S. population, 15 percent of people have no health insurance. Among native people, 24 percent have no health insurance. In 2003, Medicaid was the primary insurance for 25 percent of native people. Only 50 percent of tribal people had employer-based insurance versus 72 percent of whites. Because over 50 percent of tribal people live in off-reservation settings, the majority of Indian Health Service (IHS) facilities, which are typically located in rural and frontier reservation facilities, are unavailable to them. Funding for urban health care for tribal people is capricious and unreliable.

Behavioral health care issues: Tribal people in the U.S. are the most likely subgroup to be victims of a violent crime -- 124 out of 1000 (two and one half times the prevalence for all other races). Seventy percent of this violent crime against tribal

Americans is by members of other races (perpetrators are 60% white and 10% black). The rate of alcoholism among American Indians ranges between 500% and 625% that of all other races; on average, between 20 and 25 of every 100 native people meet the criteria for alcohol dependence versus 4 out of 100 in the general population. Related to the alcohol statistic, the accidental death rate for native people is 212%, or more than double the accidental death rate for all other races.

In many tribal settings, the rates of posttraumatic stress are much higher for native people (22%) than the general population (8%). Some recent dissertation studies have defined this as much higher for some specific tribes, such as the Klamath of Oregon (posttraumatic stress disorder being 10 times that for the general population). Lifetime prevalence of posttraumatic stress for AI/AN (45 – 57%) is much greater than that of all other races. Large-scale epidemiological studies of other behavioral disorder rates in the tribal communities have not been completed.

Behavioral health issues for tribal youth: Tribal youth are raised in native families and communities subjected to ongoing cultural oppression, health disparities and lack of equal access to services, lack of economic opportunity and chronic poverty. Parents in these families often experience substance abuse and mental health problems secondary to this sociological asymmetry. For tribal families, these factors translate to double the number of native youth reporting using marijuana, cocaine, tobacco, and alcohol in past month prevalence data than youth of other races. By age 12, lifetime prevalence rates for use of almost all substances are higher for tribal youth than for any other racial group. Nearly one in five native youth are involved in substance abuse to a level that is a threat to themselves or their community. The alcoholism death rate for

tribal youth aged 15 to 24 years is over 17 times the rate for all other races. One study indicated that at least 75 percent of native youth with a substance abuse disorder had a co-occurring mental health disorder, usually conduct disorder, depression and anxiety, along with trauma-related symptoms, self-esteem, alienation issues, and suicidal behavior.

Death, homicide, suicide, and youth suicide in the tribal community: The accidental death rate for tribal children aged 5 to 14 is double the U.S. rate. Thirteen percent of tribal deaths occur to natives under the age of 15 versus 4 percent in the general population. Violent death (by accidental injuries, homicide, and suicide) accounts for 75% of deaths in tribal people in their second decade of life. The prevalence rate for native suicide is 1.5 times the national average. The suicide rate for native youth aged 15 to 24 is 2.4 times that of the general population; native males aged 15 to 24 account for two-thirds of all native suicides.

I've provided some statistics, which show us the crisis facing AI/AN, but allow me to make these numbers come alive by elaborating briefly on my all too frequent personal and professional experiences with native suicide by providing some case studies.

Case Studies

At this point, I would like to describe a week in which suicide and suicidal behavior deeply affected the tribal community for which I was working as a psychologist at the time.

First Case Study - On Sunday night, a despondent 21-year-old male tribal member killed himself. Friends and relatives reported that although he had suicidal

ideation, a severely depressed mood, anxiety over fiscal issues, ongoing substance abuse, and a history of suicide attempts, this young man had never presented himself for help at my office, the community mental health center, or the tribal medical clinic. He had not sought clinical services at the community mental health center, because he did not believe they possessed adequate cultural sensitivity. I was the only person he would have seen, and he was too ashamed to contact me. Unfortunately, I was so overwhelmed with clients that I had no time for outreach activities to reduce the stigma of seeking tribal mental health services. That week and on average, I had over 40 active clients, and I worked with between 20 and 25 clients a week. There was an average waiting list of more than 20 persons.

The suicidal act is symbolic of this young native man's current situation. He recently learned to scuba dive professionally and hoped to dive for harvesting sea cucumbers and other delicacies. However, he was in deep financial trouble; he had never graduated from high school and had never held a decent job. On this Sunday evening, he was using methamphetamine and drinking with friends. When they stopped their car by a bridge in the community, he got out and walked to the bridge rail, mounted it like a professional diver, turned around and flipped over backwards as though he were entering the water in scuba gear from the transom of a boat. He fell eight stories to his death. Afterward, we tried to determine if this was actually a planned suicide or an incident of substance-induced misjudgment. No matter what his original intent, his action resulted in suicide. The entire tribal community went into shock. Tribal enterprises and businesses were shut down for grieving. Although mental heath professionals spent extra time asking patients about suicidal ideation, and educators began talking to children about the

issue of self-harm (with children as young as four and five counseled), the outreach to the family and community was not sufficient.

Second Case Study - By Wednesday of that week, a second teenage native male died from a self-inflicted hanging. This young man, a family relative of the first suicide victim, lived hundreds of miles away in Canada. According to his relatives, he had been despondent, anxious over finances and romances, and had a depressed mood. When he found out about the first suicide in our community, he reported to family members that the first young man was fortunate because he had found a way "out of his pain."

Culturally appropriate clinical services for this young man were not available, and there was no professional outreach. The family had not sought mental health intervention despite the young man's report that he might also end his pain through self-harm. The psychological effects of this second suicide reverberated in the community, with expressions of fear and concern. Which young tribal member would be next? The community felt powerless.

Third Case Study - That Saturday, a week and a day after the first suicide, a pregnant native 17-year-old female, and a friend of the first native suicide victim, attempted to kill herself by consuming a massive dose of Tylenol and other pills. This attempt followed serious alcohol binging by the girl and her friends. They reported that once she became inebriated, she said, "He was the lucky one." She did not succeed in killing herself. Yet, she did destroy most of her liver and required transfer from the local hospital to a Seattle Medical facility, where she received care for over a month. She lost her child. Her liver remains severely compromised, and it is likely that she will require a liver transplant by age 30.

Aftermath to suicides in a vulnerable population - During this week, several of my regular mental health clients reported greater then average thoughts about suicide and less fear in attempting it. In addition, I was receiving increased phone calls about the issue and concerns not only from tribal members, but also from tribal police. Other tribal health providers were also expressing concern. Professionals began expressing doubts about their capacities and concern they might lose control of the situation. I called the University of Washington School of Nursing for assistance and contacted Dr. June C. Strickland, a Cherokee and an expert in suicide and its assessment. Together we worked with tribal health professionals and tribal police to plan and present workshops scheduled for Friday. One workshop was conducted for children and youth, and a second workshop was for family members and tribal members. Workshops were also held for mental health and medical professionals who feared that more suicides were going to occur, and they felt powerless to intervene.

Acting out and suicidal ideation in tribal youth- One of my clients was a young tribal male, aged 12, who lived with his grandmother and dealing with his mother's alcohol abuse, feelings of abandonment and cultural oppression. He was diagnosed with posttraumatic stress, depression, attention deficit disorder, and intermittent explosive disorder.

When local police officers came to his grade school, they stated that they or the school counselors could provide help for parents' alcohol or drug abuse. This young man was desperate for help. He hoped that by contacting the school counselors, they would work together with the police to arrange substance abuse treatment for his mother. Instead, they used the information as the basis for removing him from his mother's care.

She was prosecuted and put in prison for 18 months. He lost contact with his mother over this period and lost all trust in authority figures. He went to live with his disabled grandmother, who was living in a two-room apartment on $580.00 a month. This boy was not performing well in school and exhibited significant behavioral problems. On Thursday, he hit a teacher, trashed a room, overturned desks and threw materials everywhere. When brought to my office, he reported that he hated everyone and that he wanted to kill himself. When I asked how he would do this, his reply was "Jump off a bridge!"

I was not able to have county workers hospitalize him, due to prohibitive costs associated with hospitalization, their sense that he would not talk to them, and their belief that I was over-reacting. During the past year, three tribal clients in this western state killed themselves after having reported suicidal intent to tribal health providers but county workers denied them residential care as a cost containment measure. As a tribal mental health professional, I did not have the authority to commit this boy to a hospital. I was powerless, and so I arranged for his grandmother to call me hourly until the crisis passed. This was the best I could offer them.

On Thursday night, a 17 year-old male tribal member, with whom I had been working on issues of depression, substance abuse, and being a teen parent with limited resources was arrested (for methamphetamine) and placed in juvenile detention. He reported suicidal intent and was placed in a safe room, with rubberized walls and a television monitoring system. He attempted to injure himself by running head first into the wall as hard as he could in order to "break his neck." No assessment or intervention by the county was provided. That night, the specialist from the University of Washington

came, and we planned two community workshops. The next day, we provided community suicide prevention workshops – one for adults (both tribal members and tribal professional staff) dealing with emotional trauma who felt a sense of helplessness and powerlessness. We also provided a large workshop for the children and adolescents. This workshop was open to older tribal members, many of whom observed quietly.

The following Monday, one week and two days after the first suicide, I was driving home after work and noticed a large crowd of tribal members and police in front of a huge tree at the corner of the road. Forty feet up that tree was a 9-year-old tribal member I had been seeing in therapy for about a year. This boy's mother had been a victim of sexual and physical abuse and had a volatile relationship with her partner, who was a chronic alcoholic and was often arrested for domestic violence. He lived with his 16-year-old sister, who had chronic depression, and with two brothers ages eight and ten. This boy was diagnosed with bipolar disorder, attention deficit disorder, and posttraumatic stress disorder. This 9-year-old boy was threatening to jump from the tree. Despite the fact that neither the officer on duty nor I were trained to talk to persons threatening to jump, we first climbed onto the lower branches so as to be available to break a fall if it occurred. Fortunately, we were able to talk him into coming down from the tree. The county refused to hospitalize him and, again, we provided the family with the option of hourly calls to me and frequent drive bys by the police officer on duty. I increased our sessions together and began seeing him bi-weekly for the next six months.

Other personal and professional experiences with suicide - As a tribal person who was raised on a reservation, I was exposed, early and frequently, to violent death and suicide. It has been a common occurrence in my home community, amongst my tribe,

and in each native mental health and substance abuse setting in which I have trained or worked in over the past 15 years. In 1978, my youngest brother, Mike Desjarlais, killed himself at the age of 18 with a self-inflicted gunshot to the head, following issues with drug abuse. That same year, a 19-year-old male tribal member and family friend whose sister I once dated in high school, hung himself in the jail in Cut Bank, Montana, following his arrest on alcohol-related charges. Later, in 1980, when I was in the Navy, my younger brother Kevin sent me word that one of my 20-year-old cousins, whom we all called Conan because of his physique and athleticism, had hung himself following a bout of drinking. Recently, the 17-year-old son of a licensed native mental health professional with whom I was working killed himself with a gunshot to the head. The lack of available residential treatment services for substance abuse prevented us from referring this young man to the appropriate level of care.

My staff and I all have clients on our caseloads who report a higher than average baseline propensity for suicide. This is regarded as the leading source of worker stress in the mental health provider field. It is a common addition to the otherwise extremely complicated caseloads we all maintain and likely would not be an acceptable level of risk for a private practitioner or in most agencies. These individuals would be moved on – one way or another. However, we must aid these individuals because they have nowhere else to go. This contributes to worker burnout.

There is a lack of qualified native professionals and informal de facto cost containment at native client's risk - During my third year of graduate school, I had been providing individual counseling to an adult female native woman at the Indian Alcohol and Recovery House Program in Salt Lake City. I was concerned when I left the area for

another training placement that she could not find another native mental health provider in the community to work on her issues. Feeling isolated and helpless, she committed suicide.

Native youth suicide issues are one of the most frequently voiced concerns when I am asked to consult with other community program treating native clients. Often, these conversations hinge on whether or not I have access to fiscal resources to pay for more intense treatment. I have found that both county and state agencies are often reluctant to hospitalize mentally ill native clients and / or suicidal native clients whenever it is apparent that the costs must be born by the county or state. However, this reluctance is never openly acknowledged as a cost containment measure and always takes the form of "diagnostic disagreements" with my and other native professional's clinical judgment and recommendations regarding the suicidal native client's need for residential treatment. In some of these cases, native suicide has occurred.

Clearly, steps to ameliorate suicide in the tribal communities are required and the American Psychological Association and I propose the following recommendations to the committee.

Recommendations

Suicide Prevention Initiatives

- Designate suicide prevention as the top preventative focus for the IHS.
- Dedicate funding to support urban AI mental health and suicide prevention programs.

- Establish a national center for excellence for suicide prevention in native and tribal communities, which is operated and managed by AI/AN experts and professionals.
- Develop school-based mental health services to promote a positive school environment and help prevent youth suicide:
    - Mental health professionals would identify children with mental health problems early on (with the support of trained school personnel) and provide needed treatment that is culturally appropriate for AI/AN children and their families.

Collaboration and Access

- Professional tribal mental health providers should be able to make direct referrals to residential treatment centers.
- Increase the collaboration between county and state system gatekeepers and tribal mental health providers to ensure adequate access to suicidal AI/AN clients.
- The exclusion of AI/AN clients must be formally examined, and appropriate changes should be made in policies, which have excluded tribal youth from access to residential treatment centers.

Education and Workforce

- Increase the number of qualified native mental health professionals in the field to a number proportionate to that in the general population:
    - Funding for Indians into Psychology (INPSYC) Programs should be doubled with at least two additional university INPSYC sites

established to provide mental health training for AI/AN in the filed of psychology;

- Funding for professional programs to train native and tribal social workers and professional counselors should be increased; and
- Develop university sites to train professional AI/AN social workers and professional counselors should be established.

Funding

- Provide an additional $170 million, as recommended by the *Friends of Indian Health*, to IHS to address the level of need for health and mental health care:
  - Ensure that the number of IHS mental health care providers meets the ratio of mental health and care providers for the general population; and
  - Each IHS Area should ensure that there exist community-based mental health and suicide prevention programs.

In conclusion, I encourage this committee, when you are considering and discussing the needs of American Indians, that you consider the need for adequate resources to prevent tribal suicide. Thank you for your time and attention to this matter.

Native Youth Suicide Prevention: Appendix One.

Written testimony of Joseph B. Stone, PH.D., CAC Level III, ICADC, CADC Level III, Confederated Tribes of the Grand Ronde Behavioral Health Program Manager and Clinical Supervisor, Grand Ronde, Oregon on behalf of the American Psychological Association (APA) before the
Senate Committee on Indian Affairs
on
Youth Suicide Prevention

June 15, 2005.

Introduction: I am Joseph B. Stone, an enrolled member of the Blackfeet Nation of Northern Montana and a descendent of the Turtle Mountain Chippewa of North Dakota and Lakota of South Dakota. I am an honorable discharged veteran of the U.S. Navy and my professional credentials include being a Licensed Psychologist in Washington State and Oregon State, a Licensed Mental Health Counselor in Washington State, a Certified Addiction Counselor Level III in Arizona, a Certified Alcohol and Drug Counselor Level III in Oregon, and an Internationally Certified Alcohol and Drug Counselor. Currently, I am the Confederated Tribes of Grand Ronde Behavioral Health Program Manager and Clinical Supervisor.

On behalf of the Tribal members of the Confederated Tribes of Grand Ronde (CTGR), the CTGR Tribal Council sends their greetings to this committee and thanks the committee for their attention and provision of resources to the issue of native youth suicide prevention. The Tribal Members and Tribal Council of the Confederated Tribes of Grand Ronde are committed to the health and well being of their youth and other native youth and to the prevention of native youth suicide and we encourage the work of this Senate committee in addressing this difficult and tremendously important tribal health issue.

Finally, it is my pleasure to represent the American Psychological Association (APA), of which I have been a member since 1998. The APA represents 155,000 members and affiliates, and works to advance psychology as a science, a profession, and as a means of promoting health and human welfare.

The genesis of the disturbing statistics and behavioral issues in the tribal community that often result in native youth suicide that I discussed in the oral and written testimony is the cumulative intergenerational effect of historical trauma and chronic situational stress surrounding native families and communities (post-colonial stress) described in this appendix and more fully in appendix two. A brief description of post-colonial stress and historical trauma follows.

Unregulated Arousal (UA): The less than adequate control of affect or emotion that develops in a child if the parent is surrounded by situations that cause chronic unremitting stress (post-colonial stress or historical trauma), anxiety (Posttraumatic Stress Disorder),

major depression (as a result of uncontrolled internal feelings of anxiety or unremitting chronic external situational stress), or substance abuse (often initiated to cope with the emotional residual of post-colonial stress or historical trauma). Because the parent is so busy coping with situations of unremitting stress or historical trauma (including economic, social, or political oppression) in the moment, that parent sacrifices their capacity to provide a fully adequate developmental framework within the family or community for the child. Thusly, due to parenting styles impacted by chronic stress and oppressive environmental situations, the child does not receive adequate parental interaction to stimulate optimal development of the limbic system in the center of the child's brain never learns to control the arousal and thus unregulated arousal develops. Adult tribal people impacted by post-colonial stress and historical trauma often develop anxiety, depression, substance abuse patterns, and therefore have difficulty providing an adequate developmental. The consequence of chronic situational stress surrounding native adults, families, and communities from post-colonial stress and historical trauma sets-up and perpetuates an intergenerational cycle of unregulated arousal leading to lowered resilience to situational psychological insults and traumas and increased risk of developing and exhibiting behavioral disorders as adults (compromised behavioral immunity).

Compromised Behavioral Immunity (CBI): The result of unregulated arousal during a child's development is compromise to brain function, creating a brain that is susceptible to further developmental insults. Thusly, the developing native individual is more likely to develop psychopathology as a result of situational determinants. As each generation of tribal people grows up, further incidents and situations of historical trauma, chronic post-colonial stress (oppression, racism, economic, social, and cultural deprivation) cause further anxiety and depression within tribal families and communities surrounding developing native children furthering the cycle of unregulated arousal and compromised behavioral immunity across generations (graphically in the example below, with the generations labeled one to five described in paragraphs in the following section).

Intergenerational Pattern of Historical Trauma and Post-Colonial Stress

1.) ----- Dispossession and Biological Warfare (Smallpox) -----

2.) ----- Indian Wars (Example: Sand Creek Massacre) -----

3.) ----- Federal Residential Schools & Religious Boarding Schools -----

4.) ----- Foreign Wars, Termination & Relocation -----

5.) ----- Crystal Methamphetamine & Gangs ------

1.) Five hundred years ago, when the colonists arrive, the processes of forced removal

from homelands and use of biological warfare to disseminate tribes by providing them with infected blankets causing smallpox leads to the first generation of chronic stress surrounding native individuals and families. Child-rearing takes second place to survival and children experience increased unregulated arousal and compromised behavioral immunity, become vulnerable to further direct psychological impacts and insults. One issue is the perceived failure of native spiritual and healing methods and ways (because of new foreign germs, tribal people have no immunity and therefore previously effective methods of psychologically activating their immune systems through ceremony are not longer effective interventions to disease). This is the first generation of posttraumatic stress leading to depression, impacting parenting, and setting up an environment of chronic stress leading to developmental unregulated arousal and compromised behavioral immunity for the next generation of tribal peoples.

2.) This next generation of natives experiences the Indian wars with many battles and many massacres of native people and communities causing further psychological insult and emotional injury (posttraumatic stress) to a people who have now experienced a generation of unregulated arousal and compromised behavioral immunity and whom are thusly both more vulnerable to psychiatric symptoms and are therefore more likely to exhibit less adequate parenting within the current generational crucible of chronic stress surrounding tribal families and communities.

3.) This third generation of tribal people brings forward the unregulated arousal and compromised behavioral immunity and subsequently experiences the Federal Boarding School system and its' effects on Indian men, particularly the impact of physical abuse and sexual abuse, thusly setting up and condition the behavior of the next generation of Indian men who return to their communities using learned physical violence to control wives and children and to acting out learned sexual abuse as incest in their families and communities (physical violence to children, such as occurred in the boarding schools to both native boys and girls). In addition, the religious boarding schools had similar effects on tribal children, including sexual abuse and physical abuse, thus setting up these children to become the next generation of child sexual abusers and perpetrators physical violence and decreased capacity to protect their children.

4.) Clearly, this fourth generation of American Indian men continued bringing their own PTSD, unregulated arousal and compromised behavioral immunity and subsequently developed wartime post traumatic stress secondary to their U.S. military experiences and as victims of physical and sexual abuse in their homes from parents who had learned these behaviors in the Federal and religious boarding school systems. This is the first generation of incest on Indian women, resulting in posttraumatic stress from parents who learned sexual abuse in the boarding school systems. This is the generation of tribal people that experiences the increased use of beverage alcohol to cope, when relocated to the cities from the reservations (another failed Federal program). Thusly the beginning of Adult Children of Alcoholics in the tribal communities and the first generation of tribal families with children exposed to alcohol in utero, therefore the next generation is the first generation of alcohol related neurological disorder in native communities.

5.) This is the current generation of tribal people, bringing forward the deep seated intergenerational effects of post-colonial stress and historical trauma: unregulated arousal, compromised behavioral immunity, issues of being raised in alcoholic families, and issues with alcohol related neurological disorders. This generation of tribal people now experience issues with crystal methamphetamine and gang involvement. This generation's native adolescents react to the intergenerational effects of historical trauma and post-colonial stress by an enormous vulnerability to suicidal ideation and suicide.

Conclusion: Historical trauma and post-colonial stress factors that have affected native individual development and family functioning across generations in the current native youth's behavior with a concurrent lack of economic parity and opportunity, general health disparities, trauma to individuals and families, substance abuse, and individual, family, and community psychological functioning to contribute the individual and community vulnerability to suicide amongst native people. These various mechanisms of internalized trauma and its' effects and the current situational determinants of tribal youth influence the presentation and exhibition of psychopathology and behavioral disorder when tribal youth present for treatment in the mental health and substance abuse systems. Finally, it is the cumulative effects of tribal history, trauma experienced by tribal persons while raising their children, and situational chronic stress that has constantly surrounded native families that leads too and underlies the current epidemic of tribal youth mental health and substance abuse issues and suicide.

Ultimately, it is the attainment of a positive internal self-image integrating bi-cultural competence and native/tribal identity integrated with solid behavioral treatment that best benefits these clients. This must be community defined, developed, implemented, and modified as need to facilitate healing for indigenous clients and patients. The cause of native youth suicide are natural consequences of history (historical trauma and post-colonial stress) and the answers to solving the current symptom of this these historical factor: native youth suicide lies in and acknowledge of this and the effects and in tribal self-determination and recapturing of native spirituality and cultural identity as defined by each tribal unit.

Native Youth Suicide Prevention: Appendix Two

Written testimony of Joseph B. Stone, PH.D., CAC Level III, ICADC, CADC Level III, Confederated Tribes of the Grand Ronde Behavioral Health Program Manager and Clinical Supervisor, Grand Ronde, Oregon on behalf of the American Psychological Association (APA) before the
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Dedication - Mike Desjarlais: February 1960 – August 1978

Of all my family members, you are the one who has most often crossed my mind and lead me to wonder who, what, how, and most poignantly, why... So, I've asked our brothers and our father that question. Our father said it was a puzzle and that you were watching that DeNiro film: The Deer Hunter, over and over. One brother remembers a strong willed and independent little boy and he said that you had a look in your eye that did not fit in the last photo that he saw... He still sees you in his dreams. One brother remembers that you were always playing tricks on people and full of humor...you were supposed to be with him the next weekend and that the event was all shrouded in mystery and controversy.

For me, it was the wondering why that accompanied a sense of loss... I realize that in part asking myself, why, has shaped who I've become. I've thought a lot about Native people and Tribal families and their losses and the manner of these things. So, I've written down what I think begins to answer the why, at least for me, in this paper. This paper is for you, little brother, and it is for all the injured young First Nations men and women who have chosen to take the path of suicide. In the beginning, to try and understand why, I hope that I am honoring you ... all of you. The Shawnee poet wrote about an elder, Horse Man, who had passed over:

> *I have seen the rain speak and the wind dance. I have seen the lightning knife cut the sky. I have seen the hills at the first light of day whispering secrets in the Southwind People's ears. I am happy now. I am no longer thirsty. I dance a warrior's dance. I am not sick, I am free. This night, I dream a new dream. Now, I come to drink the stars! (Jennifer Pierce Eyen, 1997).*

In time, we will dance that warrior's dance together ... "Ike".

Joseph B. Stone, Ph.D., CAC Level III, ICADC, CADC Level III, 2002

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Finally, it is my pleasure to represent the American Psychological Association (APA), of which I have been a member since 1998. The APA represents 155,000 members and affiliates, and works to advance psychology as a science, a profession, and as a means of promoting health and human welfare.

The genesis of the disturbing statistics and behavioral issues in the tribal community that often result in native youth suicide that I discussed in the oral and written testimony is the cumulative intergenerational effect of historical trauma and chronic situational stress surrounding native families and communities (post-colonial stress) described in this appendix. Part I was originally published as a portion of a monograph (see reference Stone, J.B. [2002]) and part II was originally published as a portion of a dissertation literature review section (see reference Stone, J.B. [1998]):

Post-Colonial Stress Disorder: Intergenerational Pre-determinants of Neuro-Development, Developmental Psychopathology, & Post-Traumatic Stress Disorder Implications for Behavioral and Addictive Disorders and Suicide in Native Youth

Tribal communities are impacted by a historical trend of violence, trauma, genocide, and post-colonial stress perpetrated by the clash of cultures between native cultures and tribes and the dominant or affluent Euro-American culture and colonists to America. This clash of cultures has incorporated numerous systemic influences on tribal persons and communities across history, including, but not limited to the following: 1.) Dispossession of lands and property, 2.) Biological warfare through introduction of foreign diseases in blankets and other gifts, 3.) Disruption of language and culture, 4.) Indian wars and massacres, 5.) The federal and religious boarding schools (disruption of

family and language, which is the carrier of culture), 6.) Governmental termination of tribal and native status, 7.) Federal relocation programs of natives to cities, 8.) Modern influences on urban and rural tribal people and communities (gangs & drugs, of concern - methampethamine). Each of these systemic influences on native people and communities has underlain chronic stress within specific generations, in turn; predisposing less then adequate parenting practices within specific generations in the tribal communities and thusly negatively impacting the neurodevelopment of native youth. In addition, negative influences of neurodevelopment led to unregulated arousal, decreased resilience, and increased risk (compromised behavioral immunity).

Understanding this systemic intergenerational process of historical trauma and post-colonial stress affecting tribal communities and individuals gives the professional behavioral health worker insight into the depth and breadth of the underlying dynamic often manifesting itself in the form of psychiatric disorders and addictive behaviors. Certainly, the recent epidemic of native youth suicide concerning tribal people and their representatives is a natural consequence of intergenerational trauma, post-colonial stress, and genocide across time. Although this paper was originally written with a focus on research, the issue of post-colonial stress and historical trauma described herein is relevant to the current high incidence and frequency of native youth suicide and, in fact, the most areas of tribal health disparity. Of great importance, therefore, in the regaining of a healthy tribal youth are reclaiming tribal identity and spirituality, some methods for which are described and recommended.

PART I.

Introduction

Clearly, Indian Country presents even the most seasoned and careful researcher, clinician, administrator, or social worker with numerous professional issues and clinical challenges. Three of the most salient of these issues represent complex and interwoven challenges: 1) appropriate understanding and acknowledgement of postcolonial stress in the tribal communities, and 2) the use of participatory action research methods and models in a culturally sensitive manner, and 3) the provision of culturally competent clinical services (Brown & Tandon, 1983; Brydon-Miller, 1997; Duran, 1984; Duran & Duran, 1995; Locust, 1995; Lewis, Duran, & Woodis, 1999; McTaggert, 1991; Park,

1999; Walters & Simoni, 1999; Weissberg & Greenberg, 1998; Whyte, Greenwood, & Lazes, 1989; Wisner, Stea, & Kruks, 1991; & Yellow Horse Brave Heart, 1998).

While it is beyond the scope of this critique to describe fully the postcolonial stress theoretical perspective, we must briefly acknowledge the issues of trauma and grief, which robustly impact tribal peoples across and within generations. This has led to Natives and tribal families being immersed in an intergenerational and intra-generational crucible of stress. Thus, it follows that a higher level of posttraumatic stress within First Nation individuals, families, and communities, and also secondary consequences similar to those exhibited by Jewish Holocast and Khmer Rouge survivors, exist as a result of postcolonial stress (Last & Klein, 1984; Nadler, Kav-Venaki, & Gleitman, 1985; Rowland-Klein & Dunlop, 1998; Sack, Clarke, & Seeley, 1995; Yehuda, Schmeidler, Elkin, Wilson, Siever, Binder-Brynes, et al., 1998). Consequently, a high incidence and prevalence of psychiatric disorders and social problems, per se, lateral violence, ***suicide***, and high rates of substance abuse secondary to posttraumatic stress are observed in indigenous peoples. (Ball, 1998; Gagne, 1998; Nagel, 1998; Weaver and Yellow Horse Brave Heart, 1999). In 1992, Herman suggested that symptoms of sequelae of prolonged and complex trauma across time on psychological functioning might be very significant. The primary effects of this sort of stress in the lives of long-term sexual abuse survivors and combat veterans are a highly coherent description of many of the symptoms and issues faced by tribal people (Ford, 1999; Ford & Kidd, 1998; Zlotnick, Zakriski, Shea, & Costello, 1996). At this point, I would like to discuss the methodology for this review.

Review and Methodology Procedures

The primary task for this paper was the review of four articles provided to the author prior to their presentation and discussion at the recent American Indian Research and Program Evaluation Methodology Symposium, and published in this monograph. In addition, the author reviewed two recent Fisher and Ball (2002a, 2002b) articles on postcolonial (or tribal) participatory action research, the reference lists of several recent books, several review articles, and various other published studies and documents, and also manually searched several recent journals. Keywords included *posttraumatic stress, postcolonial, intergenerational trauma, unresolved historical grief, resiliency,*

attachment, neurodevelopment, developmental psychopathology, participatory action research, and collaborative community research.

Numerous studies, articles, and books were located that contained relevant information referenced in the body of this paper. The author used the postcolonial stress theory and the postcolonial participatory action research model proposed and described by Fisher and Ball (2002a, 2002b) as the basis for developing a coding instrument that was used to analyze the four reviewed articles. It is important to discuss research and evaluation methodology in First Nations communities within the context of a postcolonial stress theory.

Next, I will describe the general background of the postcolonial stress disorder theory as it applies to tribal people, and then move to a brief discussion of my personal theoretical perspective on the origins and implications of postcolonial stress in tribal individuals, families, and communities.

Clearly, native people and tribes face numerous behavioral health challenges including high frequency rates, incidence rates and prevalence rates of substance abuse (alcohol & drug abuse and dependency), depression, anxiety, lateral violence (child maltreatment and domestic violence), and ***suicide***. Historically, the context of these mental health and substance abuse behaviors by native individuals and in tribal communities is related to a long history of oppressive detrimental relationships and interactions with the dominant culture.

In this document and the often accompanying workshop, several areas of concern related to these current issues in tribal behavioral health are examined. In addition to examining these areas of concern, we turn our attention to healing efforts and methods. Integration (bringing together) of culturally relevant tribal coping and healing methods with modern western methods will be described and proposed.

Detrimental Systemic Influences

Unfortunately, native/tribal behavioral health service clients often exhibit diagnosable behaviors that are self-defeating, or toxic behaviors that cause problems to others (family members, other tribal members, employers, health care providers, or representatives of the criminal justice and court system) with whom the native person interacts. Often, these problematic behavioral and substance abuse disorders are directly

related to the tribal client's personal history, which was influenced by their parenting and thus, indirectly by the experiences of their parents and grandparents. In many historical situations (some recent), tribal individuals, their parents, and their grandparents have been adversely impacted by various traumatic experiences.

Historical impacts to tribal families, in combination with a culture of poverty, lead to situations within which parents, grandparents or other caregivers were not able to provide adequate care. Finally, in some cases, situations evolved within which tribal clients were sexually or physically abused, resulting in the development of post-traumatic stress disorder (PTSD). This type of personal history, culminating in the development of PTSD has lead to higher then average incidence of depression and anxiety in parents and has contributed to various behavioral problems and disorders and acting out behaviors: substance abuse, lateral violence, and suicide in native communities.

Intergenerational PTSD, Attachment, and Attachment Disorder Influences: Behavioral Immunity and Compromised Behavioral Immunity

Thus, each successive generation of tribal parents has experienced their own adverse impacts, roughly in the following order: 1.) The introduction of disease into the system, for which there was no immunity; 2.) Dispossession of property and enforced moving to reserved lands (i.e., typically of marginal value); 3.) Persecution and murder during the various "Indian Wars"; 4.) Enforced assimilation and acculturation through the general allotment act and the federal boarding school system; 5.) Oppression of and outlawing of religion, cultural, and language (i.e., which is the carrier of culture); 6.) Introduction to vices, such as alcohol and drugs; 7.) Inappropriate and inefficient management of governmental and health care systems by dominant culture bureaucrats; 8.) The acting out of internalized oppression through domestic violence and child sexual abuse on other tribal peoples, both within and outside the nuclear family by native people.

As a result, each successive generation of new, young tribal parents has been struggling with their own increased incidence, prevalence, and frequency of anxiety and depression. Because of this anxiety and depression, and the simultaneous loss of oppression of previously effective tribally based parenting and emotional coping

mechanisms, each generation of young tribal parents has provided less than optimum parenting during the development period for their infants. This negatively affected those infants with respect to attachment, attachment disorder, and neurological development during critical periods of brain development. I regard this as compromised behavioral immunity, per se; the individual impacted by compromised parenting is subsequently much more likely to develop and exhibit psychiatric and substance abuse disorders. This contrasts with behavioral immunity to such symptoms, per se; the resiliency that is imparted by good adaptive parenting processes.

Therefore, not only were tribal/native people being affected by the gross social mechanisms listed in preceding section, but by incremental increases in compromised behavioral immunity imparted by the less then fully adequate parenting which is usually a consequence of parental anxiety and/or depressed mood. Successive generations of attachment disorder and its' antecedent consequence to the developing infant: PTSD have caused compromised behavioral immunity or lessened resilience that underlies the current high prevalence, frequency, and incidence of psychiatric and substance abuse disorders in native/tribal communities.

Theoretical Background

Clearly, the literature in the scientific area of attachment and infant mental health is vast. It is not my goal herein to offer a completed theoretical discussion of attachment, regulation, or infant mental health. Rather, I am providing a simplified version of this complex area as a heuristic mechanism to initiate further discussion of the issues central to attachment, self-regulation, and infant mental health as a possible mechanism to describe the occurrence of postcolonial stress in tribal peoples. It is not my goal to suggest that this perspective on postcolonial stress is "right or correct", it is my goal to suggest that it might be considered and investigated for potential value as a possible correlate to postcolonial stress. It is possible that the description of tribal history might have a relationship with attachment, self-regulation, and infant mental health that has some as an influencing factor in postcolonial stress. Further, perhaps researchers should consider taking postcolonial stress into account as an important variable in developing a participatory research agenda with tribal communities, even if this description of the

possible relationships of attachment, self-regulation, and infant mental health ultimately fails the scientific test.

Recently, B. Perry (personal communication, May 1, 2002) asserted that the first four years of life are the most critical for brain development of the child. Borrowing from Perry's and Willis & Widerstrom (1986) description's, I would like to provide a simplified description of brain development during the first four years of life. Initially, the infant's cognitive abilities are limited by the not fully developed pre-frontal cortex and nerve fiber system, which is involved with thinking and memory (representation of visual and verbal experiences). Neonates appear capable of storing and retrieving sensory information even delivered to them prenatally, however, lacking speech, they are unable for some months to engage in the type of inner speech that one might characterize as thought. During this initial period of time, the infant is capable of feeling arousal because the limbic system is well enough developed to generate feelings of arousal (Nieuwenhuys, Voogd, & van Huijzen, 1981; Papuz, 1937).

I believe that one important goal of infant behavior is emotional regulation, which is the effort to find calmness through control, modulation, and mediation, when unmet needs or noxious environmental events cause an uncomfortable arousal state, thus achieving homestasis or "emotional balance" (Post, 2002). Thus, some of the reasons why infants cry include signaling their experience of painful arousal to the caregiver in order to be fed, cleaned, or when they are otherwise uncomfortable in order to signal to adult caregivers their high levels of arousal (Post, 2002). Self-soothing behavior is a complicated area to discuss and understand, perhaps infants learn to self-sooth by recalling a representation of the caregiver, for example, via transitional objects such as blankets, stuffed animals, etc. They might be soothed by their caregiver's voice (prosodic verbal memory) and items of clothing that smell (olfactory memory) like the caregiver? Perhaps one critical aspect of the infant becoming capable of self-regulation of their internal limbic system-mediated arousal is that this capability is learned through the type of response that the infant receives from caregivers or parents to its signals of need (Schore, 1994; Stern, 1985; Greenspan, 1981).

In general, although the range of caregiver responses to children's needs is quite wide, I would like to point out the effects of the two polar extremes of caregiver response

to the infant's development of a capacity to control or modulate its own arousal. These polar extremes are the responses of *adequate caregivers*, who equitably meet the child's developmental needs for care that facilitates adaptive brain development, versus the responses of *inadequate caregivers*, who do not adequately meet the child's developmental need for care that facilitates adequate brain development. Additionally, there are 'difficult to sooth" infants who present temperaments that challenge adequacy in caregivers as well as reverse socialization processes that included "slow to warm" infants that leave caretakers feeling rejected and gradually less willing to be involved in attachment and bonding behavior with the infant. In the next section, I would like to consider a simplified description of adequate caregivers and the implications for child brain development.

The Implications of *Adequate* Caregiver Behavior for Child Brain Development

Consistent caregiver response to a child's expressed needs and the caregiver's unconditional attention to the child are likely the most significant and important features of caregiver-child interaction underlying adaptive brain development of the child (Noshpitz & King, 1991). For example, if a child cries when in an arousal state related to a basic need (food, comfort, safety, etc.) and the caregiver responds in an adaptive and beneficial manner, the child becomes calmer and over time more capable of self-regulation (soothing itself or modulating its own limbic system-mediated level of arousal). First, the caregiver provides the desired or needed items or care. It is likely that of greater importance to the child's adequately developing the capacity to regulate arousal (soothe itself) is the effect of the caregiver's contact and soothing behaviors during the interaction (Amini, Lewis, Lannon, Louie, Baumbacher, McGuinness, et al., 1996; Gazzaniga & LeDoux, 1978, Heineman, 1998). A caregiver who consistently picks the child up and holds the child close and who is simultaneously in a relaxed and calm state will physically impart that regulated state to the child. The child will synchronize and regulate heart rate, breathing, and state of muscle tension to those of the caregiver. Thus, through the act of holding and soothing a child, the child's brain is repeatedly stimulated in the process of self-soothing or regulation of arousal that parallels

the regulated state of the caregiver. Over time, with consistency, as the child's brain is developing, this process becomes second nature to the child (e.g., simultaneously, the brain of the child develops the capacity for self-regulation of arousal and the process of self-regulation of arousal is learned) (Schore, 1994). Of interest, simultaneously, the development of the child's prefrontal cortex and the enervation (growth of nerve fibers connecting various areas of the brain) of the brain is occurring during the first few years of life. This process of brain development and enervation underlies the development of various areas of the brain communicating with and signaling to each other with biochemical neurotransmitters. Thus, neurodevelopment leads to communication between the prefrontal cortex and the limbic system (Schore, 1994; Birch, personal communication, June 4, 1999).

This is tremendously important, because simultaneously with the developing capacity for self-regulation developing during consistent caregiver responses, the child is also developing the capacity to maintain a set of internal verbal, visual, and auditory images (stored and integrated in the prefrontal cortex). Clearly, these processes are dependent on approximate ages and sequences of development. Receptive language precedes expressive language, sometimes by years in boy infants. Therefore, the question arises, how does understanding speech at 10 months help in self-regulation? For example, a mother smiles and says "no" gently to a 10-month old daughter and the baby clearly stops, smiles, and hesitates, watching the mother carefully. In this case, the mother did not have to regulate the child herself, bodily, and speech extended her range of interaction as well as the baby's ability to self-regulate via understanding of the verbal cue. The complexity of how a child can develop the capacity to integrate and control self-regulation through improved communication between the prefrontal cortex and the limbic system, based on the growth of nerve fibers connecting these areas of the brain, is indeed a complex process that exceeds the scope of this paper to describe. Apparently all aspects of the caregiver and the context of the care become associated with increased capacity to self-regulate arousal. Thus, the child can than produce internal visual, verbal, and auditory representations of safety and care that are learned during interactions with the caregiver. The child integrates these representations of visual, verbal, and auditory stimuli in the pre-frontal cortex and attaches meaning to them. This process becomes the

basis of a biochemical and electrical message from the developing prefrontal cortex to the limbic brain through the newly developing connective nerve fibers. It is like that a complex developmental process of caregiver-child interaction occurring simultaneously with brain development that underlies a child's capacity to self-regulate arousal (Emde & Buchsbaum, 1989; Fair, 1992; van der Kolk & Fisler, 1994). Two of the most critical aspects of developmental process of self-regulation are that 1) the caregiver is consistent and available to facilitate the developmental process of self-regulation, and 2) the caregiver is capable of self-regulation and is consistently and predictably self-regulating her or his arousal during this developmental process. Adaptive parenting is likely adequate facilitation of child attachment.

There exists a polar opposite in parenting style, which is the inadequate caregiver model, contributing to development of dysregulation of arousal. Perhaps chronic dysregulated arousal in a child can be described as reactive attachment disorder and the issues that surround the dysregulation of arousal of might be a product of caregiver-child interaction.

The Impact of *Inadequate* Caregiver Behavior on Child Brain Development

The scientific literature is clear; there are several types of caregiver behaviors that are inadequate, per se; excessive anxiety, depression, substance abuse, and psychotic process in the caregiver underlie the expression of psychopathology in the child and developmental psychopathology as the child ages (B. Post, personal communication, June 25, 2002). Of course, it is equally reasonable that within tribal families affected by or functioning within stress, native caregivers in stress act as the primary facilitators of the children's development. Therefore, I believe that in addition to caregivers with defined psychiatric conditions, such as those discussed above, the caregivers in families impacted by ongoing stress are also often rendered inadequate in their provision of developmental care to the children in these families by the stressful conditions impacting the families.

Caregivers who have anxiety, depression, or substance abuse on board are less consistent, are less capable of self-regulation, and thus are less capable of providing an adaptive developmental experience during the aforementioned critical period of child neurodevelopment. Within families impacted by stress or families where the caregiver is

compromised or inconsistent, the child does not receive the type of consistent care needed for self-regulation of arousal. Additionally, in many cases, caregivers in this type of families are themselves not as capable of self-regulation. Therefore, the child cannot directly experience an adult model of self-regulation while in direct contact with an adult who is capable of self-regulation. Thus, the child's brain cannot fully develop a capacity for self-regulation of arousal.

I believe that inadequate caregivers can not provide the child with a consistent experience in self-regulation because of depression, impairment by substance abuse, or extreme anxiety and concurrent incapacity to self-regulate arousal. Consequently the child experiences an inconsistent process of what it means to be soothed, and it follows that the child develops an inconsistent ability to regulate arousal. Often, children with inadequate or inconsistent caregivers receive care in intermittent spurts of stimulation. Therefore, these children often do not develop the capacity to regulate arousal in a consistent manner. These children's limbic systems actually do not develop the capacity to regulate arousal consistently as a result of inconsistent stimulation during childcare.

Caregiver attention that comes in spurts of stimulation (positive but inconsistent and/or varying to negative) subsequently conditions the child to regulate arousal by engaging in a stimulation-seeking process. These children become indiscriminate in the types of stimulation that they might elicit to activate arousal-regulatory mechanisms in their limbic system. Many times children conditioned indiscriminately "act out" in a manner that elicits negative stimulation or punishment, because this is equally effective in helping them activate their capacity to regulate arousal. In these situations, the child acts out in order to be punished or abused, because even that type of response stimulates the brain to dampen uncomfortable levels of arousal (to self-regulate).

Of course, if inconsistent caregiver attention creates a limbic response that is sensation-seeking as a means of stimulating regulation, there is an unfortunate additional effect to the developing prefrontal cortex and enervation. That is, the verbal, visual, and auditory images of the caregiver and environment that are integrated into meaning in the prefrontal cortex are disjointed and inconsistent (Brown, 1991; Coen, 1985; George, 1996; Krystal, 1990, 1991; Green, 1995, Dubowitz, Black, Harrington, & Verschoore, 1993). Furthermore, in addition to the fact that the verbal, visual, and auditory images

that stimulate the flow of chemical and electrical messages that are designed to control limbic arousal might exist in this disjointed manner, the actual set of nerve fibers is smaller and less robust. That is because the development of these nerve fibers is dependent, in part, on adaptive developmental care (Rakic, 1991).

The child receiving inconsistent care develops a limbic system that regulates arousal based on stimulation that is both positive (adaptive behavior) and negative (maladaptive behavior). Additionally, these children often have cognitive distortions about what represents appropriate stimuli for regulation of arousal. Finally, they often must seek intense stimulation in order to create a biochemical and electrical message of great enough magnitude to overcome the deficient nerve fibers connecting prefrontal cortex and limbic system.

There is a second problem that children experience from care given by adults who can not control their own arousal. These children can not develop the process of self-regulation because they have no model or contact with another human who is self-regulated. These children must replicate the level of self-control and self-regulation experienced by their caregiver. If that is limited, the children's capacity to self-regulate arousal is limited. We are aware that this has long-term implications because if the critical period of brain development passes, then it is likely that these children will always have greater difficulty with regulation of arousal. One model for understanding this is recent research on the children of depressed caregivers versus the children of non-depressed caregivers. On a brain scan study of infants of depressed caregivers, the infants had similar responses to the depressed caregiver walking *toward* them as infants of non-depressed caregivers had to their caregiver walking *away* from them. It was postulated that these infants might have experienced dysregulated arousal during interactions with depressed caregivers (B. Post, personal communication, June 26, 2002).

Obviously, children with inconsistent caregivers or caregivers who could not regulate their arousal become adult clients with up and down behavioral phases across time of living well, not living well, living well, not living well. Another example is falling in love, falling out of love, falling in love, falling out of love with very exciting and toxic people who are highly stimulating. Adults who get themselves into risky situations as a mechanism to stimulate modulation of arousal. Perhaps they jump out of

airplanes with parachutes for fun. Perhaps they engage in high-risk sexual escapades in order to have the type of stimulation that helps them regulate their arousal. Perhaps they engage in substance abuse in order to use the derivative chemical interactions secondary to substance abuse as a mechanism to regulate arousal.

Often when children have had inconsistent parenting in infanthood, as adult they seek stimulation, they ride on this wave of stimulation, they must have stimulation in order to regulate arousal. But that stimulation is not necessarily provided by consistent, healthy, or adaptive behaviors. Furthermore, the child whose early capacity to self-regulate is compromised by inconsistent or unregulated developmental interactions with the caregiver is set up to be an adult susceptible to anxiety, depression, and consequently substance abuse. I call this result of developmental process *compromised behavioral immunity* (CBI).

Compromised Behavioral Immunity

Initially, I became aware of the phenomenon of compromised behavioral immunity as I worked with war veterans and victims of violent sexual assault as adults. In both of these populations, I found that the impacted individual might have a very similar experience to his or her peers. However, some individuals responded well to treatment and improved rapidly, but others did not. As I became more aware of the clients' individual histories, I saw a trend emerge. Individuals who appeared to make good progress in therapy and to improve from treatment usually reported much more adaptive developmental experiences as children and adolescents. They usually had adequate caregivers and usually were not impacted by as many or as intensive a set of developmental insults as adolescents. On the other hand, individuals who reported experiencing inadequate caregivers as children usually exhibited a greater magnitude of psychiatric symptoms as a result of war experiences or adult sexual assault. I term this phenomenon compromised behavioral immunity (CBI), which is the result of the impact of inadequate early developmental experiences on resiliency in adulthood.

Compromised behavioral immunity (CBI) seems to reduce resiliency in adults, and thus underlies the expression of psychiatric disorders of greater magnitude. The experience of families in stress (wherein the adults are not as available to facilitate child brain development) and families with caregivers who have psychiatric and substance

abuse issues describes the milieu of development leading to dysregulated arousal, reactive attachment disorders, and compromised behavioral immunity. This was the crucible of child development for tribal families and their children across the past five hundred years. I believe many psychiatric and substance abuse issues of postcolonial stress emerge from and are described by the following model of colonial impact on tribal communities, families, and individuals.

Postcolonial Neurodevelopment and Developmental Psychopathology in First Nations Communities

This aforementioned theory of neurodevelopment is greatly simplified with respect to the large body of scientific literature that is available, and a complete description is clearly beyond the scope of this paper. However, perhaps a simplified model of attachment, self-regulation, and infant mental health has some descriptive value when integrated into a postcolonial stress model? I think we need to marry our concepts of historical trauma, the postcolonial mechanisms that have shaped tribal communities and families, and the impact of these events and systems on the development of tribal children across generations. Understanding these interrelated phenomena and dynamics leads to understanding the neurological impact of what being a tribal person in this country has brought to each and every one of us who are tribal people.

This model describes a simplified version of neurological development and human development in the Native community across the past several generations. Further, one must bear in mind that this postcolonial stress model demonstrates the tremendous resiliency and strength of survival demonstrated across the generations. Perhaps one reason that this resiliency and survival in the tribal community is evident is related to the strength of tribal spirituality.

Another thing to remember is that the events discussed within the various generations in this section are examples of ongoing processes, so the reader must consider that the negative and oppressive dynamics described herein and experienced by our tribal ancestors are in many cases continuing for contemporary tribal people in the U.S.A. Finally, it is important to note that this postcolonial stress model of intergenerational neurodevelopment and developmental psychopathology can likely be

adapted and applied to other indigenous colonized populations, such as New Zealand Maori, Australian Aborigines, South American Indigenous, and South African Blacks.

This intergenerational postcolonial stress model of neurodevelopment and developmental psychopathology secondary to colonization and compromised behavioral immunity in the tribal communities is by no means representative of any given individual Native family. I initially thought about this intergenerational postcolonial stress model as it applied to understanding my personal tribal family history for heuristic reasons. Following my professional training, I later integrated scientific aspects of the postcolonial stress model and generalized the theory. I think the generalized postcolonial stress model is somewhat representative of most tribal people's developmental experiences in general, given the need for a more robust examination and subsequent integration of attachment, self-regulation, and infant mental health literature if warranted. Furthermore, it is clear that a growing number of studies support that idea that intergenerational transmission of attachment and attachment problems exists (van Ijzendoorn, 1995a, 1995b; van Ijzendoorn & Bakermans-Kranenburg, 1997; van Ijzendoorn, Juffer, & Duyvesteyn, 1995; Zeanah, Finley-Belgard, & Benoit, 1997).

Dispossession and Biological Warfare

I'll start my description of postcolonial stress in the early 1600s on the East Coast and with the first colonization of this country. Early in the colonization period tribal people were dispossessed of property: the enforced movement of Native people from the prime country in which they lived. Tribal people experienced forced moving from the places that they loved and were spiritually attached to. Of course, dispossession was almost always enforced at musket point and with violence.

Beginning with early tribal dispossession, we can begin to see correlation with posttraumatic stress in the dispossessed Native communities, families, and individuals. I assume that the first generation of dispossession, which occurred in the eastern coastal area of the U.S in the 1500s and 1600s, began inducing anxiety, in the form of posttraumatic stress, into the tribal community.

Occurring simultaneously with tribal dispossession was the biological warfare that began to occur back in that era. Biological warfare also introduced anxiety in the form of posttraumatic stress disorder into tribal communities, families, and individuals.

The colonizers distributed blankets infected with smallpox and other foreign bacteria and viruses to decimate tribal communities. Initially, that type of biological warfare killed a lot of Native people outright. It also made the communities, families, and individuals less capable of engaging in their customary economic and social process. It destroyed our Native communities' capacity to engage in the economy, that was mainly gathering and hunting. If a lot of the gatherers and hunters are down and sick and dying, they can't gather and hunt. If the other tribal people are helping them, then these other Natives can't gather and hunt while providing care to the sick.

This early biological warfare conducted against the Native communities was very destructive to traditional child-rearing patterns and to the tribal knowledge base. It was very destructive of our tribal knowledge base because our Native libraries were the elders, who kept tribal knowledge in the forms of oral histories. The elders were most susceptible to disease, and thus our historical knowledge that stretched back as an oral history for centuries was devastated by this biological warfare as elders died. The biological warfare also devastated children, because they were young and susceptible to infection.

In some tribes, when children were born the parents took a whole year just to nurture that child. Other tribal members hunted and gathered for them while the parents just took care of their child. Then at the end of that year the child was turned over to the tribal elders and was raised to become who they would become. The tribal elders would choose to teach the child what he or she would need to learn to optimally function and support the tribe. So you can imagine the effects of biological warfare impacting these two portions of our tribal community.

The most pernicious effect of the biological warfare was its impact on tribal spirituality. In our First Nation communities the capacity to cope with difficult situations and/or health crises was enhanced or made greater by our Native spirituality. Our tribal spirituality was tied in to the context within which it was practiced. Native spiritual practices, such as smudge, or whatever we burned, the smell of that, the chanting, the drumming, the use of tribal medicine, and the presence of tribal healers all occurred in an environment where indigenous people were confident that it influenced healing. When the spiritual ceremonies and practices that enacted healing would occur, of course healing

would follow, because those ceremonies and practices would activate the tribal member's immune system. People were confident that they would get well. Their immune system would be enhanced by a ceremonial and so they would get well. However, when a foreign microbe invaded the tribal community, the tribal member's immune system could not cope with that foreign microbe. Therefore, even if an enhanced immune function occurred in a tribal member secondary to a ceremony, the person still did not get well because the immune system could not cope with the microbe. In fact, even, the most highly respected medicine people and healers could not help others or themselves. So, we saw the abrupt and total failure of tribal spirituality to activate the immune system and help Native people deal naturally with the microbes introduced by the colonizers. Of course, the same tribal spiritual practices were used to cope with emotional disturbances secondary to the trauma of illness and dispossession. Consequently, when their tribal spiritual practices were disrupted, what coping mechanisms would Native people turn to for emotional coping?

I think that whole process of tribal lifestyle, health care, oral history, child rearing, and emotional coping was extremely disrupted by the biological warfare that was initiated about 500 years ago. Of course, in addition to these effects of biological warfare in the Native community, individual tribal people developed posttraumatic stress disorder as a result of their family members dying around them.

The First Generation of Anxiety and Depression Secondary to Colonialism

Of course, posttraumatic stress disorder is an anxiety disorder that exists on a continuum with depression (at the opposite polar extreme). Furthermore, subjectively speaking, anxiety feels very much like arousal. If one is anxious one feels as if one is experiencing a higher level of arousal most of the time. If one doesn't have a coping mechanism to help reduce or regulate that anxiety, one is susceptible to becoming depressed. For these anxious individuals, their experience with anxiety is like a dog sitting on a steel grating getting electrical shocks that it can not escape. The dog jumps as a result of the electrical jolt and attempts to escape. Historically, I think that following a jolt of anxiety tribal people used ceremonial community-based spiritual coping to reduce that anxiety. However, when tribal spirituality was disrupted, these Natives' subsequent experience was similar to a dog, receiving uncontrollable electrical shocks but unable to

escape the shock. Every time something happened to the Native person, their anxiety rose with nothing to control it. Soon, no matter how hard electricity hits the dog, he just lies on the grate. In parallel, the tribal person continued feeling a lot of anxiety but could not regulate it with the accustomed spiritual practices. These Native people felt helpless to regulate their anxiety. Tribal people began experiencing a shift in the anxiety-depression continuum. They developed depressed mood stemming from uncontrollable anxiety that was no longer ameliorated by use of tribal spiritual practices as coping mechanisms.

So, during this generation, the first generation of colonization, we really start to see our first tribal people experiencing anxiety and depression disorders manifested in the families and in the caregiver's behavior toward the children. Furthermore, these tribal families were in continual stress from other external factors predicated on colonization.

It is logical that parents who are in a crucible of family stress, such as oppression, racism, warfare, and other factors predicated on colonization, are distracted from their children and child-raising practices. These tribal parents were distracted by anxiety and unavailable because of depression. Thus, this generation of Native parents became less than optimal caregivers for the children's developmental processes. So, we have our first generation of colonized effects on tribal families (families within which ongoing stress, anxiety, and depression are manifested). Of course, the dispossession and biological warfare are ongoing processes across the Eastern seaboard, so it is highly likely that most tribal people are affected. If most tribal people are affected, then most young tribal people who marry and have children become families in stress, with these new parents having their own issues from becoming the first generation of Natives manifesting anxiety and depression as a result of the effects of colonization.

This is our first generation of colonization-impacted Native parenting practice. By definition, we have established that children who receive parenting from inadequate parents (families in stress, anxious parents, or depressed parents) are more likely to manifest reactive attachment disorder or a dysregulation of arousal. This gives us our first generation of Native children beginning to have some dysregulation of arousal, resulting in reactive attachment disorder and compromised behavioral immunity. Postcolonial stress-impacted Native adults (anxious and depressed) are providing

parenting within families under further continual colonization stress from external factors.

We have defined reactive attachment disorder as stemming from a high level of unregulated arousal that sets up a child for compromised behavioral immunity and greater susceptibility to developmental insult. Furthermore, we must be aware that the discrete generational events or occurrences we are discussing in fact occurred across generations and are cumulative effects from one generation to the next generation. So it wasn't just this generation of tribal people having dispossession and biological warfare occur. The next generation of Natives experienced the Indian Wars, but dispossession and biological warfare continued during the Indian War period. I will describe the Indian Wars and the impact of posttraumatic stress on the tribal community in a more definitive manner in the next section of this paper.

Neurodevelopment, Developmental Insult, Posttraumatic Stress Disorder, and the Indian Wars

Envision Colonel Chivington on the hill overlooking Sand Creek in Colorado and his pony soldiers in a skirmish line across the bend in Sand Creek. There is a camp of the Cheyenne in the bend of the creek, and it is dawn. Tribal people are getting up and preparing for the day. We see older people (men and women) and adult women and children of the camp getting up and breaking camp at dawn and getting water to start their day.

The fact that there are no Cheyenne men in the camp is why the U.S. cavalry is here. Colonel Chivington sees this as a political opportunity to "put down an Indian insurrection." The Cheyenne men are off the reservation against the orders of the U.S. government. The Cheyenne men might be hunting because the rations provided to the tribe are not adequate and the people are hungry. Of course, oral historians suggest that the Cheyenne men might be off and engaged in the Ghost Dance religion, which is also against the government's rules.

Colonel Chivington is poised to attack the Cheyenne elders, women, and children at Sand Creek: it is politically expedient for him to prosecute the savages and it enhances his ability to be elected to office. Another famous pony solder, General Custer, tried that route to political office, also, and we saw how that turned out, but that's another story.

We'll envision Chivington's mini-guns on top of the hill overlooking the Sand Creek Cheyenne camp because that's where the colonel, being a good military man, put his mini-guns. Mini-guns are small cannon that are easily hauled by horse team. Of course, the Colonel, being frugal, loaded the mini-guns with grapeshot. Grapeshot was the stuff swept up off of the floor of the blacksmith shop at the fort—bits of metal from shoeing horses, nails, and other chunks of material. You can imagine that since grapeshot was a product of the fort's blacksmith shop it was mixed with large quantities of horse manure. That means grapeshot was very, very dirty and that being hit, even in a non-lethal manner with grapeshot could induce sepsis. So, when shooting a mini-gun loaded with grapeshot at tribal people, it was not necessary to hit a Native directly. All that was required was a grazing wound or a scratch, which would induce sepsis or infection (more biological warfare). A Native injured in such a manner might die or lose an arm or leg.

Colonel Chivington sets mini-guns up on the hill overlooking the Cheyenne camp down in Sand Creek. The Cheyenne warriors are gone. The Cheyenne's buffalo hide lodges are not invulnerable to shells and shelling and these buffalo hide lodges can not turn away mini-gun grapeshot. The colonel is on the hill with his mini-guns loaded with grapeshot and he has his pony soldiers in a skirmish line across the river and he orders the pony soldiers to draw sabers because he wants to save on pistol cartridge rounds.

At dawn, when the Cheyenne people are breaking camp, Colonel Chivington orders the mini-guns fired. We hear a round of grape shot sprayed through the camp at Sand Creek that knocks tribal people over immediately, or wounds them with that deadly sepsis-inducing grapeshot so they might die or lose an arm or leg from infection later. Then the colonel sends his pony soldiers across the river with their sabers and they start hacking folks up. Now, this discussion of the Sand Creek massacre is only an example of the type of aggressive attacks on tribal communities that goes on across the country over and over and over during the Indian Wars.

As a result of this type of scene, we have two hypothetical young tribal people coming out of the first generation's postcolonial stress-influenced parenting (tribal parents having some anxiety and depression). Thus, two hypothetical young Native people with some symptoms of unregulated arousal, reactive attachment, and resulting

compromised behavioral immunity, getting posttraumatic stress as a result of their presence in the Indian Wars. Therefore, we now have a second generation of young tribal parents facing continued externally generated stress, secondary to colonization, and developing internal anxiety and subsequent depression, secondary to the Indian War experiences, impacting their parenting. Since this hypothetical young tribal couple is anxious, depressed, in a social crucible of poverty, dispossession, and forced movement from historical land base, biological warfare, Indian warfare, and disruption of spirituality, culture, and religion, we can assume then that they're not 100 percent invested in or capable of adequate parenting. So, when this hypothetical Native couple has their children, they are raising the next generation of tribal children developing with unregulated arousal, reactive attachment disorder, and compromised behavioral immunity.

We are now two generations into this intergenerational process, so what is next on the colonial agenda for tribal people in this country? Since we're going to finish the Indian Wars, what is the next stage of colonial assimilation and acculturation? The next generation of postcolonial stress-impacted tribal people experienced the impact of the boarding schools.

The Federal and Religious Indian Boarding Schools, Neurodevelopment, Developmental Psychopathology, and Native People

Envision sending a young Native male to the federal Indian boarding school system. Let's consider the federal Indian boarding school system. Created by whom? General Richard Pratt created the federal Indian boarding school system for the express purpose, as was clearly written in our Congressional Recordof "killing the Indian to save the man." Now, when these Native children are sent to the federal Indian boarding school systems, who become their instructors and teachers? Who is there to teach these impressionable young Native students? Well, as you can well imagine, if Richard Pratt (retired pony solder general) is the superintendent of the newly formed federal Indian boarding school system, then it follows that he recruits other retiring pony soldiers as staff and teachers. So the largest group of teachers in the federal Indian boarding school system is retired pony soldiers: lieutenants, sergeants, enlisted men, etc.

The era of the federal Indian boarding school system continues to have pernicious effects in our Native communities, effects (often political in nature) that are observable even today. For example, Indian policemen enforced attendance of tribal children at the boarding schools. Indian policemen would go to other tribal members' families and forcibly take their children. Of course, in many cases, families resisted and serious fights would result, often resulting in either the death of Indian policemen or of tribal family members. In most cases, the Native children were taken to boarding school, ultimately. In the tribal communities, we still see political effects of that period of enforced boarding school attendance lingering three or four generations. In some tribal communities, we have families with incredible animosities towards one another but no rational reason why those animosities should be occurring. Tribal members who achieve political power often act out these animosities against one another within the political forum, rather than collaborating for the good of the tribe in general. Apparently, they can not overcome their historical animosity derived from the boarding school era, when an ancestor from one family was Indian police taking the child of another families' ancestor. Rather than the source of this dysfunction being tribal, it was the splitting or atomization effects of the larger culture using one part of the tribe (the Indian police) against another part of the tribe (the families of students forced into the boarding schools). However, the old animosities still exist and are played out to the detriment of functioning in modern Native society.

The first things that happened when tribal kids got to the federal Indian boarding schools were that their hair was cut and they were prohibited from speaking their language, even if that was the only language they knew. These tribal children were put into regiments and into units and into uniforms.

Around the locations of the federal Indian boarding school system there are killing fields or vast unmarked cemeteries. These cemeteries contain the bones of the tribal children who died of broken hearts or diseases because they had been brought together from around the country with no immunity to one another's diseases.

At this point in time, tribal children in the boarding schools experience their first exposure to large-scale amounts of physical and sexual abuse. Physical abuse was a mainstay of the discipline in the federal Indian boarding schools. As a result, our first

generation of individuals return to their tribal communities trained in the boarding schools to use physical violence as a means of controlling family members: children and spouses. Family domestic violence, a product of learned behavior from the boarding schools, becomes widespread in tribal communities. Lateral violence spreads through our Native communities as an outgrowth of the violence practiced against tribal children in the federal Indian boarding school system. Further, the literature implies that situational molesters are usually previously victims of physical abuse and that they molest out of a need for power and control. Thus, a generation of situational molestation or sexual abuse is introduced into the tribal communities as yet another form of learned behavior derivative from the boarding school era.

So, this is the experience of our hypothetical young tribal man in the federal Indian boarding school system: loss of culture, language (the carrier of culture), beliefs, values, etc., and the experiential introduction to physical abuse and subsequent learning of physical abuse as a control mechanism for family functioning. Finally, it is likely that the young tribal member attending the federal boarding school experiences the devastation of identity that accompanies physical (and sexual) abuse. This loss of identity and sense of personal power by natives in the boarding schools lead to the expression of powerlessness as situational molestation within the tribal community and family. Situational molestation to achieve a sense of power and control is acted out in the Native community and family as a form of self-perpetuating lateral violence.

Envision a hypothetical young Native woman being sent to a religious Indian boarding school. The religious Indian boarding school was the equivalent of the federal boarding school for the amount of physical abuse used to control the children. One good example would be in Canada, where there is a small reserve; on that reserve there are three generations of people, aged 55-65, 45-55, and 35-45 years. For many years, each of these groups has smaller groups in all the social and political arenas of tribal life, including the schools, the police, the legal system, the health system, and the political system. Never in the history of the tribe could Natives from one of these groups cooperate or collaborate with tribal members from the other groups. There was always dissension and conflict, apparently without reason and certainly to the detriment of tribal functioning in general.

Members of the youngest group of Natives (35-45 years) go into counseling and psychotherapy. In psychotherapy, members of the youngest group of tribal members remember and discuss sexual and physical abuse that they experienced at the hands of the slightly older group of tribal members (age 45-55). So, at this point in time some members of the youngest group of Natives begin to sue members of the 45-55 year-old group of tribal members.

As a result of the stress of the lawsuit several members of the 45-55 year-old group of tribal members go for supportive psychotherapy. In psychotherapy, members of the middle group of Natives begin to think about their own abuse at the hands of members of the oldest group (age 55-65). The middle group of tribal members initiates lawsuits against the oldest group of tribal members.

So now we have a whole bunch of lawyers getting into the fray in this Canadian reserve, helping tribal people sue each other and splitting the community up. Of course, all these lawsuits are high profile, so the Canadian government gets in there and they hire a Native psychologist to find out what is going on. The Native psychologist finds out that on that tribal reserve there was a religious Indian boarding school with a domicile. The domicile was a four-story building for the Native children and for the religious group that came in to teach the children.

The religious group lived up on the fourth floor of the domicile. The oldest group of tribal people mentioned above lived on the third floor, the second oldest group of tribal people lived on the second floor, and the youngest group of tribal people lived on the first floor. It was revealed to the consulting psychologist that as children, the tribal people on each floor were physically and sexually abusive to one another, the oldest children to the middle and youngest, and the middle children to the youngest children.

However, this whole process of tribal children abusing other tribal children derived from and was set in motion by the actions of the religious teachers. Religious teachers would come downstairs and be sexually abusive to the children on all three floors. But, these religious teachers did another thing that was very detrimental to the tribal children's future relationships with one another. The religious teachers used the oldest group of Native children to enforce their will on the second oldest group of tribal children, and used the second oldest group of Native children to enforce their will on the

youngest group of indigenous children. The religious leaders set these groups of Native children at one another's throats in order to control them.

As a result, when these tribal children grew up on that Canadian reserve, three distinct political factions emerged in which the people hated one another, were unwilling to talk to one another, and could not collaborate politically for the good of the reserve. In addition, many members of these three groups also acted out in lateral violence: sexual molestation and physical abuse in the community as a result of this happening to them in the religious boarding school.

A really tremendous social problem evolves here for the tribe. Tribal members are acting out lateral physical abuse and sexual molestation against the children of the next generation, they can not cooperate or collaborate with one another at any level, and they are all suing one another. Probably the only good thing that happened was that once this phenomenon was understood, everybody from the tribe did finally collaborate. The tribal people got together and sued the religious group. But unfortunately healing wasn't emphasized in this collaboration. Apparently the hurt was so great that when this tribe started on the path to healing they stopped and stepped back and began the process of disagreement and social disruption again. The tribe couldn't tolerate healing together, so they're sort of stuck right now with this distinctly split-up community, as a result of the influence of their attendance at a tribal religious boarding school.

We have envisioned a hypothetical male tribal person from the federal Indian boarding school with some experience of physical abuse and possibly sexual molestation. Further, we envisioned a hypothetical female tribal member from a religious Indian boarding school with a history of sexual and physical abuse. Perhaps she attended a school similar to the religious boarding school in Canada. We know that people who have been sexually abused have difficulty protecting their children from being sexually abused. People who are physically abused often become what we call situational molesters—not pedophiles, but situational molesters who use sexuality as a way of achieving power and control. So a generation of tribal people came home from boarding school with sexual abuse techniques because they'd been taught that—tribal people who experienced physical abuse, so they have a need to cope with their own powerlessness, and who have histories of sexual abuse so they can't protect their children.

These outside influences of learned behaviors (sexual and physical abuse) are subsequently acted out laterally within our own First Nation communities, as happened on the reserve in Canada, as happens in our political system yet today. We see the lateral expression and continuation of physical or sexual abuse in our Native families and communities. That is how the physical and sexual abuse, the political divisiveness, and the difficulties in collaborating socially with one another were introduced to Native people and perpetuated in the tribal community. Of course, as a result, they perpetuate themselves.

We now have this generation of Natives from the federal Indian boarding school and the religious boarding school with their physical and sexual abuse experiences. This implies that tribal people in this generation experienced posttraumatic stress disorder in the boarding schools, following a childhood characterized by unregulated arousal, reactive attachment, and compromised behavioral immunity, and leading to an adulthood with higher incidence and prevalence of psychiatric disorders.

These Native boarding school era survivors raise and parent the next generation of tribal children with dysregulated arousal, reactive attachment, compromised behavioral immunity, anxiety, and depression (still within a crucible of ongoing postcolonial stress). Also, a further complicating factor has been introduced to the tribal communities: lateral violence becomes an issue in our Native community because tribal people bring this type of abusive tendency forward and act it out. This next generation of First Nations people goes forward with dysregulated arousal, reactive attachment, compromised behavioral immunity, and experiences of physical and sexual abuse. In the next section, we will examine the effects of overseas service and wartime posttraumatic stress disorder in the tribal communities.

Wartime PTSD, Tribal Termination, Neurodevelopment, Developmental Psychopathology, and Tribal People

Tribal people, as a subgroup, are the most decorated veterans of foreign war in this country. Native warriors have joined the U.S. Military and have gone to overseas conflicts and fought in battles for the United States with great ferocity, with the greatest incidence of being rewarded for being heroic. Uniquely, it was recently revealed recent federally funded research into the issues of wartime veterans was conducted in a manner

through which the areas of the war tribal veterans were assigned to fight in was not asked about or reported. Furthermore, there is evidence in the Congressional Record that a much higher percentage of Native and other minority solders were placed in the front lines in Vietnam (D. Walker, personal communication, June 27, 2002). Of course, these warriors come home with posttraumatic stress disorder to a cultural and historical experience of combined loss of language, loss of culture, loss of spirituality, introduction of sexual abuse, introduction of physical abuse, loss of community, and dispossession. Previously, we discussed the fact that their postcolonial childhood experiences within Native families in stress contributed to a higher potential of diysregulated arousal and compromised behavioral immunity. In turn, this predetermined a less than adaptive response to the war-induced posttraumatic stress experiences. In this case, our young Native war hero comes home to a terminated reservation.

Termination was a U.S. government experiment in managing the "Indian problem" by declaring that the reservation and tribal systems within which a given tribe lived or with which it was affiliated were null and void—that the tribe and all the tribal support systems no longer were recognized by the U.S. federal government and thus no longer existed (Ball, 1998). Passing a Congressional law that stated the tribe was so terminated preceded termination of a tribe. Subsequently, the tribal people's group holdings were "nationalized;" the Natives were given a few hundred dollars and told they're no longer Natives and their tribe no longer exists. These First Nations people were than exhorted to go about their business. In 1998, Ball published a dissertation in which he examined the effects of termination with respect to causing posttraumatic stress among the members of one native Native tribe. The police and other historical factors and postcolonial experiences carefully compared the effects of termination to other forms of posttraumatic stress disorder-inducing experiences that members of this tribe had experienced, including deaths of tribal members, violence. Following termination as a tribe, these tribal people provided test scores indicating a rate of posttraumatic stress disorder that was ten times that of the U.S. population at large.

As a result of tribal terminations, yet another source of tribal posttraumatic stress disorder exists. At this point, we have a generation with two more sources of post-traumatic stress disorder: overseas war service and tribal termination. Envision equal

opportunity trauma to our hypothetical native couple. He went to war and she went through a tribal termination experience. Alternately, she went to war and he went through a tribal termination experience. It matters little what the mechanism of induction was for the developmental insults; what is critical is that these developmental insults accrue in addition to the historical postcolonial stress and concurrent ongoing postcolonial stress effects on the family that forms when this couple marries.

Imagine yet another postcolonial stress-inducing effect at this time to our latest tribal family. This postcolonial stress-inducing experience is called relocation. Before they actually meet, this young couple is sent through the U.S. federal relocation project, as individuals from two different reservations, to the city. The relocation program is designed to help young tribal people assimilate into the Western economy and culture, by transporting them to the city and providing a small of amount of money to live on as they become established. What happens is that as he returns from war and is given a bus ticket to the city, and some "seed money" to begin a new life, she leaves the reservation because, as a result of termination, she no longer has a tribal setting within which to live.

Relocation, Alcohol and Alcoholism, Neurodevelopment, Developmental Psychopathology, and Tribal People

Both of the hypothetical Native individuals go to Los Angeles or Minneapolis or Seattle or wherever; no one speaks their language, it is difficult to communicate, and they don't have the skills to interact adequately in the highly commercialized Western economy and market. But, the young Native people meet, form a couple, and have a family in the city. Let's say they are now living in relocation in Los Angeles, a foreign country with respect to their history, beliefs, values, communication skills, etc.

What happens is that this young Native couple lives in poverty, due to lack of job skills and language skills and ongoing racism and oppression. What coping mechanism do they have in the city to deal with all of the internalized pain or to regulate arousal? Of course, beverage alcohol becomes the answer to internalized pain and dysregulated arousal. A generation of tribal people is now living in the cities and is using alcohol excessively to cope with their pain and unregulated arousal (postcolonial stress). This young Native couple continues to bring forward into their family interactions and to their children the physical abuse and the sexual abuse from lateral violence they have

experienced, the trauma of termination, the trauma of war, the trauma of relocation, the cumulative effects of postcolonial stress. As a result, this generation of Native children has dysregulated arousal, reactive attachment, and compromised behavior immunity as a basis to combine with whatever developmental insults occur to them.

Since there's beverage alcohol being used extensively in this generation of tribal people, as a result of cumulative postcolonial stress and internalized emotional pain, the first generation of Native adult children of alcoholics is created within their children. This underlies a further fragmenting of the psyches of tribal people. In addition, the first generation of Native people with alcohol-related neurological deficits secondary to maternal alcohol (and drug) abuse during pregnancy is born. Thus, another generation is created of Native people with dysregulated arousal, reactive attachment, compromised behavioral immunity, alcohol-related neurological effects, sexual abuse, physical abuse, and experience of complicated and subtle oppression. The dynamics of racism and oppression are becoming quite sophisticated, and as a result young tribal people begin internalizing that process and identifying with it as a self-image.

Implications for Research with Contemporary Tribal Communities

What are the issues of this generation of tribal people? Gangs and gang membership, alcohol, drugs, and the biased dominant culture child protection services and adoption. It is this generation of tribal people who may have a child of four years of age who is reported into the child protective service system because the parents are substance abusing. Substance abuse and parenting skills are an issue. But, this young tribal family is carrying a lot of weight from the past in the form of postcolonial stress effects and concurrent ongoing oppression. These young Natives might be contending with a gang membership issue, where it is dangerous for them to withdraw from the gang, but legally they must in order to retain their child. Their ability to parent might be compromised by needing to participate in a demanding temporary aid to needy families (TANF) system, while simultaneously completing an outpatient substance abuse treatment program that was never designed for Natives and is not a culturally appropriate route to abstinence and sobriety. These are the issues of the current First Nation generation in the U.S.A: poverty, substance abuse, psychiatric disorders, oppressive political and racial systems and agenda, culturally inappropriate child protection efforts

and treatment methods, and the cumulative effects of several generations of postcolonial stress.

For purposes of this paper what is the value of discussing postcolonial stress and the cumulative effects of historical trauma and postcolonial stress as related to native youth suicide prevention? Well, if we are conducting a serious inquiry that differentiates between tribal people and other disenfranchised groups in society, we must be specific and honest about the factors that contribute to that difference and to higher incidence and prevalence of suicide in the tribal communities among our youth.

Assessment and Prevention of Native Suicide

Of the aforementioned acting out behaviors secondary to compromised behavioral immunity, suicide is often the final resort for a native person overwhelmed with the emotional/affective pain of an attachment disorder, PTSD, or both. The very gesture of attempted suicide has a functional component: it is a means of coping with internal anguish, grief, depression, or PTSD. Paradoxically, once a tribal member's suicide is prevented, then that native person is subsequently further afflicted with the psychological pain of having attempted to take their life. Thus, assessing a native client's risk of suicide and acting to prevent it actually causes further issues for treatment. Culturally appropriate assessment and treatment of suicidal ideation and attempts might "open the door" for further services to suicidal tribal members.

It is the author's professional opinion that it is important to prevent native suicides. Fortunately, there are signs and symptoms and interviewing methods that can be used to assess the risk of suicide. Once a culturally competent professional has assessed the risk of suicide than appropriate steps can be taken to prevent the completion of that native individual's suicide. Following a successful preventative intervention into a tribal client's suicide, a structured treatment program can be developed to *address the initial emotional causes (compromised behavioral immunity or lessened resilience)* that underlie the tribal/native person's suicidal ideation.

Beneficial Systemic Influences

In the long run, it is critical to both prevent and or otherwise address the underlying emotional causes of native suicide, once the actual prevention and treatment

of suicide is accomplished. Further, the manifestation of tribal psychiatric and substance abuse issues can be positive impacted and changed by ancient, historical native cultural beliefs, values, spirituality, and ceremonial practices. Fortunately, the tribal community possesses effective historical, culturally relevant healing processes that can be integrated with western healing methods for the treatment and prevention of tribal behavioral, psychiatric, and substance abuse issues and problems.

Much like the disruptive historical influences that have affected tribal members in a negative manner, there are beneficial historical tribal healing influences. Paradoxically, it is often the actual acting out of behavioral health issues, such as suicide, psychiatric disorders, or substance abuse that force native people to examine and use their culturally-based strengths in a systemic manner to heal themselves. Let us openly acknowledge and discuss current tribal behavioral health issues, in a manner designed to focus on resolving and preventing these problems using culturally based healing processes integrated appropriately with modern behavioral methods.

Appendix A: Figure 1: Systemic Influences in Tribal Behavioral Health

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PART II.

Literature Review

Floerchinger (1991) suggested that unfamiliarity with bereaved clients' cultural beliefs and practices regarding death, dying, grief, and bereavement could undermine the therapeutic relationship, perhaps leading to poor outcomes. Indeed, lack of cultural familiarity or sensitivity among doctors, nurses, mental health practitioners, substance abuse counselors, and other helping professionals have been known to impact a wide range of clinical outcomes (A. Archambault, personal communication, 1997). For example, one physician repeatedly told a native patient diagnosed with diabetes, "You will die if you don't take your medication." In this patient's tribe, open discussion of death was thought to actually invite death. An expert in traditional tribal mores advised the physician to modify his comment as follows, "If you do take your medication, you will live." Subsequently, the native patient began complying with this medical directive, which was interpreted as being health-promoting (B. Toelken, personal communication,

1994). In another case, a female Hopi tribal member who was residing in San Francisco was brought to an urban hospital after cutting her arms, pulling out her hair, and reporting that she was hearing the voice of a recently deceased relative. Although the inter-disciplinary treatment team considered hospitalization, a psychologist familiar with Hopi people advised the treatment team that the woman was exhibiting culturally appropriate bereavement behavior. Rather than hospitalization, the intervention consisted of obtaining a bus ticket for her to return home to mourn the loss of her relative (Wheeler, personal communication, 1993).

The Value of Traditional Cultural Practices and Beliefs to Indigenous Communities

Several authors have suggested that support of traditional cultural practices is critical to the maintenance of health in tribal communities. For example, 20% of Office of Substance Abuse (OSAP) high-risk-youth demonstration projects have been awarded to Native American grantees (Augustson, 1990); cognizant of the importance of tribal beliefs, almost all grantees budgeted a portion of these funds for cultural enhancement activities. Indeed, DeJong (1991) reported that tribal members believe strongly that efforts aimed at increasing youths' knowledge of their cultural history, traditions, and values cultivates positive identity and pride. The restoration of traditional ceremonials has long been considered a health-promoting activity within native communities (Jilak, 1982).

Two recent studies of recovery from heart disease among indigenous patients examined the correlates of the following activities: hobbies (beadwork and leatherwork), praying (peyote meetings, Inipi[i], and Wiwanyag Wachipi), and social activities (hand games, gourd dances, and pow-wows). Involvement in these traditional tribal activities was associated with a reduction in patient stress, and improved recovery from heart problems (Miller, Johnson, & Garrett, 1982; Miller, Garrett, McMahon, Johnson, & Wikoff, 1985).

Tribal rituals and ceremonial practices have been utilized as intervention tools within some native mental health programs (e.g., Guilmet & Whited, 1987; Mitchell & Patch, 1986). For instance, Guilmet and Whited (1987) reported that at a tribal mental

health center in Washington (state), staff and clients used several traditional practices. These traditional practices included the use of cedar and sage smoke. Cedar and sage smoke (representing power), and prayers were considered useful in "spiritual" cleansing. Pipe ceremonies, traditional talking circles, southwest shamanic practices, and the Inipi were also used in this state of Washington tribal mental health program. The integration of traditional healing practices appeared to be related to greater numbers of native clients completing therapy.

Despite evidence that clinicians' knowledge about native beliefs and spiritual practices may contribute to successful health, mental health, and substance abuse treatment of indigenous people, many traditionally important tribal beliefs and practices have not been adequately documented. Do mental health-substance abuse professionals know what comprises culturally adaptive, versus maladaptive ways of coping among native people?

The Importance of Cultural Knowledge and Sensitivity

Numerous authors recommended that mental health and substance abuse professionals intending to serve native clients develop cultural knowledge and sensitivity. It is this present author's observation that because of the lack of trained mental health workers in "Indian county," that often substance abuse professionals are the only professional helpers within a given community. Therefore, often-native clients must turn to substance abuse counselors within their communities to receive services commonly thought of as being within the domain of mental health professionals. Mental health professionals in dominant culture communities typically provide one of these services, bereavement counseling. The development of cultural knowledge and sensitivity is important because of the challenges of providing services, such as psychotherapy, across cultural boundaries. "Cross-cultural therapy implies a situation in which the participants are most likely to evidence discrepancies in their shared assumptions, experiences, values, beliefs, expectations, and goals" (Manson & Trimble, 1982, p 149).

An exhaustive review of the material recommending the development of cultural knowledge and sensitivity as the basis of effective clinical work with indigenous clients exceeds the scope of this dissertation. However, it is important to summarize the central

premise underlying this research: Cultural knowledge and sensitivity about tribal cultures may be a prerequisite for effective clinical practice with tribal clientele. Therefore, a brief review of the literature was conducted. The current author located 15 studies discussing various aspects of the importance of cultural knowledge and sensitivity to the practitioner of clinical services in native communities. Although not likely exhaustive, several cultural arenas requiring knowledge and sensitivity of practice are presented in the section that follows: a) gender stereotyping and other issues of native women; b) genuine versus pseudo indigenous spirituality; c) use of tribal archetypes (Heyoka) in counseling; d) understanding family and community variables; e) becoming familiar with language differences; f) recognizing native methods of achieving social justice; g) traditional models of tribal "group therapy"; h) identifying the healthy use of peyote rituals; and i) observing the value of ceremonies for combat veterans.

Native Women in Research

Medicine (1988) writes that the native woman is usually portrayed in stereotypical fashion in the research literature, usually either as subservient drudges (the Plains Indian, male-dominated warrior culture), or as matriarchal matrons of an Eastern horticultural group. The true diversity of the lives of female tribal clients that exists beyond the stereotypical descriptions in the literature cannot be appreciated without cultural education. Though not identified, tribal social and work roles for Indian women are as individual and diverse as they are among women in the dominant culture. Certainly, practitioners can best serve female Indian clients if they take the time to learn more about this diversity. One area of importance, when studying native people to develop cultural knowledge and sensitivity, is that of spirituality.

Native women and spirituality. Kasee (1995) explained that reclaiming a positive sense of tribal spirituality and incorporating it into one's daily lifestyle is critical for native women recovering from mental health and substance abuse disorders. She lamented the difficulties caused by exploitation of tribal belief systems and ceremonials by charlatans and "plastic medicine men or women". Professionals working with tribal women must develop accurate cultural knowledge and sensitivity about the real versus ersatz types of indigenous spirituality to which female native clients might be exposed. Such knowledge may strongly influence the social support resources clinicians may rely

upon to assist these native clients.

Tribal Archetypes (Heyoka)

According to Herring (1994) understanding the meaning of various psychological archetypes, such as the clown or contrary figure (e.g., the trickster, a tribal archetype) might underlie the development of powerful mental health interventions for native clients. Such archetypes may be represented in the thoughts and feelings of Indian clients, and may be used by clinicians to illustrate points, make interpretations, etc. For example, historically, the role or meaning of the contrary figure (or trickster) was used to draw attention to the tendency of individuals or groups of tribal peoples to engage in "black and white" or overly polarized thinking or behavior. That is, the clown behaved in a satire or parody of the polarized thinking or behavior and called attention to it as a possible problem, in an indirect and non-threatening manner. Clinicians may use their knowledge of this archetype to help tribal clients gain insight into maladaptive, dichotomous thinking

Indeed, Herring (1994) strongly cautioned workers to recognize that there is always an underlying, metaphorical message carried within the humor of the clown figure. He only included a few lines about the Lakota contrary figure or "Heyoka" in his writings. However, if Herring's views are correct, it would be important to learn more about the metaphorical meaning and relevance of the Heyoka, in order to work effectively with Lakota clients. For example, telling a Lakota client a culturally appropriate story incorporating a Heyoka might be an effective means of providing an indirect and therefore, non-threatening confrontation.

Value of Tribal Affiliation and Spirituality

Garrett and Garrett (1994) suggested that mental health-substance abuse professionals must not separate native clients from their spirituality or affiliation with their tribal group. Therefore, it is incumbent upon workers to understand as much as possible about the meaning of tribal affiliation and spirituality to their clientele.

For example, tribal individuals often belong to historical clans or groups. These tribal groups or clans once had numerous roles that have changed over time. However, a native client may serve a traditional role within the tribe's historical clan system, or is

expected to participate in grieving according to a predetermined manner. Responsible clinicians would strongly support the client's full participation in these roles, particularly those who are clinically depressed because of bereavement.

Understanding Community and Family Variables

Horejsi, Heavy Runner-Craig, and Pablo (1992) described 12 situational, cultural, and community factors that might impact Child Protective Services (CPS) providers working with indigenous families. Of these 12 factors, three are important to discuss in this paper: Foster care, extended family structure, and living in a tribal community. First, it is doubtful that most clinicians in the dominant culture appreciate the fact that tribal cultures have no words for the concept of foster care (Cross, 1987). The extended family among Indian people is essential to tribal economies and the social fabric. If uninformed professionals attempt to promote foster care, they may be offering recommendations that are offensive, because the concept is at odds with tribal and family values. Rather, clinicians must realize that the extended family can be used to support clinical interventions and compensate for inadequacies in parenting skills among biological parents.

Silence and Language Issues

The phenomenon of interpersonal silence represents another area in which non-indigenous therapists likely need additional training. For example, therapists at a Seattle family therapy clinic were having difficulty communicating with a female native client. Following an observation of their interviewing methods, a consultant familiar with the client's culture recommended that the practitioners add several more seconds of silence after posing a question. Additional silence following a query was more familiar to the native woman, and she responded by becoming a more communicative and hard-working client (T. Tafoya, personal communication, 1995). Several authors have written about the value of silence as a safe or culturally appropriate response by a native client to unpredictable, uncontrollable, or unfamiliar situations such as counseling or psychotherapy (Guilmet, 1976).

Promoting active verbal interaction with clients is a value held by many training programs in the dominant culture. Aggressive pursuit of verbal dialogue with native

clients may be counter-productive, however. Often, there is a deeply held belief within native communities that it is inappropriate to notice or discuss another person's problems or personal issues. (Spindler & Spindler, 1957). Such tribal beliefs call into the question the common or general applicability of verbally based psychotherapy for this population (Guilmet & Whited, 1987).

Tribal Judicial Systems

Often, mental health-substance abuse professionals provide assessment reports and expert testimony to tribal courts. This occurs, despite the fact that such assessment methods are not normed on particular tribes, and are rooted exclusively in the judicial system of the dominant culture. Understanding the normative limitations of psychological tests and the value of tribal traditions in achieving social justice may be very important to practitioners working with tribal judicial systems.

Two recent articles argued that native communities have age-old and effective, formal methods of dispensing justice (Bluehorse & Zion, 1993; & Mansfield, 1993). For example, several traditional Northwest tribes recommend that traditional methods of justice (e.g., peacemaking) be formally reincorporated into the tribal court and used to supplant modern methods (Mansfield, 1993). Also, Bluehorse and Zion (1993) recommend the re-introduction of the Hozhooji Naat'aanii or Navajo justice and harmony ceremony. Mental health practitioners who work with tribal courts might benefit tribal justice systems by shaping their recommendations and testimony so as to support tribal traditions and values, rather than those more typically associated with normative testing outcomes.

Traditional Tribal "Group Therapies"

Within the dominant culture, practitioners regard group therapy as a popular, powerful method for effecting change in clients (Cohn & Osbourne, 1992; & Corey, 1990). Such methods can complement traditional native ceremonies and practices. For example, among the Lakota, there are two tribal ceremonies which bear similarities to group counseling work: the Inipi (Sweatlodge ceremony) and the "talking circle." The Inipi and talking circle are important ceremonies, which have elements in common with western group therapy models (Stone, 1994, unpublished manuscript). It has been suggested that these ceremonies be studied and recommended, at appropriate times, by

practitioners working with tribal clients (Garrett & Osbourne, 1995).

Appropriate Tribal Use of Peyote Rituals

Even within the American military, the Native American Church peyote religion has been accepted. For example, a recent general order allowed indigenous military personnel to practice the ritualistic use of peyote (Peninsula Daily News, April 14. 1997, p 7.) Clearly, the ethno-psychedelic use of peyote as a preferred treatment for alcohol dependence among native people has long been documented (Albaugh, 1974, Chuelos, 1959; MacLean, 1961; & Smith, 1958). However, such a native practice might be viewed as unhealthy or destructive by clinicians adhering to a (dominant culture) Alcoholic's Anonymous model, which strongly advocates total abstinence from all drugs. It would be gravely irresponsible for dominant culture health practitioners to automatically interpret a native client's use of peyote as an attempt to "escape or avoid reality" or responsibility for personal problems. However, given the fact that dominant culture training models shape the views of most mental health-substance abuse professionals, it might be difficult for these workers to attain the cultural sensitivity necessary to understand the relevance of the peyote ritual to native people.

Traditional Treatment for Post-Traumatic Stress

According to Scurfield (1995) and Silver (1994), the outcome of treatment for post-traumatic stress disorder (PTSD) manifested by tribal Vietnam veterans has been clearly improved by the addition of indigenous beliefs and rituals. Both of these authors stressed the importance of integrating traditional native practices and beliefs into the treatment of indigenous Vietnam veteran's exhibiting PTSD symptoms. For example, both Scurfield (1995) and Silver (1994) reported that the addition of the native sweat lodge ceremony or Inipi benefited tribal veterans. Uniquely, beneficial effects of integrating the Inipi and other traditional tribal rituals into the formal treatment model also proved salutary for dominant culture Vietnam veterans.

Summary

In summary, there is sufficient documentation in the literature to justify the suggestion that mental health-substance abuse professionals need to develop cultural

knowledge and sensitivity. Furthermore, it naturally follows that specific tribal clientele would benefit from culturally specific knowledge and sensitivity among practitioners. Therefore, it was deemed important to conduct the present research project to inform professionals about contemporary and traditional native/tribal and western mental health and substance abuse treatment beliefs and practices. Many of the clinical practices of mental health workers in the dominant culture may or may not be consistent with the indigenous culture. Also, culturally sensitive clinicians may best help tribal clients by encouraging their involvement in particular native ceremonies and practices.

Assessment and prevention of native youth suicide should be emphasized as a clinical need for tribal communities. Funding needed for this effort is critical. Of great importance is understand that the underlying mechanisms of unregulated arousal and compromised behavioral immunity secondary to historical trauma and post-colonial stress continue to influence the current incidence and prevalence of native youth suicide. Ameliorating the effects of post-colonial stress and historical trauma in the native communities is possible, but, it must be done in a manner that incorporates the full input of the aboriginal communities and which takes advantage of the resiliencies, strengths, and spirituality of those indigenous communities in combination with demonstrated best practices and scientific methods (May et al, 2005).

References

Albaugh, B.J., & Anderson, P.O. (1974). Peyote in the treatment of alcoholism among American Indians. American Journal of Psychiatry, 131(11), 1247-1251.

Amini, F., Lewis, T., Lannon, R., Louie, A., Baumbacher, G., McGuinness, T., & Schiff, E.Z. (1996). Affect, Attachment, Memory: Contributions toward Psychobiologic Integration. *Psychiatry, 59*, 213-239.

Augustson, K.L. (May 21, 1990) [Memorandum to Thomas R. Burns, Special Assistant to the Director, Alcoholism and Substance Abuse Branch, Indian Health Service].

Ball, T. (1998). *Prevalence Rates of PTSD and Lifetime Trauma in an Adult American Indian Sample.* Unpublished Dissertation, University of Oregon

Birch, M. (1999) *Attachment Issues and Attachment Disorders in Children: Clinical Training for Port Angeles, Washington Child Protective Service (CPS)* Attended a 12-hour training in Port Angeles, Washington, June 4, 22, & July 13.

Bluehorse, P., & Zion, J.W. (1993). Hozhooji naat'aanii: The Navajo justice and harmony ceremony. Special Issue: Native American Perspectives on Peacemaking. Mediation Quarterly, 10(4), 327-337.

Brown, L.S. (1991). Not outside the range: One feminist perspective on psychic trauma. *American Imago, 48*(1), 119-133.

Brown, L.D., & Tandon, R. (1983). Ideology and political economy in inquiry: Action research and participatory research. *The Journal of Applied Behavioral Science, 19*(3), 277-294.

Brydon-Miller, M. (1997). Participatory action research: Psychology and social change. *Journal of Social Issues, 53*(4), 657-666.

Chuelos, N., Blewett, D.B., Smith, C.M., & Hoffer, A. (1959). Use of d-lysergic acid diethylamide in the treatment of alcoholism. American Journal of Studies on Alcohol, 20, 577-590.

Coen, C.W. (Ed.). (1985). *Functions of the Brain.* Oxford: Clarendon Press.

Cohn, B, & Osbourne, W.L. (1992). Group Counseling: A Practical Self-Concept Approach for the Helping Professional. Chappauqua, NY: LS Communications.

Corey, G. (1990). Theory and Practice of Group Counseling (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Cross, T. (1987). Cross-Cultural Skills in Indian Child Welfare: A Guide for the Non-Indian. Portland, Oregon: Northwest Indian Child Welfare Association, Inc.

Dubowitz, H., Black, M., Harrington, D., & Verschoore, A. (1993). A follow-up study of behavior problems associated with child sexual abuse. *Child Abuse and Neglect, 17*, 743-754

Duran, E. (1984). *Archetypal Consultation: A Service Delivery Model for Native Americans*. New York: Peter Lang.

Duran, E., & Duran, B. (1995). *Native American Post-Colonial Psychology*. Albany, NY: State University of New York Press.

Emde, R.N., & Buchsbaum, H.K. (1989). Toward a psychoanalytic theory of affect: II. Emotional development and signaling in infancy. In S.I. Greenspan & G.H. Pollock (Eds.), *The Course of Life: Vol 1. Infancy*. Madison, CT: International Universities Press.

Fair, C.M. (1992). *Cortical Memory Functions*. New York: Norton.

Fisher, P, A., & Ball, T. (2002a). Redefining the relationship between researchers and American Indian/Alaska Native communities: Native American postcolonial participatory action research. Manuscript submitted for publication.

Fisher, P.A., & Ball, T. (2002b). The Indian Family Wellness project: An Application of the Tribal Participatory Research Model. *Prevention Science, 3*(3), 233-238.

Ford, J.D. (1999). Disorders of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or co-morbid but distinct syndromes. *Journal of Consulting and Clinical Psychology, 67*(1), 3-12.

Ford, J.D., & Kidd, P. (1998). Early childhood trauma and disorders of extreme stress as predictors of treatment outcome with chronic posttraumatic stress disorder. *Journal of Traumatic Stress, 11*(4), 743-761.

Floerchinger, D.S. (1991). Bereavement in late adolescence: Intervention on college campuses. Special issue: Death and adolescent bereavement. Journal of Adolescent Research, 6(1), 146-156.

Gagne, M.A. (1998). The role of dependency and colonialism in generating trauma in First Nations citizens: The James Bay Cree. In Y. Danieli (Ed.), *International Handbook of Multigenerational Legacies of Trauma (pp. 355-372).* New York: Plenum Press.

Garrett, J.T., & Garrett, M.W. (1994). The path of good medicine: understanding and counseling Native American Indians. Journal of Multicultural Counseling and Development, 22, 134-144.

Garrett, M.W., & Osbourne, W.L. (1995). The Native American sweat lodge as metaphor for group work. The Journal for Specialists in Group Work, 20(1), 33-39.

Gazzaniga, M. & LeDeux, J. (1978). *The Integrated Mind.* New York: Plenum Press.

George C. (1996). A representational perspective of child abuse and prevention: Internal working models of attachment and caregiving. *Child Abuse and Neglect, 20*(5), 411-424.

Green, A.H. (1995). Comparing child victims and adult survivors: Clues to the pathogenesis of child sexual abuse. Journal of the American Academy of Psychoanalysis, 23(4), 6655-670

Greenspan, S.I. (1981). *Psychopathology and Adaptation in Infancy and Early Childhood.* New York: International Universities Press.

Guilmet, G.M. (1976). The nonverbal American Indian child in the urban classroom. Unpublished Doctoral Dissertation, Department of Anthropology, University of California, Los Angeles.

Guilmet, G.M., & Whited, D.L. (1987). Cultural lessons for clinical mental health practice: The Puyallup tribal community. American Indian and Alaska Native Mental Health Research, 1(2), 32-49.

Heineman, T.V. (1998). *The Abused Child: Psychodynamic Understanding and Treatment.* New York: The Guilford Press

Herman, J.L. (1992). *Trauma and Recovery.* New York, NY: Basic Books, Inc.

Herring, R.D. (1994). The clown or contrary figure as a counseling intervention strategy with Native American Indian clients. Journal of Multicultural Counseling and Development, 22, 153-164.

Horijsi, C., Heavy Runner-Craig, B., & Pablo, J. (1992). Reactions by Native American parents to child protection agencies: Cultural and community factors. Child Welfare, 71(4), 329-342.

Jilak, W.G. (1982). Indian Healing: Shamanic Ceremonialism in the Pacific Northwest Today. Surrey, British Columbia, Canada: Hancock House Publishers, Inc.

Kasee, C.R. (1995). Identity, recovery, and religious imperialism: Native American women and the new age. Special Issue: Women's Spirituality, Women's Lives. Women & Therapy, 16(2-3), 83-93.

Krystal, H. (1990). An information processing view of object-relations. *Psychoanalytic Inquiry, 10*, 221-251

Krystal, H. (1991). Integration and self-healing in post-traumatic states: A ten-year retrospective. *American Imago, 48*(1), 93-118

Last, U., & Klein, H. (1984). Impact of parental Holocaust traumatization on offspring's reports of parental child-rearing practices. *Journal of Youth and Adolescence, 13*(4), 267-283.

Lewis, E.W., Duran, E., & Woodis, W. (1999). Psychotherapy in the American Indian population. *Psychiatric Annals, 29*(8), 477-479.

Locust, C. (1995). The impact of differing belief systems between Native Americans and their rehabilitation service providers. [Special double issue: Spirituality, disability, and rehabilitation.] *Rehabilitation Education, 9*(2-3), 205-215.

May, P.A., Serna, P., Hurt, L., & DeBruyn, L.M. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian Tribal Nation. *American Journal of Public Health, 95*(7), 1 – 7.

McTaggart, R. (1991). Principles for participatory action research. *Adult Education Quarterly, 41*(3), 168-187.

MacLean, J.R., MacDonald, D.R., Byrne, U.P., & Hubbard, A.M. (1961). The use of LSD-25 in the treatment of alcoholism and other psychiatric problems. American Journal of Studies on Alcohol, 22, 34-45.

Mansfield, E. (1993). Balance and Harmony: Peacemaking in Coast Salish tribes of the Pacific Northwest. Special Issue: Native American Perspectives on Peacemaking. Mediation Quarterly, 10(4), 339-353.

Manson S.M., & Trimble, J.E. (1982). Toward an understanding of American Indian concepts of mental health: Some reflections and directions. In A. Marsella & P. Pederson (Eds.), Intercultural Applications of Counseling and Therapies. Beverly Hills, CA: Sage.

Medicine, B. (1988). Native American (Indian) women: A call for research. Anthropology & Education Quarterly, 19, 86-92.

Miller, P., Johnson, N., & Garrett, M. (1982). Health beliefs of and adherence to the medical regimen by patients with ischemic heart disease. Heart and Lung, 11(4), 332-339.

Miller, P. Garrett, M., McMahon, M., Johnson, N. & Wikoff, R. (1985). Coping methods and societal adjustment of persons with cardiovascular disease. Health Values, 9(4), 10-13.

Mitchell, W., & Patch, K. (1986). Religion, spirituality, and the recovery of Native American alcoholics. IHS Primary Health Care Provider, 11, 129.

Nadler, A., Kav-Venaki, S., & Gleitman, B. (1985). Transgenerational effects of the holocaust: Externalization of aggression in second generation holocaust survivors. *Journal of Consulting & Clinical Psychology, 53*(3), 365-369.

Nagle, J.K. (1988). Unresolved grief and mourning in Navajo women. *American Indian & Alaska Native Mental Health research, 2*(2), 32-40.

Nieuwenhuys, R., Voogd, J., & van Huizen, Chr. (1981). *The Human Central Nervous System* (2nd rev. ed.) Berlin: Springer

Noshpitz, J., & King, R. (1991). *Pathways of Growth: Essentials of Child Psychiatry: Vol. I. Normal Development.* New York: Wiley.

Papuz, J.W. (1937). A proposed mechanism of emotion. *Archives of Neurological Psychiatry, 38*, 725-743.

Park, P. (1999). People, knowledge, and change in participatory research. *Management Learning, 30*(2), 141-157.

Post, B. (2002). Education and the child of trauma. www.bryanpost.com/articles/edutrauma.htm

Rakic, K. (1991). Development of the primate cerebral cortex. In M. Lewis (Ed.), *Child and Adolescent: A Comprehensive Textbook.* Baltimore: Williams & Wilkins.

Rowland-Klien, D., & Dunlop, R. (1998). The transmission of trauma across generations: Identification with parental trauma in children of Holocaust survivors. *Australian and New Zealand Journal of Psychiatry, 32*(3), 358-369.

Sack, W.H., Clarke, G.N., & Seeley, J. (1995). Posttraumatic stress disorder across two generations of Cambodian refugees. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(9), 1160-1166.

Schore, A. (1994). *Affect Regulation and the Origin of Self: The Neurobiology of Emotional Development.* Hillsdale, N.J.: Lawrence Erlbaum.

Scurfield, R.H. (1995). Healing the warrior: Admission of two American Indian war-veteran cohort groups to a specialized PTSD unit. American Indian & Alaska Native Mental Health Research, 6(3), 1-22.

Silver, S. (1994). Lessons from child of water. American Indian & Alaska Native Mental Health Research, 6(1), 4-17.

Slaby, A.E. (1991). Dual diagnosis: Fact or fiction. In M.S. Gold & A.E. Slaby (Eds.), Dual Diagnosis in Substance Abuse (pp. 3-29). New York: Marcel Dekker, Inc.

Smith, C.M. (1958). A new adjunct to the treatment of alcoholism: the hallucinogenic drug. American Journal of Studies on Alcoholism, 19, 406-417.

Spindler, G., & Spindler, L. (1957). American Indian personality types and their socio-cultural roots. Annals of the American Academy of Political and Social Science, 311, 148-149.

Stern, D.N. (1985). *The Interpersonal World of the Infant.* New York: Basic Books.

Stone, J.B. (2002). Focus on post-colonial issues in research: Developing and implementing Native American postcolonial participatory action research (pp. 98 – 122) in Davis, J.D., Erickson, J.S., Johnson, S.R., Marshall, C.A., Running – Wolf, P., & Santiago, R.I. (Eds.). (2002). *Work Group on American Indian Research and Program Evaluation Methodology (AIRPEM) Symposium on Research and Evaluation Methodology: Lifespan Issues Related to American Indians/Alaska Natives with Disabilities.* Flagstaff: Northern Arizona University, Institute for Human Development, Arizona University Center on Disabilities, American Indian Research and Training Center.

Stone, J.B. (1998). Traditional and contemporary Lakota death, dying, grief, and Bereavement beliefs and practices: A qualitative study. Utah State University: Unpublished Dissertation.

Stone, J.B. (1994). The American Indian sweat bath ceremony: A brief description, Unpublished Manuscript, Psychology Department, Utah State University, Logan, Utah.

van der Kolk, B.A. & Fisler, R.E. (1994). Childhood abuse and neglect and loss of self-regulation. *Bulletin of the Menniger Clinic, 58*(2), 145-168.

van Ijzendroon, M.H. (1995a). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin, 117*, 347-403.

van Ijzendroon, M.H. (1995b). Of the way we are: On temperament, attachment, and the transmission gap: A rejoinder to Fox. *Psychological Bulletin, 117*, 411-415

van Ijzendoorn, M. H., & Bakermans-Kranenburg, M.J. (1997). Intergenerational transmission of attachment: A move to the contextual level. In L. Atkinson & K.J. Zucker (Eds.) *Attachment and Psychopathology*. New York, NY: The Guilford Press.

van Ijzendroon, M.H., Juffer, F., & Duyvesteyn, M.G.C. (1995). Breaking the intergenerational cycle of insecure attachment: A review of the effects of attachment-based interventions on maternal sensitivity and infant security from a contextual perspective. *Journal of Child Psychology and Psychiatry, 36*, 225-248.

Walters, K.L., & Simoni, J.M. (1999). Trauma, substance abuse, and HIV risk among urban American Indian women. *Cultural Diversity & Ethnic Minority Psychology, 5*(3), 236-248.

Weissberg, R.P., & Greenberg, M.T. (1998). Prevention science and collaborative community action research: Combining the best from both perspectives. *Journal of Mental Health, 7*(5), 470-492.

Weaver, J.N., & Yellow Horse Brave Heart, M. (1999). Examining two facets of American Indian identity: Exposure to other cultures and the influence of historical trauma. *Journal of Human Behavior in the Social Environment,* 2(1), 19-33.

Whyte, W.F., Greenwood, D.J., & Lazes, P. (1989). Participatory action research: Through practice to science in social research. *American Behavioral Scientist, 32*(5), 513-551.

Wisner, B., Stea, D., & Kruks, S. (1991). Participatory and action research methods. In E.H. Zube & G.T. Moore (Eds.), *Advances in Environment, Behavior, and Design*. Edmonton, OK: Environmental Design Research Association.

Yehuda, R., Schmeidler, J., Elkin, A., Wilson, S., Siever, L., Binder-Brynes, K., Wainberg, M., & Aferiot, D. (1998). Phenomenology and psychobiology of the intergenerational response to trauma. In Y. Danieli (Ed.), *Intergenerational Handbook of the Multigenerational Legacies of Trauma* (pp. 639-655). New York, NY: Plenum Press.

Yellow Horse Brave Heart, M (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention. *Smith College Studies in Social Work, 68*(3), 288-305.

Zeanah, C.H., Finley-Belgard, E., & Benoit, D. (1997). Intergenerational transmission of relationship psychopathology: A mother-infant case study. In L. Atkinson & K.J. Zucker (Eds.) *Attachment and Psychopathology*. New York, NY: The Guilford Press

Zlotnick, C., Zakriski, A.L., Shea, M.T., & Costello, E. (1996). The long-term sequelae of sexual abuse: Support for a complex posttraumatic stress disorder. *Journal of Traumatic Stress, 9*(2), 195-205

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[i] Important traditional native ceremonial practices are referred to by their tribal names for two reasons: 1.) respect for tribal cultures and spiritual beliefs of indigenous people; 2.) to familiarize the readers with these terms

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United States Senate Committee
On Indian Affairs
Washington DC 20510 – 6450

Dear Committee Members:

I would like to thank the committee for their interest in behavioral health issues and suicide in the American Indian Community and I will respond to two questions posed by Vice Chairman Dorgan in a fax dated June 24, 2005.

Senator Dorgan stated that, "I am a strong supporter of the Indians Into Psychology Program. I was pleased to see your recommendations include expanding that program significantly. How do you think the federal government can encourage more American Indians and Alaska Natives to enter the mental health field?

I was trained at Utah State University, Logan Utah, in the American Indian Support Project in Psychology followed by an internship at the Sturgis South Dakota Fort Meade Veterans Affairs Medical Center (including a rotation at the Rapid City Indian Health Service Hospital – the Sioux San Inpatient Mental Health Treatment Program). Currently, there are four training sites in the country dedicated to supporting and training native Psychologists: The Indians Into Psychology Doctoral Education (INPSYDE) at the University of North Dakota, the Indians Into Psychology (InPsych) at Montana State University, the American Indians Into Psychology (AIIP) training program at Oklahoma State University, and the American Indian Support Project in Psychology at Utah State University. The first three programs mentioned are funded under public law: Section 217, Title H of Public Law 102-573. The Utah State program is not an IIP program, but could benefit from becoming integrated into the funding umbrella that feeds to IIP sites. Currently, 0.4% of members of the American Psychological Association (APA) are native, 0.5% of APA associates are tribal, and 0.4% of fellows of the APA are indigenous. The total percentage of APA members whom are of aboriginal background is 0.4%. Thusly, there exists a huge gap between the need for competent mental health

providers and psychologists of indigenous heritage in the tribal community and the actual number of aboriginal providers capable of filling that role.

Several things might happen to encourage tribal members to enter into professional mental health training:

- Increase the number of Indians Into Psychology training sites from three to six
- Locate Indians Into Psychology training sites at fairly equidistant placements from one another that are contiguous to areas of larger tribal population
- Increase the federal support for the Utah State University American Indian Support Project
- Develop a centralized clearing house to evaluate applications and to help potential Native students whose performance is marginal for advancement in a rigorous psychology training program into remedial preparatory experiences or into alternative types of professional mental health training, such as: Social Work or Psychosocial (Psychiatric Nurse Practitioner) Nursing. These types of training programs are typically of shorter duration and require a different form of academic preparation and different level of skill and capacity to complete.
- Funding for dedicated training in counseling, social work, and/or psychosocial nursing at the master's level should be created and funded at various university sites in this country.
- A pipeline from the Psychology Doctoral training program into tribally and native relevant Pre-doctoral internship sites might be established.
- Fiscal support of the Native Student must recognize that often such students are more mature and have greater fiscal burdens and responsibilities then the average matriculated graduate student.
- Loan forgiveness programs must be universal and easily accessed by newly degreed native psychologists and other native mental health practitioners
- The Indian Health Service Loan repayment program should not be so restricted; the IHS loan repayment funding must be robust enough to allow for newly degreed native psychologists to access from urban placements and from non-hardship placements. This IHS loan repayment funding must be robust enough to allow all trained native psychologists to easily access it. When roadblocks appear within the system, the newly degreed students should have an ombudsman from outside the IHS who can facilitate their capacity for IHS loan repayment
- Salaries for instructors in the InPsych programs must be made competitive with those paid to IHS field workers or psychologists in the private sector.
- Begin encouraging interest in mental health in grade schools, middle schools, and high schools, with a large emphasis on working with undergraduates and possibly increased funding for the final two years of undergraduate training for promising young native scholars.
- Exposure to the IHS system and clients for pre-doctoral training.
- Development of dedicated post-doctoral training in several specialty areas, such as neuro-psychology, forensic psychology, child or pediatric psychology,

substance abuse treatment and assessment, and health system management and public health.

- Provision of summer mentoring programs to promising students
- Development of liaison and interdisciplinary training tracks
- Increased outreach and recruiting – possibly a dedicated position for this within the Indian Health Service
- Funding to support adequate infrastructure and support to Native students once they are accepted and progressing in their respective training programs

Thank you for your question regarding encouragement of tribal people into the mental health field, if you have any further questions, please call (503) 871-3101.

Sincerely

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Dear Committee Members:

I would like to thank the Senate Committee on Indian Affairs for their interest in behavioral health issues and suicide in the American Indian Community and I will respond to two questions posed by the Committee Vice Chairman Senator Dorgan in a fax dated June 24, 2005. This response is to the second question posed by Senator Dorgan.

Senator Dorgan asked, "In your experience, how significant a factor is the involvement of alcohol and other drugs in contributing to suicide among Indian youth? Do you have any suggestions for how we try to address alcohol and drug abuse in the context of suicide prevention?

In response to this question, let me briefly talk openly about myself and my history. I am an enrolled tribal member of the Blackfeet Nation on my mother's side of the family and a descendent of the Turtle Mountain Chippewa and Lakota tribes from my father. As a child, I was faced with the impact of parental alcoholism, which affected both my father and mother deeply and strongly influenced their behavior. Neither ever freed themselves from the effects of beverage alcohol and my biological father died recently in an alcohol related automobile accident at age 70. My mother continues to drink and this continues to adversely affect her health. My father left me early on, prior to my birth and was married several times. My mother remarried, to a Montana cowboy with much love for his children, my brothers and sisters and I, but also a serious drinking problem (common enough where I came from). One of my biological father's marriages resulted in the birth of several other brothers and sisters, who were also affected by his drinking and other wild behaviors. My youngest brother, Mike Desjarlais (August, 1978) from my father's side of the family committed suicide at age eighteen:

Mike Desjarlais: February 1960 – August 1978

Of all my family members, you are the one who has most often crossed my mind and lead me to wonder who, what, how, and most poignantly, why... So, I've asked our brothers and our father that question. Our father said it was a puzzle and that you were watching that DeNiro film: The Deer Hunter, over and over. One brother remembers a strong willed and independent little boy and he said that you had a look in your eye that did not fit in the last photo that he saw... He still sees you in his dreams. One brother remembers that you were always playing tricks on people and full of humor...you were supposed to be with him the next weekend and that the event was all shrouded in mystery and controversy.

For me, it was the wondering why that accompanied a sense of loss... I realize that in part asking myself, why, has shaped who I've become. I've thought a lot about Native people and Tribal families and their losses and the manner of these things. So, I've written down what I think begins to answer the why, at least for me, in this paper. This paper is for you, little brother, and it is for all the injured young First Nations men and women who have chosen to take the path of suicide. In the beginning, to try and understand why, I hope that I am honoring you ... all of you. The Shawnee poet wrote about an elder, Horse Man, who had passed over:

> *I have seen the rain speak and the wind dance. I have seen the lightning knife cut the sky. I have seen the hills at the first light of day whispering secrets in the Southwind People's ears. I am happy now. I am no longer thirsty. I dance a warrior's dance. I am not sick, I am free. This night, I dream a new dream. Now, I come to drink the stars! (Jennifer Pierce Eyen, 1997).*

In time, we will dance that warrior's dance together ... "Ike".

The version of the paper which I referred too in this description of my brother's death by suicide and the effect on me was included in my written testimony. Additionally, drugs and alcohol were implicated in Mike's life and his death. Furthermore, all of my brothers and sisters on both sides of my family – maternal and paternal – have experienced drug and alcohol problems and issues as have I. It was alcohol and drug dependence that lead me to treatment. Treatment lead to sobriety and abstinence, which that opened the door to success at the university. I was re-introduced to my cultural identity as a tribal person while at the university and became interested in helping other native people gain abstinence and reconnection with their cultures and selfhood. This kindled an interest in psychology and that lead to an undergraduate degree and acceptance into the Utah State University American Indian Support Project in Psychology. While attending there, I

began to formulate the historical trauma and post-colonial stress path analysis theory which I elaborated on in the written testimony. It is absolutely critical that I do not further elaborate on my experiences with native youth substance abuse and suicide issues without first clarifying the intergenerational context within which these tribal youth alcohol and drug and suicide issues matriculated. This is more then a clinical and theoretical path analysis of cause and effect, it is the personal story of my family and I. I will share an abridged version here, and subsequently provide a direct response to the question.

The genesis of the disturbing alcohol and drug and suicide statistics and behavioral issues in the tribal community that often result in native youth suicide that I discussed in the oral and written testimony is the cumulative intergenerational effect of historical trauma and chronic situational stress surrounding native families and communities (post-colonial stress) described in this appendix and more fully in appendix two. A brief description of post-colonial stress and historical trauma follows.

Unregulated Arousal (UA): The less than adequate control of affect or emotion that develops in a child if the parent is surrounded by situations that cause chronic unremitting stress (post-colonial stress or historical trauma), anxiety (Posttraumatic Stress Disorder), major depression (as a result of uncontrolled internal feelings of anxiety or unremitting chronic external situational stress), or substance abuse (often initiated to cope with the emotional residual of post-colonial stress or historical trauma). Because the parent is so busy coping with situations of unremitting stress or historical trauma (including economic, social, or political oppression) in the moment, that parent sacrifices their capacity to provide a fully adequate developmental framework within the family or community for the child. Thusly, due to parenting styles impacted by chronic stress and oppressive environmental situations, the child does not receive adequate parental interaction to stimulate optimal development of the limbic system in the center of the child's brain never learns to control the arousal and thus unregulated arousal develops. Adult tribal people impacted by post-colonial stress and historical trauma often develop anxiety, depression, substance abuse patterns, and therefore have difficulty providing an adequate developmental. The consequence of chronic situational stress surrounding native adults, families, and communities from post-colonial stress and historical trauma sets-up and perpetuates an intergenerational cycle of unregulated arousal leading to lowered resilience to situational psychological insults and traumas and increased risk of developing and exhibiting behavioral disorders as adults (compromised behavioral immunity).

Compromised Behavioral Immunity (CBI): The result of unregulated arousal during a child's development is compromise to brain function, creating a brain that is susceptible to further developmental insults. Thusly, the developing native individual is more likely to develop psychopathology as a result of situational determinants. As each generation of

tribal people grows up, further incidents and situations of historical trauma, chronic post-colonial stress (oppression, racism, economic, social, and cultural deprivation) cause further anxiety and depression within tribal families and communities surrounding developing native children furthering the cycle of unregulated arousal and compromised behavioral immunity across generations (graphically in the example below, with the generations labeled one to five described in paragraphs in the following section).

Intergenerational Pattern of Historical Trauma and Post-Colonial Stress

1.) ----- Dispossession and Biological Warfare (Smallpox) -----

2.) ----- Indian Wars (Example: Sand Creek Massacre) -----

3.) ----- Federal Residential Schools & Religious Boarding Schools -----

4.) ----- Foreign Wars, Termination & Relocation -----

5.) ----- Crystal Methamphetamine & Gangs ------

1.) Five hundred years ago, when the colonists arrive, the processes of forced removal from homelands and use of biological warfare to disseminate tribes by providing them with infected blankets causing smallpox leads to the first generation of chronic stress surrounding native individuals and families. Child-rearing takes second place to survival and children experience increased unregulated arousal and compromised behavioral immunity, become vulnerable to further direct psychological impacts and insults. One issue is the perceived failure of native spiritual and healing methods and ways (because of new foreign germs, tribal people have no immunity and therefore previously effective methods of psychologically activating their immune systems through ceremony are not longer effective interventions to disease). This is the first generation of posttraumatic stress leading to depression, impacting parenting, and setting up an environment of chronic stress leading to developmental unregulated arousal and compromised behavioral immunity for the next generation of tribal peoples.

2.) This next generation of natives experiences the Indian wars with many battles and many massacres of native people and communities causing further psychological insult and emotional injury (posttraumatic stress) to a people who have now experienced a generation of unregulated arousal and compromised behavioral immunity and whom are thusly both more vulnerable to psychiatric symptoms and are therefore more likely to

exhibit less adequate parenting within the current generational crucible of chronic stress surrounding tribal families and communities.

3.) This third generation of tribal people brings forward the unregulated arousal and compromised behavioral immunity and subsequently experiences the Federal Boarding School system and its' effects on Indian men, particularly the impact of physical abuse and sexual abuse, thusly setting up and condition the behavior of the next generation of Indian men who return to their communities using learned physical violence to control wives and children and to acting out learned sexual abuse as incest in their families and communities (physical violence to children, such as occurred in the boarding schools to both native boys and girls). In addition, the religious boarding schools had similar effects on tribal children, including sexual abuse and physical abuse, thus setting up these children to become the next generation of child sexual abusers and perpetrators physical violence and decreased capacity to protect their children.

4.) Clearly, this fourth generation of American Indian men continued bringing their own PTSD, unregulated arousal and compromised behavioral immunity and subsequently developed wartime post traumatic stress secondary to their U.S. military experiences and as victims of physical and sexual abuse in their homes from parents who had learned these behaviors in the Federal and religious boarding school systems. This is the first generation of incest on Indian women, resulting in posttraumatic stress from parents who learned sexual abuse in the boarding school systems. This is the generation of tribal people that experiences the increased use of beverage alcohol to cope, when relocated to the cities from the reservations (another failed Federal program). Thusly the beginning of Adult Children of Alcoholics in the tribal communities and the first generation of tribal families with children exposed to alcohol in utero, therefore the next generation is the first generation of alcohol related neurological disorder in native communities.

5.) This is the current generation of tribal people, bringing forward the deep seated intergenerational effects of post-colonial stress and historical trauma: unregulated arousal, compromised behavioral immunity, issues of being raised in alcoholic families, and issues with alcohol related neurological disorders. This generation of tribal people now experience issues with crystal methamphetamine and gang involvement. This generation's native adolescents react to the intergenerational effects of historical trauma and post-colonial stress by an enormous vulnerability to suicidal ideation and suicide.

Conclusion: Historical trauma and post-colonial stress factors that have affected native individual development and family functioning across generations in the current native youth's behavior with a concurrent lack of economic parity and opportunity, general health disparities, trauma to individuals and families, substance abuse, and individual, family, and community psychological functioning to contribute the individual and community vulnerability to suicide amongst native people. These various mechanisms of

internalized trauma and its' effects and the current situational determinants of tribal youth influence the presentation and exhibition of psychopathology and behavioral disorder when tribal youth present for treatment in the mental health and substance abuse systems. Finally, it is the cumulative effects of tribal history, trauma experienced by tribal persons while raising their children, and situational chronic stress that has constantly surrounded native families that leads too and underlies the current epidemic of tribal youth mental health and substance abuse issues and suicide.

Ultimately, it is the attainment of a positive internal self-image integrating bi-cultural competence and native/tribal identity integrated with solid behavioral treatment that best benefits these clients. This must be community defined, developed, implemented, and modified as need to facilitate healing for indigenous clients and patients. The cause of native youth suicide are natural consequences of history (historical trauma and post-colonial stress) and the answers to solving the current symptom of this these historical factor: native youth suicide lies in and acknowledge of this and the effects and in tribal self-determination and recapturing of native spirituality and cultural identity as defined by each tribal unit.

Alcohol, Drugs, and Suicide in Tribal Youth

It has been my experience that the use of alcohol and drugs among tribal youth is a form of coping with two simultaneous ongoing issues: 1.) the current social, economic, and emotional contexts within which they find themselves and 2.) the intergenerational emotional effects of historical trauma and post colonial stress which impacts them internally and often without reference to cause (it is an unrecognized source of internal emotional pain). Thusly, alcohol and drugs provide a buffer against cognitive perceptions of helplessness and hopelessness and a buffer against the internalized emotional consequences of history.

Typically, youth who are referred to see me individually or within one of the programs I manage are diagnosable with both a substance abuse and mental health disorder. Suicide and suicidal ideation are typically ways these youth conceive managing or disconnecting from their emotional pain. In my experience the majority of completed suicide or attempted suicide among tribal youth occurs during alcohol or drug abusing periods of time. Thusly, we must provide adequate alcohol and drug treatment in order to help ameliorate the rate of native youth suicide.

However, this alone is insufficient. Two critical aspects of treatment must be integrated and applied. First, entire tribal communities must develop a robust cognitive understanding of the issues of historical trauma and post-colonial stress, not as a mechanism for placing blame, but as a means of understanding the self. Secondly,

communities must define their individual tribally specific methods for recapture of their self-hood as native peoples. This means a reintegration of cultural identity and cultural values, beliefs, and practices to the extent that the community defines it as health enhancing.

Programmatic responses must be directed to the individual youth suffering from alcohol and drug related behaviors, but must be extended to the healing of the entire community. These efforts, by definition, will require vast resource allocation and support. Such efforts must be by tribal definition and direction and cannot be containerized as "best-practices" or "evidence-based". Rather they must be practice based and acceptable to the communities within which they are applied.

I recommend that each tribal community and urban center have a healing center – where the alcohol and drug services are delivered within the context of solid re-acculturation and robust community defined and community based reclamation of the solid values, beliefs, and strengths of the culture. If the tribal youth have an opportunity to integrate this into their lives, then, slowly, over the course of the next couple of generations, we can reverse the effects of historical trauma and post-colonial stress. This will result in a dramatic reduction of native youth alcohol and drug issues and suicide without requiring a direct external treatment model. Thank you for the opportunity to discuss these issues, if you have further questions, please call (503) 871-3101.

Sincerely

Joseph B. Stone, Ph.D., CAC Level III, ICADC, CADC Level III
Oregon Psychologist # 1437
Washington Psychologist # 2445

Biography: Joseph B. Stone, Ph.D., CAC Level III, ICADC, CACD Level III, Program Manager and Clinical Supervisor: Confederated Tribes of Grande Ronde Behavioral Health Program and *Kinuk Sisakta Consultation, Training & Research*

BIOGRAPHY

Dr. Joseph B. Stone is an enrolled member of the Blackfeet Tribe of Northern Montana. He is a licensed psychologist in Oregon and Washington States, a Licensed Mental Health Counselor in Washington State, a Certified Addiction Counselor Level III, an Internationally Certified Alcohol and Drug Counselor, and Certified Alcohol and Drug Counselor Level III. Between 1995 and 2000, Dr. Stone was the Lower Elwha Klallam Tribal Behavioral Health Program Director in Port Angeles, Washington. In 2000, Dr. Stone became the Confederated Tribes of Grande Ronde Behavioral Health Program Manager and Clinical Supervisor in Grand Ronde Oregon. *Kinuk Sisakta Consultation, Training, & Research Services* is Dr. Stone's private behavioral health consultation business since 1992.

His grandparents, Joseph and Mary Stone raised Joe on a ranch north of Cut Bank, Montana, where he grew to love the classical western life: riding, working cattle, and breaking horses. He had various job experiences, including: being an oil field roughneck, logger, cowboy and ranch-hand, construction worker, US Navy electrician, and was a Hood Canal Floating Bridge Technician. In 1984, he returned to Montana from Washington State and enrolled in the Montana State University (MSU) electrical engineering program. It was at MSU that Dr. Stone's first academic interest in psychology was reawakened. In 1990 Dr. Stone graduated with an undergraduate degree in home economics and non-teaching minor in psychology.

Joe met Deanna, his wife and beloved life companion at MSU. They were married in the MSU Chapel in August of 1990. Joe and Deanna spent the next four years in Logan, Utah at Utah State University where Joe completed the didactic portion of his clinical training, and Deanna obtained a degree in English and Health Education. Following this, Joe and Deanna moved to Rapid City, South Dakota for his internship at the Fort Meade Veteran's Affairs Hospital and Indian Health Service Regional Hospital (Sioux San).

Deanna recently earned an MSW with a specialty in children and families from the University of Washington School of Social Work. She is a full-time care provider for Jerry (6) & Jessie (5), who are enrolled in the Dine Nation and who joined the family in 2001. As Jerry recently explained to his little brother, "Nana and Doe and Jerry and Jessie are a family...and the dogs."

Dr. Stone's clinical and research interests are in the area of assessment and treatment of child physical and sexual abuse, dual diagnosis of behavioral health and substance abuse disorders, addictive behaviors, and post colonial stress. He is a national trainer for Project Making Medicine: Indian Health Service Training in Treatment of Child Physical and Sexual Abuse. Joe is an avid hobbyist, who would rather play foosball, but who wouldn't. He enjoys shooting hi-powered pistols and listening to the blues, but not at the same time. He is equally comfortable with modern western society or "rez" life. The Iniupi or sweat lodge is Joe's current favorite form of self and family healing practice.

Oral presentations and discussions are a greater passion and interest than writing at this point. Dr. Stone regards learning more as a product of social interaction, than as a product of lecture. He always walks away from leading an academic discussion feeling like he learned more then he taught and when this enjoyable part of the "teaching/learning" process ceases, Joe will stop "teaching". Hearty interaction and participation in his classes and workshops is strongly encouraged, so come to his training session equally prepared to share and teach as much as you are prepared to learn. But, remember, some of us participate silently, by listening with respect and interest: this is a fully acceptable way of being present.

Biography: Joseph B. Stone, Ph.D., CAC Level III, ICADC, CADC Level III

Dr. Stone is enrolled as a member of the Blackfeet Nation of Northern Montana (u 201 - 10415) through maternal lineage. Further, he has paternal native lineage and family affiliation with the Turtle Mountain Chippewa and Lakota tribes. Currently Dr. Stone lives with his wife, Deanna L. Crask-Stone (M.S.W.) and two little boys: Jerry (6) & Jessie (5), siblings who are enrolled in the Dine Nation (Navajo). Jesse and Jerry are foster children, who are scheduled for adoption on 06/17/2005. Dr. Stone's employment, professional experience, and credentials are listed briefly, as follows:

2001 – Current	Licensed Psychologist in Oregon (1437)
2000 – Current	Licensed Psychologist in Washington (2445)
2000 – Current	Licensed Mental Health Counselor in Washington (4415)
1997 – Retired	Certified Mental Health Counselor in Washington (3422)
1995 – Current	Arizona Certified Addiction Counselor Level III (RR117)
1998 – Current	Internationally Certified Alcohol and Drug Counselor (ICADC 17538)
2000 – Current	Addiction Counselor Certification Board of Oregon (ACCBO) Certified Alcohol and Drug Counselor III.
2001 – 2003	Licensed Foster Parent – State of Washington
2003 – 2004	Licensed Foster Parent – State of Oregon
2000 - Current:	Confederated Tribes of Grand Ronde Behavioral Health Program Manager and Clinical Supervisor Confederated Tribes of Grand Ronde Health and Wellness Center 9615 Grand Ronde Road, Grand Ronde, Oregon.
1995 - 2000	Director: Lower Elwha Klallam Tribal Behavioral Health Program Lower Elwha Klallam Tribal Health Department 2867 Lower Elwha Road, Port Angeles, Washington
2002 – Current	Clinical Professor of Psychosocial Nursing and Community Health University of Washington School of Nursing University of Washington, Seattle, Washington
1992 – Current	Joseph B. Stone, Ph.D., CAC Level III, ICADC, CADC Level III, Owner and Director Kinuk Sisakta Consultation, Training, and Research Services, 252 NW Bonanza Ave, Dallas, Oregon 97338

Publications:	Two articles and one in submission.
Presentations:	One international workshop presentation Seventeen national workshop presentations Thirty-four regional training presentations Fifteen statewide training presentations Twenty-five tribal training presentations Thirty-six local training presentations Fourteen university lectures, symposia, or colloquia.

The American Indian/Alaska Native National Resource Center for Substance Abuse Services

Written Testimony of R. Dale Walker, MD, Director
One Sky Center: American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services
Oregon Health & Science University

Oversight Hearing on Teen Suicide
Before the United States Senate Committee on Indian Affairs
June 15, 2005

Chairman McCain, Vice-Chairman Dorgan, and members of the Committee, I am R. Dale Walker, MD, Director of the One Sky Center, and Professor of Psychiatry, Public Health & Preventive Medicine at Oregon Health & Science University in Portland, Oregon. I am a Cherokee psychiatrist with qualifications and 25 years' experience in the addictions field. I direct the One Sky Center, the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people. I am honored and humbled to be able to provide oral testimony before you today.

I would like to thank the Committee for holding this important oversight hearing on youth suicide prevention. I would like to commend Senator Byron Dorgan for his advocacy efforts for drawing attention to this critical issue. I would also like to extend my appreciation to Senator Gordon Smith for championing the issue of mental health by introducing and enacting legislation in light of his own personal loss, his son, Garrett. There is a mental and behavioral crisis in Indian country today, and a vital need for preventive action.

The idea of a child—a sacred human being in tribal culture—ending their own life is an unthinkable act; often leaving loved ones in a state of great disbelief, shock, and denial. As we know, unfortunately, our Indian children are committing suicide across Indian country; in some communities, at alarming rates.

In some tribal communities, the topic and discussion of suicide is still considered taboo. However, due to this crisis, tribal people are asking for help. Thankfully, this is what brings us here today: to save our young ones, our next generation. Many questions have been raised about teen suicide, and the most important questions center around how to address it, and how to prevent it.

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1. Overview

In my presentation, I will offer our strategic assessment for your consideration.

Suicide, of course, is among several, causally related behavioral problems, including community conflict, family fragmentation, gangs, youth violence, alcohol abuse, abuse of illegal drugs like methamphetamine, and abuse of prescription drugs. Such physical illness as diabetes is causally related as well. Closely associated are demoralization, loss of vision, and clinical depression.

There are many valid theories about the causes (drivers) of that group of problems, including poverty, racism, lack of law enforcement, lack of skills learning, loss of culture, services deficiencies, and lack of community leadership.

- It is our judgment that extraordinary and extreme behavioral problems exist in many American Indian/Alaska Native communities.
- We believe that the critical point of leverage is improving the behavioral health of individuals, families and communities.
- We believe that improving the degree of collaboration and alignment among services will greatly improve the efficiency and effectiveness of services.
- We believe that it is strategic to intervene in crises/emergencies both to limit the amount of damage and to take advantage of the openness to change and action that crises/emergencies bring.

It is my hope that the assessments and recommendations presented today will be seriously considered as part of the Committee's efforts to reauthorize S. 1057, the Indian Health Care Improvement Act (P.L. 94-437), or be helpful to other committees with jurisdiction for potential legislative efforts related to mental health, substance abuse prevention, and treatment of American Indian and Alaska Natives.

I will also introduce the One Sky Center that I direct, our work, and a Substance Abuse and Mental Health Services Administration (SAMHSA) "emergency contract" that we are partnering with Kauffman and Associates, Incorporated titled, "Native Aspirations." We hope that the Committee will support as a first phase towards a demonstration project for suicide prevention.

2. The One Sky Center

The One Sky Center (www.oneskycenter.org) created in 2003, is the first national resource center dedicated to improving the prevention and treatment of substance abuse and mental health among Native people. The One Sky Center's mission is to promote best practices in substance abuse and mental health services for American Indians and Alaska Natives. The goal of the One Sky Center is to improve prevention

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and treatment of substance abuse among native people. The objectives of the One Sky Center include (a) identifying culturally appropriate best practices in prevention science and treatment services designed for American Indians and Alaska Natives, (b) facilitating the implementation of evidence-based preventive programs and care systems for native people, (c) providing continuing education in substance abuse prevention and treatment so as to enhance the capabilities of educators and clinicians serving American Indian and Alaska Natives, and (d) recruiting native youth into education and health care training programs aimed at prevention and treatment of chemical dependency among American Indians and Alaska Natives.

A National Steering Committee representing tribal governments, educators, clinicians, the Indian Health Service, the Bureau of Indian Affairs, the Addiction Technology Transfer Centers, and the Centers for the Application Prevention Technology as well as the Substance Abuse and Mental Health Services Administration (SAMHSA) advise the Center. The National Steering Committee strengthens existing linkages to the Addiction Technology Transfer Centers and the Centers for Application of Prevention Technology. It is a national resource center of, by, for, and steered by Indian people—a unique trait in a national resource center.

The One Sky Center's reach is extended by consultants and subcontractors located throughout the country including the Alaska Native Tribal Health Consortium, the National Indian Youth Leadership Project in New Mexico, and United American Indian Involvement in California. In addition to conferences, workshops, and coalitions, distance learning technology is used to facilitate technology transfer, technical assistance, and consultation. The Center continues the University's linkages with tribal colleges and universities to facilitate entry of American Indian and Alaska Native youth into education and health careers focused on substance abuse prevention and treatment. Two divisions within SAMSHA, the Centers for Substance Abuse Prevention and Substance Abuse Treatment, federally fund the One Sky Center. Please visit One Sky Center's website at www.oneskycenter.org for more information.

The SAMHSA grant supporting One Sky Center is its third and final year. It is my hope that SAMHSA will continue to fund the efforts of the One Sky Center, and the Committee will support us in that effort.

Evidence Based, Cultural Best Practices Movement

The IOM (2002) purports that evidence-based practice should integrate three key components: (1) best research evidence that includes clinically relevant empirical studies; (2) clinical expertise that comprises clinical reasoning skills focused on the context of the client's conditions, values, and expectations as well as the risks and benefits of specific interventions; and (3) client values or the preferences, concerns, and expectations of the client in the practitioner-client interaction. SAMSHA has incorporated the IOM evidence-based approach into a report regarding individuals with co-occurring disorders, an area of behavioral health care. SAMHSA asserts, "Many approaches to treating co-occurring disorders that do not meet strict standards of

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evidence are nevertheless commonly accepted and believed to be effective based on the best available research, clinical expertise, individual values, common sense, and a belief in human dignity. It is incumbent on practitioners to use the best available approaches" (U.S. Department of Health and Human Services, 2002).

The One Sky Center is helping to lead a cultural movement toward identification, acceptance, and implementation of culturally appropriate substance abuse and mental health services that work in the American Indian and Alaska Native world. This activity spans awareness raising, coalition building, motivation enhancement, resource development (such as inventories of best practice), broad dissemination, training, and technical assistance.

An American Indian and Alaska Native Best Practices Consensus Panel met in October 2004 in Portland, Oregon. The small meeting was sponsored by the One Sky Center in collaboration with SAMHSA's Center for Disease Control and Prevention. The meeting provided a forum to discuss culturally appropriate, effective and promising practices in the areas of substance abuse prevention, substance abuse treatment, mental health, and co-occurring disorders for American Indian and Alaska Natives.

Meeting participants included senior scientists who are experts in the addictions and mental health fields, junior faculty-level American Indian professionals, community leaders, traditional healers, and a representative from SAMHSA's National Registry of Effective Programs and Practices. Participants reviewed the mainstream and American Indian and Alaska Native literature on best practices in substance abuse prevention and treatment, mental health and co-occurring disorders. Each of the four areas were discussed, incorporating science, community practice, indigenous knowledge, and traditional medicine practices into a culturally inclusive and relevant set of criteria to establish best practice approaches in American Indian and Alaska Native communities.

This dynamic panel meeting was the beginning of an on-going process to develop best practice approaches in tribal communities. Based on the literature reviews, discussions, and recommendations collected at this meeting, the One Sky Center will develop a set of papers for distribution to providers, educators and health policy organizations. A first draft of the monograph is expected this summer.

At the end of this month in San Diego, California, the National IHS/SAMHSA and Behavioral Conference on Alcohol, Substance Abuse, and Mental Health will be held. The One Sky Center will have a significant role at this conference. The One Sky Center will lead a one-day meeting of Best Practices, a follow up to the October 2005 meeting. The Center will also facilitate a Youth Panel to further discuss teen suicide and prevention with an impressive panel of tribal youth to hear their voices on the issues of teen suicide. Three of the youth are the three Standing Rock Sioux students who testified at the Senate Committee on Indian Affairs field hearing in Bismarck, North Dakota in May 2005.

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Traditional Health Practice

Traditional health practices include procedures such as Circles of Care, Sweat Lodges, use of botanical medicines, and specific programs like the *Red Road to Recovery*, a model that has helped thousands of American Indians lead clean and sober lives (Thin Elk 1992). Traditional Health Practices (THP) offer American Indian/Alaska Natives communities a variety of culture-based activity, health related ceremonies, philosophy, healing practices and a healthy alternative lifestyle.

Traditional health concepts include harmony as a source of health and disharmony as a source of disease. THP sees health as a process involving internal causes that create or attract disease.

Traditional health delivery contexts include cultural symbols, facility decoration, provider dress, and provider interaction style. THP addresses alcohol abuse, intentional and non-intentional injury with a special emphasis on auto related injury, diabetes and other health outcomes related to alcohol.

As a treatment intervention, the THP model focuses on the role of culture, tribe and society at large play in understanding and treating the individual's health situation. Historical trauma, cultural conflict, language, exposure to tribal culture and identify formation help determine health or lack of it.

As a prevention model, THP focuses on social support and social capital for an individual who is so often socially isolated. A major prevention intervention is supporting cultural renaissance among Indian peoples. Another major prevention intervention is assisting tribes to regain control over their circumstances: legal rights, property, institutional authority, and local self-governance.

The Surgeon General's *Report on Mental Health: Culture, Race, and Ethnicity* (DHHS 2001b) acknowledged that culture counts in the prevention and treatment of substance abuse and mental illness. Therefore, there is a need for culturally relevant practices to address the issues of behavioral health in Indian country.

Because of the complex historical, cultural, familial, economic, and legal foundation of American Indian reservations and Alaska Native villages, tackling the task of providing proactive behavioral health services for Native youth and their families is equally complex. Knowledge of behavioral health issues of Native children and youth is necessary. However, just as important is a deep appreciation and understanding of Native culture and the experiential grasp of Native life on tribal reservations and villages. Only by blending this knowledge, knowing, and experience within the behavioral health framework, will inroads be made to Native American communities to reduce the risk factors that contribute to youth violence and suicide and to heal devastated families and communities. In other words, to respond to the behavioral health needs of Native youth, children, and families, a culturally tailored and community

specific approach combined with evidence-based best practices in behavioral health must be initiated at a community level in Indian Country.

3. Behavioral Health Overview

Among today's Native youth and young adults, suicide, violent crimes, substance abuse, and school violence each are running rampant. During a 12-week period from November 2004 to February 2005, eight young Native American adults committed suicide in separate events on the Standing Rock Sioux Reservation in North Dakota and South Dakota. All but one suicide was related to alcohol. Each young adult used hanging as the method to die.

A few weeks later and only 300 miles away on the Red Lake Reservation in Minnesota, a 17 year old killed his grandfather and grandfather's partner in the family home in his Ojibwa community. Then he went to school and took the lives of two adults and five of his classmates. Then he killed himself.

Unfortunately, these two recent, tragic stories are not rare in Indian Country. In fact, suicide, homicide, violence, and substance abuse each run rampant amongst today's Native youth and young adults. The three leading causes of death for American Indians and Alaska Natives, ages 15 through 24 years of age between 1994 to 1996 were: (1) accidents; (2) suicide; and (3) homicide. In 2002, suicide rates of Native American male teens (ages 15 through 19) were highest of any ethnicity in the U.S. at 22.7 per 100,000; a rate three times higher than the national average (7.4 per 100,000) for this age group (Child Trends DataBank, 2002).

The violent crime rate in every age group below age 35 was significantly higher for Native Americans than the general population of the U.S., according to the U.S. Department of Justice (2004). In addition, the rate of violent crime victimization of Native Americans, ages 25 to 34 was more than 2.5 times the rate for all persons of the same age. When violent crimes were reported, about 62% of Native American victims experienced violence by an offender who was using alcohol, compared to 42% for the national average.

Alcohol abuse is also a common and historical health problem. Statistics in 2002 indicated that Native Americans have higher rates of illicit drug, marijuana, alcohol, smokeless tobacco and tobacco use than Whites in any age group throughout the U.S. (U.S. Department of Health and Human Services, Office of Minority Health). SAMHSA (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Office of Applied Statistics, 2002) reported that the average age of first alcohol use was earliest for Native Americans (mean, age 15.1 years old) than any other ethnic group.

Paralleling the high rates of suicide, violence, and substance abuse in Native youth and young adults is the increased amount of violence occurring at public schools and Bureau of Indian Affairs schools (U.S. Department of Education and U.S. Department of

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Justice, 2004). Last year, 22.1% of Native students reported being threatened or injured with a weapon on school property; the highest rate of violence experienced by any ethnic student group. In the same report, violence rates of other ethnic
Youth dropped but Native youth reported the biggest growth in violence (increasing nearly 9 percentage points). This reported violence was demonstrated by 24.2% of Native high school students being involved in a physical fight on campus last year and 12.9% Native youth taking a weapon to school.

These soaring rates of school violence, suicide, and substance abuse among Native youth are not stand-alone statistics but point toward the excessive amounts of poverty, domestic violence, child abuse and neglect, and historical trauma in Indian Country. Poverty continues to be the most troublesome social, educational, and health disorder in Native American communities (Cornell & Kalt, 1992). In 2000, the U.S. Census Bureau reported that one in four Native Americans experience poverty (26%); a rate that is more than double for the general U.S. population (12%). Domestic violence is noted with the homicide mortality rate for Native American females ages 25 to 34 years old being 1.5 times that for the U.S. general population (U.S. Department of Justice, Office of Justice Programs, 2004).

Similarly, Native children and youth oftentimes experience family disruption, neglect, and abuse because Native Americans have a rate of prison incarceration about 38% higher than the national rate (U.S. Department of Justice) and a higher use of substance abuse than other ethnic groups (U.S. Department of Health and Human Services, Office of Minority Health, n.d.). In addition, the historic trauma of Native Americans based on centuries of cultural oppression, loss of traditions, and racism severely affect the wellness and health of Native communities. The long-term effects of these underlying conditions have resulted in high rates of physical, mental, and behavioral health disorders for Native youth and children and their families that have been passed on from generation to generation.

4. Strengthening of Systems For Delivering Behavioral Health Services

The U.S. maintains a unique moral and legal obligation to provide health services to American Indians and Alaska Natives. This obligation is based upon the U.S. Constitution, numerous Indian treaties, federal laws, Supreme Court rulings and Executive Orders. The federal government carries out this responsibility primarily through the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. Health care, including behavioral health services, is provided to IHS eligible populations through a regional system of twelve Area Offices, each composed of community specific service units. Severe limitations on funding, however, have resulted in a system of rationed health care, where preventive services less a priority than access to acute care.

The provision of adequate behavioral health services in Indian Country continues to be challenging. A report released by the U.S. Commission on Civil Rights (2004) on the health disparities and health care services of Native Americans indicated that robust

social, cultural, structural, and financial barriers serve as roadblocks for Native Americans to receive adequate health care. The most typical barriers of the Indian Health Services (IHS) included racial and ethnic bias by health care providers; geographical location of health care facilities; wait times at facilities and for treatment; turnover rates, recruitment, and retention of health care providers; and the rationing of health services for Native Americans.

One Sky Center recommends strengthening and increasing the capacity of behavioral health services in American Indian/Alaska Native communities. We encourage the Committee's efforts to reauthorize S. 1057, the Indian Health Care Improvement Act (P.L. 94-437), or be helpful to other committees with jurisdiction for potential legislative efforts related to mental health, substance abuse prevention, and treatment of American Indian and Alaska Natives.

5. Coordination of Services

In addition, fragmentation of behavioral health services in Indian Country is commonly demonstrated by separate federal, state, and local agencies focused on suicide, substance abuse, education programs, and mental health and social services instead of an integrated, comprehensive behavioral health system. Often times, these systems do not interface or communicate well, defeating the logical, community-based, effective behavioral health care planning and implementation needed in Native communities (Walker, 2005). More specifically for the behavioral health needs of Native youth and their families, a well-functioning, integrated system involving community stakeholders and agency partnerships is crucial. Together schools, social services, mental health programs, law enforcement, and tribal leadership can be instrumental in collaborating and coordinating effective behavioral health programs for Native youth and for healing and recovery of Native communities.

Schools are a key service in the matrix of services. The role of the U.S. government in Indian education dates back to the 1800s. In 1879, the Indian boarding school, Carlisle Indian School, in Carlisle, PA was established. With the goal of assimilating Indians into the culture of white men, these boarding schools suppressed indigenous languages, cultures and dress in an effort to "Kill the Indian, save the Man" (Cohen). This history complicates the challenge of enhancing the capacity of schools to promote health in that critical setting and critical age group.

The lack of coordination includes conflicting policies among multiple school jurisdictions and lack of coordination with health services. Policies from higher levels, myopic perspectives of local staff, and lack of strategic planning drive the lack of coordination.

The nightmare of having a Columbine School scenario on an Indian reservation has now become a reality. The countermeasures include integrating substance abuse, mental health and social services into comprehensive behavioral health programs. Many tribes and tribal organizations, including the National Indian Health Board, support integrating programs which are nurturing, fulfilling, accountable, and responsible. These

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local efforts and federally supported programs offer an opportunity for wellness and balance in tribal communities.

One Sky Center recommends identifying coordination of services as a key objective for interventions supporting American Indian/Alaska Native communities to overcome the complex of problems such as suicide, youth violence, and substance abuse. An emergency/crisis is one of the few times that enough momentum can be generated to overcome some of these barriers to coordinated service.

6. Emergency/Crisis Intervention Program

Clusters of suicides or homicides create a community trauma. Survivors and those who provide care for them, as well as community leaders are in shock and often too overwhelmed to continue to function. This precipitates lasting damage to the community and its capacity to support healthy lives, which leads to further problems. This trauma needs immediate treatment, itself. But the emergency/crisis also creates an opportunity to initiate fundamental improvements—it motivates people, enables examination of causes and contexts, and calls for a plan to prevent reoccurrence.

We recommend three culturally relevant, community specific approaches for addressing community health issues and healing in the aftermath of emergencies/crises (or in anticipation of them). The *Community Suicide Prevention Assessment Tool* (Walker, 2005b), *Community Readiness Model* (Thurman, Pleated, Edwards, Foley, & Burnside, in press), and the *Gathering Of Native Americans* (GONA; Center for Substance Abuse Prevention, 1992 have been successful in Indian Country. All of these approaches have been implemented and successfully worked with behavioral health issues in Native communities including partner violence, substance abuse, HIV/AIDS prevention, suicide, and other community health issues. One Sky Center used this approach in the Standing Rock and Red Lake incidents.

Of the three tools, *The Community Suicide Prevention Assessment Tool* serves as a mechanism to collect and evaluate information about a community and its contributing factors related to the behavioral health of individuals, families, and the Native American community as a whole. The *Community Readiness Model* approach and the *GONA* forum are used primarily in a community participatory process for planning action and activities to address the behavioral health needs of the community. The common features of the Community Readiness Model and the GONA comprise: (1) empowering community members to address the community health and social issues that they face on a day-to-day basis; (2) honoring the values, beliefs, and knowledge of each Native community and its members; (3) addressing many segments and parts of a community (e.g., individuals, leaders, organizations) because of their interconnectedness with the health or social issue; and (4) generating and maintaining culturally relevant solutions, resources, and healing in a collective and community specific manner, i.e., a large group forum.

All of the community specific tools including The Community Suicide Prevention Assessment Tool, the Community Readiness Model approach, and the GONA forum are detailed below.

The Community Suicide Prevention Assessment Tool was developed by OSC by modifying two other community-based assessments, the Native Community Assessment, developed by the Canadian Task Force on Preventative Health Care in 1994 and the Suicide Prevention Community Assessment Tool published by the Suicide Prevention Resource Center. The CSPAT used by OSC focuses on gaining a comprehensive, integrated picture of the contributing factors and the overall community functioning and capacity as it relates to the behavioral health of individuals, families, and the Native American community as a whole. The framework encompasses a gathering of information regarding each community's history, culture, government, demographics, geographic features, economic resources and status, social characteristics, recreational opportunities, and health status, services, and facilities. Community specific information is acquired through several mechanisms including meetings with key informants and community leaders, semi-structured individual interviews with community stakeholders (e.g., mental health counselors, school principals), documents of relevant organizations and agencies, (e.g., Indian Health Service, tribal government, local school district), and databases records (e.g., U.S. Census data). Through the analysis of this community specific information garnered from multiple sources, recommendations then emerge and are presented to the community that focus on the behavioral health of the targeted group. The Community Suicide Prevention Assessment Tool and process has allowed Native communities to gain a clearer and integrated picture of their respective community as it relates the behavioral health needs of individuals, families, and the overall community and to set the stage for developing a plan toward community healing and health.

The Community Readiness Model originally developed at the Tri-Ethnic Center for Prevention Research at Colorado State University provides an easy method for assessing the level of readiness of a community, related to a specific prevention and/or intervention of a health or social issue (Thurman, Plested, Edwards, Foley, & Burnside, in press). To gain a clear picture of the community, the model proposes six primary dimensions including Community Efforts (programs, activities, policies); Community Knowledge of Efforts; Leadership; Community Climate; Community Knowledge About the Issue; and Resources Related to the Issue. The model addresses nine development levels of community readiness that must be worked through in order for the community to generate, implement, and maintain efforts to reduce the health or social problem. The nine developmental stages include: (1) No Awareness; (2) Denial; (3) Vague Awareness; (4) Preplanning; (5) Preparation; (6) Initiation; (7) Stabilization; (8) Confirmation/Expansion; and (9) Professionalization. By identifying the community's developmental stage to address the social or health problem, the community may then develop and apply culturally appropriate and effective strategies involving multiple community systems and within community resources and strengths.

The Gathering of Native Americans (GONA) which operates on the principle that primary prevention should be implemented from within the community rather than from the top down was developed in 1992 as a culturally specific prevention curriculum within the Community Partnership Initiative of the

Center for Substance Abuse Prevention, (SAMHSA). There are four themes to the curriculum that correspond to indigenous values that are core resiliency factors for native people. These values: Belonging, Mastery, Interdependence and Generosity are the framework for a collaborative planning process to address substance abuse issues in Native communities. The model is easily adaptable to specific tribes and tribal regions allowing local coordinators to integrate their traditional stories, songs and ceremonies into the curriculum. The curriculum has proved so valuable as a healing and planning tool in native communities, the Indian Health Service and the Office of Juvenile Justice contributed to funding of local and regional GONA trainings. Recently, IHS funded a publication of a shorter, revised GONA manual. The curriculum has been adapted to address other issues in Native communities throughout the nation, including: domestic violence, diabetes, HIV, and gang prevention.

One Sky Center recommends a program of intervention into Crises/Emergencies in Indian communities using a protocol worked out well in advance.

Today's Native youth and Native communities are experiencing more and more tragedies related to suicide, school violence, violent crimes, and substance abuse. Underlying social, economic, and health conditions in Indian Country such as poverty, domestic violence, child abuse and neglect, and historical trauma continue to deter the safe and healthy development of Native youth, children, and families. Responding to the behavioral health needs of Native youth is imperative in order to prevent youth violence, suicide, and substance abuse and in turn, help Native communities heal and recover.

More evidence-based, culturally-tailored, and community-specific approaches for addressing Native youth's behavioral health issues and Native communities' planning and healing are required to build pro-social and help seeking behaviors of Native youth and their families. Tribal leaders, school officials, behavioral health providers, and community stakeholders in Native communities must direct Native youth toward healthy and save lives. Coordination among services is needed to make them efficient and effective in dealing with behavioral health needs. A powerful intervention around crises and emergencies will facilitate these changes.

Conclusions

It is safe to conclude that the Indian health community, a majority of federally-recognized tribes, and most Indian health organizations generally agree that the Indian Health Care Improvement Act reauthorization or any other moving legislative initiatives must include provisions to enhance or improve the delivery of mental health services for American Indian and Alaska Native communities. The alarming health disparities, domestic violence, suicide, and major crimes committed on Indian reservations are

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escalating, and show no signs of relenting unless crucial federal programs are fully funded, which includes critical mental health programs for American Indian and Alaska Natives.

Tribal communities are taking a leadership role in addressing the myriad of needs associated with behavioral health problems. Building upon that local leadership and initiative offers a strategic opportunity to improve coordination of local and federal services, to bring services up to critical level of capacity, and to get going a renaissance in American Indian and Alaska Native communities. One Sky Center has been honored over the past two years to help empower tribal communities with the tools and resources to be pro-active in creating their own better futures.

The One Sky Center is willing to offer its expertise in the areas of substance abuse treatment and prevention, mental health, and best practices if the Committee should seek guidance on those matters. The One Sky Center is qualified to offer insight, experience, and recommendations addressing these problems for the Committee's consideration.

Both HHS and SAMHSA have seen the wisdom and advantages of cross agency support and funding for strategic nation-wide efforts. As the Nation's only National Resource Center in behavioral health for this population, it is our sincere recommendation that resources be directed to SAMHSA through HHS for a five year demonstration project to bring the full efforts of all federal and state agencies together to address the issues related to suicide and violence for all American Indian and Alaska Native communities across the nation. The demonstration project approach will allow model programs to develop in all regions of the country. They can be integrated with other native and nonnative communities.

The basis for this demonstration project could build upon the Native Aspirations project to be funded by SAMHSA. SAMHSA has issued a request for an "Emergency Contract" to provide a proactive, community-based effort to bring mental health assistance to children, youth, and families living on American Indian reservations and in Alaska Native villages. This proposal responds to the SAMHSA request, and provides a structured approach to engaging Native communities to collaboratively identify strategies to decrease factors that contribute to school violence and suicide and to increase protective factors that support healthy, safe environments for children and their families.

The partnership between the One Sky Center and Kauffman and Associates, Incorporated, a 100% American Indian owned contracting firm, presents an opportunity for the Substance Abuse Mental Health Services Administration (SAMHSA) to utilize two entities, each uniquely qualified, with excellent track records across Indian Country to address the serious problem of preventing American Indian and Alaska Native youth suicides, homicides, school violence and disruptive behaviors in and around schools.

The goal of the Native Aspirations project is to reduce risk behaviors, such as acts of violence and suicidal gestures, and increase pro-social and help seeking behaviors

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among American Indian and Alaska Native youth in high-risk communities. Because of the complex historical, cultural, familial, economic, and legal context of Native youth, their families, and communities, providing behavioral health services to reduce high-risk behaviors is equally challenging. Consequently, to respond to SAMHSA's Native Aspirations Project, the One Sky Center (OSC) and Kauffman and Associates, Inc. (KAI) have developed a culturally tailored and community specific approach combined with evidence-based behavioral health best practices to meet the objectives, tasks, and requirements of the contract.

The approach that OSC and KAI will use in the Native Aspirations Project includes a four-step community-based protocol including: (1) Community Selection; (2) Community Assessment; (3) Community planning; and (4) Community Implementation. First, the Community Selection process will enable OSC/KAI to identify approximately 22 high-risk Native communities through the use and analysis of qualitative information and quantitative data gathered through multiple sources. Second, the Community Assessment will involve project personnel visiting each identified community and examining contributing factors and overall community functioning and capacity as it relates to the behavioral health needs of Native children, families, and communities.

The Community Assessment focuses on each community's history, culture, government, demographics, geographic features, economic resources and status, social characteristics, recreational opportunities, and health status, services, and facilities. Next is the Community Planning process that will be conducted through a Gathering Of Native Americans (GONA) forum utilizing the Community Readiness Model allowing each community's stakeholders to formulate a plan that will direct it toward improving the behavioral health of Native youth, their families, and the overall community. Finally, the Community Implementation process will involve providing on-site supervision, training, and consultation to the tribal communities regarding behavioral health evidence-based interventions and service coordination.

The project staff of Native Aspirations will include skilled personnel and experts from OSC and KAI in the areas of behavioral health, community assessment and facilitation, Native culture and ceremony, project management, evaluation and research, and database management. In addition, approximately 14 consultants specializing in Native behavioral health issues of children, families, and communities will be engaged throughout the Community Assessment, Community Planning, and Community Implementation phases of the project.

Through this Emergency Contract, SAMHSA has provided an opportunity for OSC and KAI to respond to the behavioral health needs of Native youth in order to prevent youth suicide, violent crimes, substance abuse, and school violence and in turn, help Native communities heal and recover. Evidence-based, culturally-tailored, and community-specific approaches for addressing Native youth's behavioral health issues and Native communities' planning and healing are required to build pro-social and help seeking behaviors of Native youth and their families. Tribal leaders, school officials, behavioral

health providers, and community stakeholders in Native communities must direct Native youth toward healthy and save lives.

Recommendations

1. Strengthen and increase the capacity of behavioral health services to levels available in the broader community.

2. Create a powerful mandate to align and coordinate policies and services at the federal and local levels—a mandate powerful enough to overcome the enormous "silo" tendencies of all agencies. .

3. Creation a long-term intervention program for communities going through emergencies/crises, to deal with the crisis and to seize the opportunity, which a crisis provides.

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The American Indian/Alaska Native National Resource Center for Substance Abuse Services

July 19, 2005

The Honorable Byron L. Dorgan
Vice-Chairman
Senate Committee on Indian Affairs
836 Hart Senate Office Building
Washington, D.C. 20510-6450

Dear Senator Dorgan:

Thank you so much for allowing me the honor of testifying before the Senate Committee on Indian Affair's oversight hearing on Indian youth suicide prevention. I hope that my testimony was helpful, and insightful to your efforts to address the teen suicide crisis affecting Indian country. The One Sky Center is proud to be the nation's only American Indian/Alaska Native National Resource Center for substance abuse and mental health services. Attached are my written responses to your submitted questions. Please feel free to call upon the One Sky Center for any questions, inquires, or comment in the future.

Sincerely,

R. Dale Walker, MD
Executive Director

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RESPONSES TO SENATE COMMITTEE ON INDIAN AFFAIRS QUESTIONS SUBMITTED TO DR. WALKER, ONE SKY CENTER

I understand that you have an interest in using tele-medicine to address mental health needs in Indian Country. Can you elaborate?

I believe tele-medicine is a useful and effective tool when direct service is limited or not available in rural and urban areas of Indian country. Tele-medicine usually occurs in two circumstances. First, specialists advise local providers (case-oriented consultation), and second when providers directly follow up with and advise patients (e.g., implementation of treatment plans). However, there are infrastructure, capacity, and logistical challenges in operation and maintenance of this sophisticated technology. On some Indian reservations that will require investment of resources and technical assistance. When in operation, tele-medicine would substantially increase capacity to provide counseling, assessment, prevention, treatment and rehabilitation. Further, tele-medicine could be the vehicle for greatly improving coordination among local schools, native veteran's centers, treatment centers, and local health entities, given necessary mandates and policies governing various agencies, tribal governments, and tribal entities. Tele-medicine, supported by coordination and collaboration commitments, could offset the deficit of specialty, certified professional mental health services for American Indian and Alaska Native people.

Given your work with the Red Lake community, what can you tell me about what the situation is like there, on the ground, now?

The Tribe exhibited strong leadership during this crisis. James Brown is a key force in the on-the-ground emergency response team for crisis intervention. Like most reservations, Red Lake has many unmet needs, with funding deficits in the areas of physical and mental health services, law enforcement/security/public safety, and for their affected school. Although there was federal response initially, including our call to arms by the Executive branch, there has been no immediate delivery of requested funds for the purposes described above. Feelings of relief overcame the Tribal government, and the people felt greatly relieved when promised federal aid. Data and assessments (including One Sky's assessment and recommendations) were provided, to the federal government, as requested. But, to date, there has been limited federal action or follow through. The Tribe is feeling abandoned. The Tribe is trying to do its best with its existing resources, and focus on summer activities for youth, but the need is still great with a new school year on the horizon.

Does One Sky have an ongoing role with the Red Lake community?

One Sky Center responded to federal requests for assistance in the recent crisis at Red Lake. Center staff joined a team of IHS and SAMHSA officials to conduct a community survey leading to a strategic plan (and some incidental psychiatric support for survivors). Persons affected by the suicides and violence, community leaders, school personnel, and

other service personnel participated in strategic planning, beginning with a collective community assessment. Although each tribe and reservation facing suicide and violence are unique, there are major commonalities. One Sky Center's analysis is that three related initiatives are required. Tribal initiatives bring the key parties together to develop and follow a plan. SAMHSA initiatives include creating funding opportunities to support efforts at the local level and to provide technical assistance. Finally, interagency initiatives create policy alignment, service coordination, and support among multiple agencies (including state and federal), resulting in a more effective response to community needs. To our knowledge, there has been only limited federal funding or action by the agencies involved since that time and no formal follow-through has occurred. Our Center communication informally continues through phone calls, emails, and chance meetings were there is an opportunity for interface.

Do you have recommendations for how federal entities might better collaborate or coordinate services for teen suicide prevention?

The One Sky Center is willing to offer its expertise in the areas of suicide prevention/intervention, substance abuse treatment and prevention, mental health, and best practices. We are qualified to offer insight, experience, and recommendations addressing these problems. If a Demonstration or model project were proposed as a step towards solution, we would be willing to provide leadership to the project. As the Nation's only National Resource Center in behavioral health for this population, it is our sincere recommendation that resources be directed to SAMHSA through HHS for a five year demonstration project to bring the full efforts of all federal and state agencies together to address the issues related to suicide and violence for all American Indian and Alaska Native communities across the nation. The demonstration project approach will allow model programs to develop in all regions of the country. They can be integrated with other native and nonnative communities.

The One Sky Center submitted written testimony to the Indian Affairs Committee at its oversight hearing in April 2005. We made several recommendations in the wake of Red Lake and Standing Rock. Here is our recommendation of what we would hope the Committee would take into consideration.

Recommended Interagency Support Strategies

There are multiple local, state, and federal systems and agencies operating on reservations. At times, these systems do not interface well and that defeats logical, effective health care planning and implementation. It is critical that the various tribal programs be interconnected, coordinated and aligned. Among the benefits, interagency collaboration will increase early detection and remediation of potential suicide and violence.

Create an interagency task force comprised of an official from each of the agencies involved to address the issues below:

- Define and implement screening guidelines for schools, along with guidelines on linkages with service providers.
- Develop a systematic communications plan for all health care, social, educational, and legal services.
- Improve the quick access to behavioral health treatment for youth who are suicidal and potentially violent with underlying behavioral disorders.
- Improve the interface that youth experience between primary care, emergency care, and mental health.
- Change procedures and policies in certain settings, including primary care settings, hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and schools, to include screening and assessment of youth suicide risk.
- Ensure that youth treated for trauma, sexual assault, or physical abuse in any healthcare setting, including emergency departments, receive consultation, referral, mental health services, and support services. These support services may include domestic violence centers, rape crisis centers, etc.

This strategic plan is a model for addressing similar problems in other reservations and communities. In a broader sense, the model could be considered as a SAMHSA initiative on AI/AN suicide prevention, much like the Circles of Care grants.

Joint Statement from the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association for the Senate Indian Affairs Committee Hearing on Teen Suicide Among American Indian Youth June 15, 2005

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Introduction

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 7,600 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7 – 12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP supports research, continuing medical education and access to quality care. Child and adolescent psychiatrists are the only medical specialtists fully trained in the treatment of mental illness in children and adolescents.

The American Psychiatric Association (APA) is a national medical specialty society, founded in 1844, whose over 36,000 members nationwide specialize in the diagnosis, treatment and prevention of mental illnesses including substance abuse disorders.

The AACAP and APA would like to thank Sen. John McCain (R-AZ), chairman of the Indian Affairs Committee, for holding this hearing.

For the past 20 years, suicide has been the second leading cause of death for 15 to 24 year old Indian youths. The suicide rate for this age group is 37 per 100,000, as compared to a rate of 11-per 100,000 for the general U.S. population. More than one-half of all persons who commit suicide in Indian communities have never been seen by mental health professionals. Sadly, suicide is often the result of missed opportunities to treat such problems as depression, alcoholism, child abuse, and domestic violence; all of which are pervasive in Native American communities.

The Indian Health Service (IHS) has identified alcohol and substance abuse as the most significant health problems affecting American Indians. American Indians and Alaska Natives die at 517% higher rates than other Americans from alcoholism. Ninety five percent of American Indians have been reported to be affected either directly or indirectly by alcohol abuse. Substance abuse, especially alcohol, among youth is a serious problem in many Indian communities. The problem is already manifesting itself through alcoholism death rates for Indians 15 to 24 years old. The Indian rate is 3.7 deaths in 100,000, compared to 0.3 for the U.S. population.

Nowhere are the twin problems of alcohol abuse and suicide better illustrated then the recent tragedy that befell the students at Red Lake High School in Minnesota. Jeff Weise, a 16 year old American Indian boy, killed his classmates and then committed suicide. According to press accounts he was deeply disturbed with depression from years of family struggles with mental and alcohol problems. Weise infrequently attended Red Lake High School in the last year, which typifies the hardships of growing up on the reservation where a third of the teenagers did not regularly attend school and were unemployed and not looking for work.

The AACAP and APA believe that to prevent a similar tragedy like Red Lake, it is

imperative that Congress first and foremost address the disparity of disease that exists in Native American communities. We request the Committee to increase clinical and preventive mental health and substance abuse services to American Indians and Alaska Natives.

The American Indian and Alaska Native people need your leadership and help to prevent youth suicide and to take other essential actions to ensure adequate delivery of health care, particularly for those who suffer from mental illness and substance abuse.

Suicide and Native American Youth

Native American teens, particularly males, are at increased risk for suicide. According to the Indian Health Service, among American Indian youth, 33.9 per 100,000 commit suicide each year, which is 2.5 times the national rate for all youth.[i]

Preliminary research from the American Indian Multisector Help Inquiry (AIM-HI) study, conducted at Washington University in Stylus, found unique risk factors for suicide among Native American adolescents living on reservations and in urban settings. Previous research indicated that substance abuse and depression are the most common risk factors for suicide in Native American communities. The AIM-HI study found that a unique risk factor for Native American youth in urban areas is a lack of social support.

American Indian youth are also at higher risk of suicide due to inter-generational trauma, including the loss of parents and relatives to suicide, which adds to a lack of social support in many American Indian communities for youth.

With respect to suicide in general, suicidal behavior is a serious concern in children and adolescents. Sadly, suicide becomes increasingly frequent through adolescence. The incidence of suicide attempts reaches a peak during the mid-adolescent years, and mortality from suicide is the third leading cause of death for teenagers. In 2002, almost 4,300 young people ages 10 to 24 died in this country by suicide.[ii] More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.[iii]

Barriers to Care in Native American Communities

While Native American communities have some of the same barriers to mental health care that rural areas do, they face additional unique barriers to accessing care. The health care system for Native Americans, the Indian Health Service (IHS), is separate from other federal and state programs. This often prevents them from receiving comprehensive, integrated treatment for mental health, alcoholism, substance abuse and other general medical care. Although Native Americans are eligible for Medicaid and other state funded health care services, administrative barriers and a shortage of services on site in reservations impedes access. According to the AIM-HI study, Native American youth receive mental health services from multiple informal providers, which often impedes coordination and continuity of care.

The geographical remoteness of some Native American reservations creates additional difficulties, with many families forced to travel many hours to obtain mental health services. Multi-generational poverty in many Native American communities, both on reservations and in urban areas, creates the dual financial barriers of an inability to afford care and a difficulty in paying for transportation to service providers.

A key problem in Native American communities is low access to specialty mental health services, including child and adolescent psychiatrists. As the President's New Freedom Commission on Mental Health has noted, there is a shortage of psychiatrists and other mental health professionals trained to diagnose and treat children and adolescents nationwide. The shortage of these specialists, and all other health care professionals, is particularly severe in Native American communities. This lack of available children's mental health professionals in these communities amounts to a crisis in health care for Native Americans.

The AACAP and the APA have called for the enactment of the Child Health Care Crisis Relief Act, S. 537 /H.R. 1106 to address the national shortage of children's mental health professionals. We look forward to working with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the IHS to increase access to specialized mental health care in Native American communities.

The AACAP and the APA have been active in the promotion of comprehensive community-based systems of care across health, education, child welfare and juvenile justice systems for children and adolescents with mental illnesses, and nowhere is this model more urgently needed than in Native American communities. We look forward to working with the IHS to expand the implementation of community-based systems of care in Native American communities.

Risk Factors for Suicide

The overwhelming majority of adolescents who commit suicide (more than 90%) suffered from an associated psychiatric disorder at the time of their death. The top risk factors for attempted suicide in adolescents are depression, alcohol or other drug use disorder, and aggressive or disruptive behavior.[iv]

Suicidal thoughts or behaviors are often symptoms of depression, ADHD, and bipolar disorder in adolescents. Of these, depression has been identified as the top risk factor. About 5 percent of children and adolescents in the general population are depressed at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. The behavior of depressed teenagers may differ from the behavior of depressed adults. For example, depressed teenage boys often exhibit aggressive or risk-taking behavior.

Prevention

Public health approaches to suicide prevention have targeted suicidal children or adolescents, the adults who interact with them, their friends, pediatricians and the media. Some studies have shown that restricting access to firearms may result in a short-term reduction in the rates of suicide, but there is not yet evidence that this has a permanent effect.

SAMHSA's Circles of Care program has been identified as a model innovative community-devised wraparound mental health program that is increasing access to care for Native American youth and their families.

Treatment

The need for increased suicide screening and treatment is critical. Successful treatment depends on a number of factors, with safety considerations being of the utmost importance. The good news is that treatment options for mental illnesses, including the disorders that lead to suicidal behaviors, are increasing. Because of the need to respond to a suicide crisis, treatment should be provided within a "wrap around" service delivery system that includes resources for inpatient, short and long-term outpatient, and emergency intervention. Adolescents who have attempted suicide should be hospitalized if their condition makes behavior unpredictable. Outpatient treatment should be used when the adolescent is not likely to act on suicidal impulses, when there is adequate support at home, and when there is someone who can take action if the adolescent's behavior or mood deteriorates.

The AACAP and the APA have been active participants in the discussion about the use of antidepressants for the treatment of adolescent depression. New research, such as the Treatment for Adolescents with Depression Study (TADS), confirms that using therapy and medication results in successful treatment of adolescent depression. In the TADS study, 71 percent of the patients responded positively to the combination treatment of medication and therapy, which is a rate double the 35 percent response rate for patients on placebo.

Medication, specifically antidepressants, can be helpful and even lifesaving for some adolescents, but medication is most effective when it's used as a component of a comprehensive treatment plan, individualized to the needs of the child and family. SSRI antidepressants are generally well tolerated by adolescents, and despite frequent media reports to the contrary, there is no scientific evidence to suggest that these medications increase the risk of suicide.

When using antidepressants, the AACAP and APA emphasize the need for frequent monitoring by a physician, especially early in the course of treatment, or when medications are being changed or dosages adjusted. An accurate diagnosis by an appropriately trained physician, such as a child and adolescent psychiatrist or other psychiatrist, is critical to treating depression and any other mental illness in children and adolescents.

More research is needed, particularly long-term follow up studies, on both the safety and efficacy of antidepressants medications in children and adolescents. Fortunately, several studies are currently underway, such as the National Institutes of Mental Health (NIMH)

Treatment of Adolescent Suicide Attempters (TASA) study and the NIMH supported CAPTN, or Child and Adolescent Psychiatry Trials Network, a large simple trials network. The AACAP and APA, in conjunction with several other organizations, have developed a comprehensive website to provide and parents and physicians with information on depression and its treatment options www.ParentsMedGuide.org

Policy Recommendations

Increased access to mental health care in Native American communities will prevent adolescent suicide. The AACAP and APA support the following policies that would increase access to care for Native American teenagers:

- The creation and funding of suicide prevention programs that destigmatize mental illness and include screening instruments to identify adolescents at risk for suicide.
- Full funding for the Garrett Lee Smith Memorial Act
- Increased appropriations for the Indian Health Service including loan repayment programs for health care providers, Tribal Epidemiology Centers and funds for the IHS' director's prevention account
- Reauthorization of the Indian Health Care Improvement Act, S. 1057
- Increased appropriations for SAMHSA's Circles of Care program
- Enactment of the Child Health Care Crisis Relief Act S. 537/H.R. 1106, legislation that will address the national shortage of children's mental health professionals.
- The implementation of community-based early intervention strategies that identify children and adolescents with emotional and behavioral disorders.
- Expanded access to drug and alcohol treatment in Native American communities.
- The creation of coordinated community-based systems of care in American Indian communities, including access to psychiatric hospitalization, through the expansion of SAMHSA's Children's Mental Health program.
- The expansion of school-based mental health programs in Native American communities, through the Elementary and Secondary School Counseling Improvement program and other initiatives.
- Increased research into the causes of suicide and effective treatments.
- Enactment of state and federal mental health "parity laws" will help ease the cost barrier for children, adolescents and their families.

The AACAP and APA appreciate this opportunity to submit a statement for the record for this important hearing. Please contact Nuala S. Moore, AACAP Deputy Director of Government Affairs, for more information about the mental health needs of Native Americans including teen suicide at 202.966.7300, ext. 126 (or Lizbet Boroughs at the American Psychiatric Association, 703.907.8645).

References:

1) National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, 2001.
2) Kochanek KD, Murphy SL, Anderson RN, Scott C. Deaths: Final data for 2002. National vital statistics reports; vol 53 no 5. Hyattsville, Maryland: National Center for Health Statistics. 2004.
3) Indian Health Service. Trends in Indian health, 1997. Rockville (MD): US Public Health Service; 1997.
4) Journal of the American Academy of Child and Adolescent Psychiatry, 40:7 Supplement. Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior. July, 2001.
5) Freedenthal, S., et al., Washington University, American Indian Multisector Help Inquiry (AIM-HI) study, 2001-2005.
6) American Journal of Psychiatry, 160:11, Supplement. Practice Guidelines for the Assessment and Treatment of Patients With Suicidal Behaviors. November, 2003.

The American
Occupational Therapy
Association, Inc.

Occupational Therapy:
Skills for the Job of Living

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION FOR THE RECORD OF THE U.S. SENATE COMMITTEE ON INDIAN AFFAIRS OVERSIGHT HEARING ON

YOUTH SUICIDE PREVENTION

June 15, 2005

The American Occupational Therapy Association (AOTA) submits this statement for the record of the June 15, 2005 hearing. We appreciate the opportunity to provide this information regarding the relationship of occupational therapy services to the prevention of suicide among youth and commend the committee for holding an oversight hearing on such a difficult but crucial social and public health problem. It is critical for Congress to understand we are facing an epidemic of youth suicide, and its devastating effects on individuals, families and communities cannot be overstated. Since the 1950's the suicide rate has tripled nationwide (Gutman, 2005). Nowhere is this epidemic more evident than among Native American communities which have incidence rates of youth suicide that are 2.5 times the national average and continue to rise (HHS, 2001). This hearing is critical to the development of a better and more effective plan of how to address the growing problem of youth suicide across the country and specifically among Native American youth.

The American Occupational Therapy Association represents more than 40,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy is a skilled health, mental health and rehabilitation service that helps individuals whose lives have been affected or could be affected by injury, disease, disability, or other health risk. The profession began in the early 20th Century in response to many identified societal needs including those of patients in mental health institutions who benefited from the new strategies used by Occupational therapists. Clients who benefit from occupational therapy include infants and children, working age adults, and older persons who are dealing with conditions affecting their ability to engage in everyday activities or "occupations." Occupational therapy is a covered Medicare service for treatment of an illness or injury to recover or improve function. Occupational therapy is also a covered professional service under Medicaid, SCHIP programs, private health insurance, workers' compensation, and other programs including the Indian Health Service Act.

Why Occupational Therapists Are Concerned About Youth Suicide Prevention

Occupational Therapists are skilled professionals trained to work with individuals and groups to improve their ability to perform daily activities or *occupations* necessary to function more effectively at home, school, work, or in the community. An important goal of occupational therapy is to help people lead more independent and satisfying lives. Nearly 30% of AOTA members work with youth either in school-based practice, early childhood intervention or other settings. This creates not only a deep concern and depth of understanding about the problem of

youth suicide but a valuable point of access for interventions targeted toward prevention. When working with Native American communities, cultural competence, or an understanding of culture and meaning, is essential to all successful intervention strategies and are critical components of Occupational Therapy Theory. Occupational therapists are also trained at group and individual engagement and facilitation skills from a clinical perspective. The skill set occupational therapists possess, as well as the fact that they currently practice in settings that would rightly be targets for new prevention programs, make their involvement essential to success. Along with other mental health providers, occupational therapists working in schools and communities on Indian Reservations and throughout the country stand ready to use their particular area of expertise to help reduce the prevalence of youth suicide.

How Occupational Therapy Can Help Prevent Suicide

The causes of suicide are multifaceted and arise from a confluence of genetic, biological, psychiatric and environmental factors. Because suicide and suicidal ideation are brought on by many disparate factors, the treatment and prevention programs must be suitably broad. Occupational therapy has demonstrated an ability to improve an individual's independence by both improving their quality of life and raising their self-esteem. In fact, the action oriented focus of occupational therapy relates well to research on suicide prevention that supports the development and utilization of skills that help individuals manage their suicidal thoughts and behavior (Gutman, 2005). One intervention strategy for which occupational therapy is uniquely suited is the development of alternate activities in which the person having suicidal thoughts can engage in to reduce stress, distract and stop the obsessive cycle of negative and suicidal thoughts (Scheinholtz, 2005). Often participation in a previously prepared or planned activity can have a significant positive impact on suicide prevention. Occupational therapy can also help individuals to regain some level of independence and function to enable people to engage in activities or occupations that provide hope and a purpose to their existence. Occupational therapists are instrumental in raising suicide awareness for young mothers, students and families and can help people develop plans that specify emergency steps to follow if they or someone they know is demonstrating early signs of illness and suicidal ideation. For individuals previously diagnosed with mental illness and at elevated risk for suicide, OT's can help improve medication compliance which is a crucial part of reducing risk. Another pillar of occupational therapy practice that relates directly to building resilience and to suicide prevention is engaging people in activities of meaning and purpose to them personally. This approach leads occupational therapists to work closely with individuals in order to determine activities that are important to their daily lives; supporting those activities and facilitating success improves resiliency, self-esteem and reduces depression as well as feelings of helplessness and a lack of hope which are clear risk factors for suicide (Amini, 2005).

What Occupational Therapists Have Done Recently On Reservations Around The Country

Occupational Therapists and Occupational Therapy Assistants are currently engaged in efforts to help restore independence and function for people and communities on many reservations. Beyond the work that is regularly done in academic settings all over the country, including

reservations, some special projects and programs are currently underway related to substance abuse prevention and awareness as well as efforts to celebrate, support and increase greater community knowledge about Native American culture in areas surrounding Reservations. Specifically, in Nebraska on the Omaha Reservation, occupational therapists managed and participated in a successful project that taught the community about the brain, neurological function and demonstrated what happens when one abuses alcohol and drugs including the use of inhalants which is a significant problem with Native American youth as well as a nationwide concern. And also in East Moriches on Long Island, Occupational Therapists developed a program that highlights Native American culture and values in order to educate the local non-Indian community (Burkhardt, 2005).

Recommendations:

AOTA is concerned about youth suicide prevention in all areas of our country but realize that the rate of suicide among Native American youth exceeds that of all other racial or ethnic groups. Therefore priority should be given to target the population most dramatically affected by youth suicide. AOTA and our members want to offer our service and expertise to help address this social and public health epidemic of youth suicide. We believe that occupational therapy is an underutilized service that can meet and address the mental health needs of children and youth in schools and communities that are at elevated risk for suicidal behavior.
Among the many initiatives possible to improve suicide prevention, one that is not often discussed is the importance of trained mental health and medical service providers. Although lack of funding is a clear barrier to service provision on many Reservations and other medically underserved areas, the availability of qualified professionals is another significant issue. Title VII funding for allied health professional education is an essential part of any plan that will successfully improve the availability of trained professionals to practice in medically underserved areas. Although Title VII funding is not under the jurisdiction of this Committee, the effects of changes to that program will certainly be felt by individuals and communities under the oversight of this Committee. The need for professionals to carry out the initiatives that will hopefully be developed as a result of this hearing and the Committee's work in this area of youth suicide prevention is as pressing as the need for funding and leadership.

One area where the Committee can use its direct influence is to expand, in scope and funding, loan repayment to healthcare practitioners in the Indian Health Service Act. Currently, there is a loan repayment appropriation in the Indian Health Service Act that must be strengthened if the shortage of healthcare professionals willing and able to work in Indian Country is going to be addressed in a meaningful way. Another consideration, in terms of expanding the scope of opportunities available, would be expanding internship opportunities for medical and allied health professionals under the Indian Health Service Act.

AOTA thanks you for the opportunity to present this statement and thanks you for caring about the health epidemic faced by this Nation's youth and families. Please contact Tim Nanof, AOTA Legislative Representative for more information about Occupational Therapy and strategies for youth suicide prevention at (301)652-6611 Ext. 2100

References:

Gutman, S.A. (2005). Understanding suicide: What therapists should know. *Occupational Therapy in Mental Health*, 21(2), 55-77

U.S. Department of Health and Human Services, Public Health Service. (2001). National strategy for suicide prevention: Goals and objectives for action. Rockville, MD: Author

(D, Amini, M.Ed., OTR/L, CHT, personal communication, June 21, 2005)

(A, Burkhardt, OTD, OTR/L, BCN, FAOTA, personal communication, June 16, 2005)

(M. Scheinholtz, MS, OT/L, personal communication, June 13, 2005)

Testimony of Tolly Estes on Suicide on the Crow Creek Sioux Tribe Reservation

- History of Suicides on the Crow Creek Reservation

My name is Tolly Estes I work on the Crow Creek Sioux Tribe Reservation contracting with Indian Health Service to provide suicide prevention to the Crow Creek Communities. My official title is Suicide Prevention Community Coordinator. I have been contracting with Indian Health Service since February of 2004.

I have lived on the Crow Creek Sioux Tribe Reservation since 1970. My mother was born on the Crow Creek Sioux Tribe Reservation and is an enrolled tribal member and my father was from the Lower Brule Sioux Tribe Reservation. My mother lived most of her life on the Crow Creek and Lower Brule Reservations. And thus I lived on those reservations most of my life.

I have worked with youth throughout my life living on the Crow Creek Sioux Tribe. I was a youth coordinator for the Episcopal Church in South Dakota and worked with all the reservations in South Dakota. I was a baseball coach for 4 years with all ages. I was the first chairperson for the Suicide Task Force in the middle 1980's and served as such until 1991. I have been actively involved with suicides since the 1980's with prevention, intervention, religious involvement and by literally burying persons. I worked as an EMT for 10 years with paramedic training and provided injury prevention and various types of training to the community and to the EMS on the Crow Creek Reservation.

Let me start by stating that I have had extensive experience in dealing with suicide on the Crow Creek Reservation. My father was a minister in the Episcopal Church and I worked close with my father especially with the suicide situation over the years. I was instrumental in starting a grassroots organization on suicide prevention and was the first chairperson for the suicide task force started in the 1980's. I have extensive experience in the subject of suicides on the Crow Creek Reservation and have been witness to events over the past 25 years.

I initially got involved with suicide prevention in the 1980's with a friend who came to me for help and I didn't know how to help him and he eventually shot himself. Shortly after that my first cousin killed himself. I became more and more involved because people kept coming to me for help because there was no one available to help. Over the years I have been involved with hundreds of people who have been suicidal. I have been involved with families after the suicides in helping them to cope and deal with the suicides. I helped organize a suicide support group for survivors in the late 1980's. I also work now with a group called Crow Creek Survivors of Suicide. There is one lady I have been working with for 18 years whose son killed himself and after 18 years was finally able to talk about her son's death. I have spent countless hours with mothers and fathers trying to cope and understand the horrific reality of suicide. I have had to step out of the suicide picture from time to time in order to heal myself from the pain that I have heard and felt for so many years from families dealing with suicides.

I have sat with persons with loaded weapons to their heads on numerous occasions because there wasn't anyone else around. I have witnessed persons kill themselves and have taken death rides in vehicles with persons extremely suicidal. So as you can see I have experienced suicide and its affects on all levels and fully understand the complexity of suicide and its victims. But I have also seen hope happen with persons and seen successes and experienced the joy of breakthroughs with persons. But this has been at a huge toll to my own life and my own personal sacrifice toward suicide prevention.

I have coordinated suicide prevention efforts and established prevention projects over the years. A huge part of the suicide prevention problem has been the inadequate funding and personnel in other agencies to meet the needs this includes; BIA Law Enforcement who has been understaffed and funded for many years, BIA Social Services who have been understaffed and under-funded for many year and certainly Indian Health Service Mental Health Program that has been understaffed and under-funded for many year, the tribal schools have been having to deal with under-funding as far as I can remember. So the suicide problem is truly the many problems of the whole community not just persons trying to kill themselves.

For 25 years I have begged for help and received none. I have seen groups come and do a presentation and feel that they have solved the suicide problem and I have seen psychologists and social workers come and feel that they are the savior to Indian People and when things would get rough they just leave. Time after time I have talked about the problem and the solutions but no one has heard the pain or felt the despair. But in all of the time I have given to suicide prevention and studying the problem I still don't have all the solutions. But I do know this that I have been through probably 12 different mental directors and I am still here and in the next 25 years after many more mental health directors who have advanced their careers I will still be here.

Prior to the 1980's completed suicides on the Crow Creek Sioux Tribe were rarely heard of. Though there were attempted suicides and gestures of suicide. But it wasn't until the 1980's that we began to see clusters of suicides and clusters of suicide attempts. The clusters began after a report by the Methodist Church called the 12 poorest counties in the Nation with Buffalo County being the second poorest county in the nation. It was immediately after this report that we saw suicide attempts in mass numbers and huge amounts of depression. This report had severely damaged the psyche of the Crow Creek Community and most likely other South Dakota Reservations as well.

In the early 1980's there were no mental health professionals on the Crow Creek Sioux Tribe at this time. With mass amounts of suicides and attempted suicides the community pulled together and called for action. There was formed a Suicide Task Force that was comprised of community members and was led mostly by the Ecumenical Church's. The Church's were the leaders in response to the suicides primarily due to their having to bury persons who had killed themselves. The Suicide Task Force began a process of developing some suicide prevention and put forth a plan that included financial support and an organizational plan with an organizational chart. Funding requests to support the Suicide Task Force were submitted to Indian Health Service, Bureau of Indian Affairs

and the Crow Creek Tribal Council, universities in South Dakota and to this date not one of the requests were ever supported or funded.

The big question is what is happening and what is causing the suicides and especially the cluster of attempts and completed suicides.

I will attempt to help people to understand the situation that came to be because I was involved with the situation most of my life and I am still living out the realities of suicide. Today I am contracting with Indian Health Service and carry the official title of Suicide Prevention Community Coordinator. I have been operating in this position since February of 2004. I was asked to take this position that was created out of the Suicide Crisis the Crow Creek Sioux Tribe was having and was basically asked to stop the suicides using my experience, knowledge and respect of the community.

To fully understand why there are cluster of suicide and clusters of attempts we need to look back 2 generations and see the things that were happening and what led up to the suicide problem and acknowledge what historic event occurred and effected what is happening now. Remember prior to the 1980's our tribes in South Dakota did not see the clusters like we see today. Also for the past 25 years Buffalo County has led South Dakota with suicide rates and is presently twice the suicide rate of all the other counties in South Dakota. The Crow Creek Sioux Tribe has been involved with this nightmare for 25 years with no one hearing the cries until now. This has been a long struggle and we aren't out of the woods yet and won't be for a long long time.

Prior to the 1950's Indian People weren't allowed to purchase alcohol. And I believe it was in 1956 that liquor was allowed to be sold to Indian People. So from 1956 to 1960 there were extreme amounts of alcohol consumption and misuse. And similar events occurred when prohibition was repelled there became mass amounts of alcohol misuse.

So from about 1956 to 1980 there was a generation that grew up with extreme alcohol abuse. Along with alcohol abuse there became many other social problems associated with alcoholism and alcohol abuse. But the most devastating thing was the destruction of families from alcohol abuse. A generation of young persons experienced and grew up with extreme forms of alcohol abuses from physical violence, traumatic deaths from car wrecks to murders and accidents of all natures and deaths from cirrhosis, there were many cases of documented and undocumented sexual abuse, verbal, mental, elderly and child abuse were at one point rampant. In 1980 I worked at a shelter called Red Horse Lodge and went into many homes to remove children because of the abuses relating from alcohol. The affects of alcohol were devastating for this generation.

Also during this period there were no laws or ordinances to protect persons and there were very little resources to help people. In 1980 there was 1 BIA Social Worker. In 1980 there were no mental health staff, there were no ordinances, and there was no way in the world any community could have prepared for the effects of alcohol from 1956 to 1980.

With all the things going on and all the effects of alcohol from 1956 to 1980 there still wasn't suicide or clusters of suicides. Things were certainly in place for clusters to happen but there needed to be a spark. And the spark came in the 1980's either 1983 or 1984 I am not sure what the date was but it came by way of a report from the Methodist Church called The Twelve Poorest Counties in the Nation.

The damage this report did to the psyche of the Crow Creek People was unbelievable. And I remember being so upset when I first heard the report and hearing elderly persons being so upset and so many people being so upset with that report because we didn't feel that we were poor. If the report had said the twelve most impoverished counties there probably wouldn't have been a problem but for Indian People at that time there thinking of poverty and being poor were 2 different things. I was asked by the tribal council to contact the Methodist Church and the group that sponsored the report and to ask what their intention were and if they had any intentions of helping with the problems that the report had created. Their response was that this was a school project that some students were doing for their education requirements. The report was well intentioned but did severe damage. It was immediately after this report that we began to see clusters of suicide attempts and clusters of suicides. We had no mental health, we had no prevention plan and we had no way to respond to the huge amount of attempts.

There was no established data system at that point in time and personally I had kept my own records and in a 4 year period had documented over 400 suicide attempts that I was personally involved with.

If one was able to track and use data that had been collected one would see over and over similar data that shows cause and effect and it is the data that needs to be used in order to have an effective suicide prevention plan.

Since the late 1960's to the present there has been a response by tribes and government through 638 contracting of substance abuse prevention. But this component never included mental health or suicide components. All of the data shows that alcohol is involved to a very high degree. Relationships are also the other huge factor in suicides. This stems from the alcohol and the break up of families. Even though there are 638 monies for substance abuse prevention substance abuse remains at unbelievable high levels and the 638 contracts for substance abuse prevention in the past 30 years have been in my opinion very ineffective as far as for community leadership for alcohol abuse prevention.

Most of the 638 substance abuse prevention contract services on reservations can most likely boast about their effectiveness with some individuals but to the larger degree have done very little in the communities to curb alcohol abuse and mass usage. And this is due to the way that they are structured and involves their history of management and leadership direction from Indian Health Service the ones whom the 638 contracts come from.

If we continue to follow data there are extreme amounts of violence occurring with young people from physical, sexual, child, mental and tons of abuse to young people from the alcohol abuse in families that stem from the 1956 allowing of liquor to be sold to Indian People. In essence youth and children were in a crisis because of all the abuse that was occurring due to the alcohol abuse that was rampant. And to a large extent is still rampant today and the children and youth are still in crisis.

From 1956 to the 1990's there was 1 BIA Social Worker who had to deal with all the affects with children and youth from alcohol abuse. The only response and available thing that made sense to BIA during this period because of lack of resources was to remove the children and displace them and even adopt them out. This was a scenario that was played out over and over with families. And to a large extent is still happening because of lack of funding by way of personnel and funding. This is why the ICWA or Indian Child Welfare Act came to be in 1978 because of the solution that this government agency opted to use at that point in history. In the 1980's and 1990's many of the suicidal persons were from families that had been split apart and adopted out through this agency.

The Methodist report isn't what caused the suicides to occur but was the spark that ignited the fuse that eventually ignited the powder keg of alcohol abuse and depression coupled with violence and abuse that ignited the deep depression, pain, hurt, anger and emotions that had been pent up for so long.

The next important part of the puzzle I feel has always been the thinking that mental health under Indian Health Service was going to solve the problem because they are the experts in mental health. When the tribes started seeing suicide and large scale attempts Indian Health Service was asked to respond and their response was mental health programming. Psychologists and social workers were brought in and hired to help the problem and in fact created a larger mess. The professionals of Indian Health Service mental health programs were brought in and given little to no resources to work with. They didn't understand the community and were unable to function in that community and today is still unable to function in that community. The problem with this is and has been that the mental health professionals may be great therapists and can function in their role as therapists but they are very poor at crisis management and most of the situations with suicide on reservations are crisis management situations. Crisis happens after hours and on weekends and Indian Health Service offers services usually during the week from 8 to 4:30. When all of the programming evolves around 1 or 2 individuals that program is usually ineffective. When life decisions need to be made by a few individuals who aren't available during the times they are needed there is great problems.

There was no infrastructure to deal with suicides in the 1980's. That's why there was a problem and why there is still a problem with suicide. Suicides on reservations involve different agencies and different regulations of agencies. A suicide doesn't just involve Indian Health Service. In fact Indian Health Service is most likely the last agency to deal with the suicidal person. The schools, law enforcement, social service, ambulance and community or usually involved with suicidal persons first and then mental health once

everything is stabilized and safe gets to come in and take the glory for successfully working with a suicidal person. The infrastructure for the other agencies and programs is extremely under-funded and is based on strategies and structure of 50 years ago and older.

In my 25 years of living and working in this community I haven't experienced one mental health director who has worked with the community, trusted the community and listened to the community or was even willing to work with the community as a partner. Every mental health director in Indian Health Service that I have ever worked with has always had to have things their way or they just wouldn't work with you or the community. Everything has had to be set around mental health's schedule and when they would be able to fit things in and when they felt like doing things. There has never been a time when the community could set the schedule. And this has been a large part in why things have failed and have been going wrong because its all about suiting the mental health and if they don't like it they don't participate. There is no accountability to the community that mental health serves.

I and many others were and still are being told we are the experts not you. But our experts who are supposed to be providing the care aren't available, don't live in our communities and don't have a pulse as to what is going on and have absolutely no respect for our culture or society that exists today.

To help you understand this let me put it quite bluntly. All the reports on suicide and data provided comes from Indian Health Service and who mental health sees within their facility and this is a documented suicide attempt, gesture or ideation. But if you were to look and look and look you won't find the real hero's who are in the middle of the suicide crisis and dealing with the suicides they aren't even mentioned in any reports, or even acknowledged. Instead you only hear what mental health is doing because it's mental health's report and since mental health in their mind is the expert you only hear about what they report about what they see themselves doing and what they want in the reports, you never see added what the rest of the community is doing.

The law enforcement are involved way more than mental health with suicide and yet they never get mentioned in the reports, the EMS is involved in suicides to a huge degree and yet they don't get mentioned in any of the reports, Social Services are extremely involved but they aren't mentioned, the domestic violence shelter is involved yet they don't get mentioned and the tribal schools certainly they are involved and they aren't mentioned and many, many more agencies and yet they never get mentioned its always what Indian Health Service Mental Health is doing. But maybe they don't want to mention the others that are actually involved with crisis's because the mental health aren't truly involved with the communities they serve and aren't able to hear what people and the community are saying. Indian Health Service Mental Health is so caught up in its own self serving institutionalism that it forgets that it serves the public and not the other way around.

In a lot of respects the mental health program of Indian Health Service has had to use who it could get to qualify for the position as a therapist because there aren't that many

available and as a result in my opinion many of the ones I have dealt with have been incompetent. But every one of them have told me that I am not qualified to challenge their incompetence because that needs to come from some one that has equal education as them in order to challenge there competency.
And the other reality of the situation is that the mental health programs within Indian Health Service are about making money through third party billing. So you must have persons who are billable and persons who can bill.

When I first came to Indian Health Service as a contractor in February of 2004 the Tribe was in a suicide crisis with clusters of suicides and clusters of attempts and things were totally out of control. The Mental Health Program was responding but the public had lost all faith and belief in the Mental Health Staff and especially the leadership of the director of mental health. And this is why I was brought in to stop the suicides because no one trusted mental health anymore and especially the mental health director.

The plain fact is Indian Health Service knew what the problem was and still is and has chosen to do other things instead of change the leadership and remove persons who are incompetent. The follow up care was a joke and persons with severe mental health issues basically went un-helped.

There was a mental health technician who was trained in QPR or Gate Keeper training which is a suicide intervention training tool. Training was offered over and over to the community and hosts of school teachers and other government staff were given this training and we still had the suicide attempts and suicides. The reason is that the ones who were given the training don't live here. Most of the teachers in the school system don't live here. Most of the government employees didn't live here on the reservation. So all the people who were receiving the training don't live here. And most of the suicide attempts were happening after hours and on weekends when all the people who received the training weren't around.

The Mental Health Director doesn't live here, the superintendent of Tribal Schools doesn't live here, and the BIA Superintendent doesn't live here. All the important persons in the community don't live here and yet there the ones who receive all the training and all the needed incentives within their jobs to take the trainings and yet none of them live here. And none of them use the training to help people who needed help because they didn't know anyone and aren't involved with the community.

If there is going to be an effective suicide prevention plan than it must absolutely include those having the problem and must target that population and must engage that population.

So part of my job was finding a way for the prevention and intervention training to happen. First we had to find out through available data what the problem was and who was having the problem and this involves looking at data. Not just data from Indian Health Service but data from the whole community. All of the data clearly showed that ages 14 to 21 years of age were and still are in crisis. I gathered data from the Tribal

Courts, BIA Law Enforcement, Ambulance Service, Mental Health, BIA Social Services, Tribal Schools, BIA Social Services and from what ever program I could get data from. All the data correlates and reflects the crisis of suicide and what ages are having the problem but the data also reflects crisis of substance abuse and violence.

Prior to my contracting with Indian Health Service the only data gathered and used was data from Indian Health Service and especially mental health. This data in no way reflects the magnitude of the situation and the suicide problem. And in my opinion only reflects less than 50% of the actual suicide problem since the data is only about Indian Health Service Mental Health Data and doesn't reflect the involvement of all the other agencies involved with the suicide problem.

So it was simple in my mind target population and what is going on with this group. So I designed a simple project called Peers Helping Peers. In this project we would target the age group of 15 to 21 years of age. In this project we would need to address suicide, substance abuse and violence or as we called it family relations.

So I coordinated with mental health to provide QPR training to this age group. I also coordinated with Violence Shelter to provide relationship or violence prevention and intervention. I coordinated with the Tribal School Substance Abuse Counselor to provide substance abuse prevention and intervention training. This project would specifically target persons having problems with suicide. And we needed to have a non threatening way to be able to present this to this age group. We also needed to find a way to get this target group to participate.

One must remember that we were in the middle of a suicide crisis and were averaging an attempt a day at this period and had just had a successfully completed suicide.

So we asked organizations to donate financially to this project. The plan was to provide an incentive of $200 per persons to be in the project for 1 week. They would receive three days of training on suicide, violence and substance abuse prevention and intervention. We would use all the data collected from the various agencies to provide awareness as to what was happening in their community and with their friends and peers. The goal was to challenge this targeted age group to help their peers and to stop the suicides and suicide attempts.

The other concern was how to get the persons participating to retain the information and how to help those participating to reach their friends and peers. So within the project after the three days of training the participants were required to make 10 contacts with their peers and there was a questionnaire that the participants were required to use when talking with their peers. On the questionnaire were 5 questions pertaining to suicide, 5 questions pertaining to violence and 5 questions pertaining to substance abuse.

The other problem that occurs with clusters of suicides and especially young people is secrecy. All the friends are talking about suicide and persons are swearing their friends to secrecy. And all the young people know who was trying to kill themselves but not the

adults. So in the questionnaire on suicide the question would ask are you thinking about killing yourself and if yes do you have a plan and may I refer you for help and would you go for help if I go with you. There were similar questions on substance abuse and violence.

We were able to raise $14,500 and this allowed us to have 72 persons participate. Our goal was 200 participants and $40,000 but that just didn't happen. Out of those 72 participants they contact 758 other people and provided awareness, prevention and intervention to them. I had 192 persons who had applied. About 70% of those who had participated were persons who had attempted within the past year at least once.
I am providing a brief data report on the project.

PEERS HELPING PEERS PROJECT QUESTIONAIRE DATA

MALE	FEMALE
382	376

C/R-A(YES)	C/R-A(NO)	C/R-B(YES)	C/R-B(NO)	C/R-C(YES)	C/R-C(NO)
555	203	619	139	535	223

S/1-Q1	S/1-Q2	S/1-Q3	S/1-Q4	S/1-Q5
Y---N---B	Y---N---B	Y---N---B	Y---N---B	Y---N---B
35-535-188	12-542-204	92-467-199	42-515-201	105-453-200

SA/1-Q1	SA/1-Q2	SA/1-Q3	SA/1-Q4	SA/1-Q5
Y---N---B	Y---N---B	Y---N---B	Y---N---B	Y---N---B
220-400-138	198-366-194	175-306-277	95-509-154	52-551-155

FR/1-Q1	FR/1-Q2	FR/1-Q3	FR/1-Q4	FR/1-Q5
Y---N---B	Y---N---B	Y---N---B	Y---N---B	Y---N---B
53-486-219	42-476-240	47-440-271	75-443-240	36-481-241

FHX			PHX		
U	Y	N	U	Y	N
166	229	363	166	143	450

AGE

9 Y/O-	1	16 Y/O-	125	23 Y/O-	11	33 Y/O-	4
10 Y/O-	1	17 Y/O-	123	24 Y/O-	10	38 Y/O-	2

PERSONS INTERVIEWED

PARTICIPANTS

AGE	NO.
15--	10
16--	15
17--	18
18--	10
19--	10

11 Y/O-	1	18 Y/O-	92	25 Y/O-	7	41 Y/O-	1	20--	6
								21--	2
								22--	1
12 Y/O-	7	19 Y/O-	81	26 Y/O-	1	42 Y/O-	1		
								TOTAL	**72**
13 Y/O-	31	20 Y/O-	74	29 Y/O-	8	45 Y/O-	2	**MALE**	**FEMALE**
								29	**43**
14 Y/O-	43	21 Y/O-	28	30 Y/O-	5	46 Y/O-	1	**TOTAL APPLIED**	
								192	
15 Y/O-	70	22 Y/O-	17	32 Y/O-	3	47 Y/O-	2		
						49 Y/O-	6		
								TOTAL	
	154		**540**		**45**		**19**	**758**	

This project targeted ones having the suicide problem and having the suicide crisis. This project also exposed persons to programs that can help them with crisis of suicide, violence or substance abuse, thus breaking the stigma about getting help from those services. We also did follow ups on all the persons that had indicated on the questionnaire that they were having crisis issues. There were 35 persons who indicated that they were having suicide thoughts and were thinking about killing themselves. We followed up on those individuals and made interventions. This project was also about intervening with people and in my opinion this was a very successful project.

Another problem with suicide is what to do when there is a crisis. This project specifically trained people on what to do and was specifically designed to use what community resources were available. The peer's participants were the designed resource and they were challenged to intervene and save their friends lives. This group responded and accepted the challenge and stopped the suicide clusters and clusters of attempts.

We also designed and worked with BIA Social Services on a project that we name Ikceya Wawokiya or Natural Helpers. This project targeted persons that were in the most poverty situation and were receiving GA or Government Assistance and had no other financial income. There were over 100 participants in this project.

These two projects were projects that specifically targeted persons and families having the crisis of suicide and attempts.

These two projects were created to stop the immediate crisis. This project was scary and yet a very bold attempt at stopping suicide. And in reality was very cost effective. $14,500 reached out and helped the whole community.

Presently we are into the second year of Peers Helping Peers and once again only able to secure $16,000 that will reach 80 young people and another 800 indirectly. This year we have included a youth survey that will show what the youth at truly dealing with.

Every one that I have submitted funding to for the Peers Helping Peers don't like the idea and feel that Peers Projects are ineffective and don't want to fund them. This project isn't just a Peers Project but so much more.

This leads me to the next stage of this testimony and that is being able to monitor suicide activity and to tract what is going on with young people. During the school year we see all types of adult supervised activities and suicide activity is closely monitored. There are teachers, counselors, bus drivers, janitors, advisors and a host of staff and established referral processes to get persons help if the crisis occurs. And this is the most productive prevention time because the resources are so available. And this needs to be continuously worked on and fully developed to keep those lines of communication and referral processes open and available.

But the times that we run into problems are during the school breaks. This is during the holiday season and during the summer months. This is when all those resources aren't available there aren't adult supervised activities to monitor suicide activity or activity of young people. The school resources are gone on break mostly because most of the staff don't live on the reservation and during this period its not there responsibility.

Most of the documented suicides have happened during the holiday season. This is when the intensity of substance abuse peaks at unbelievably high levels and violence occurs most often. And this is also the time when we don't have any way to monitor suicide activity until it presents itself in a severe attempt or completed suicide. Historically the holiday seasons are times in any community when depression increases greatly while on the reservations the depression reaches devastating proportions. It was historically the holiday season when tribal historic events occurred. The Crow Creek Tribe came to be from the Minnesota Uprising which happened during x-mas season. Wounded Knee Massacre happened during the x-mas season, Sand Creek Massacre happened during the X-mas season and countless other historic events happened during this period. This is ingrained and plays a huge role in the depression during the holiday season. Also during the holiday season are many memorial reminders of persons who killed themselves. And anniversary dates of death after death during this time.

The other time that suicides are difficult to monitor is during the summer months when school isn't in session. And this is also times when there aren't any adult supervised activities happening.

The Peers Helping Peers was also designed so that we could monitor suicide activity and to be in contact with young people during the summer months.

For the holiday season we worked with SAMHSA and received an emergency grant for a project called SAFE HOUSE. The safe house was offered to the community as a place to

get away from the alcohol and drugs and depression during the holiday session and for an opportunity for us to monitor suicide activity. There was 4 trained staff on at all times to provide safety and to be available for crisis intervention. In a 2 month period there were over 900 persons who came to the safe house. In this period we also made over 90 referrals involving suicide, violence and substance abuse. This project also specifically targeted persons to come to the safe house so as to get through the depression of anniversary dates of completed suicides. There were 6 completed suicides the holiday season before and this was a very difficult time for families and individuals.

Without the funding from SAMHSA and having available staff through this period we most likely would have had more suicides. Part of the SAMHSA funding was used during the school year prior to the holiday break to work with a project we called Tribal School Peers. This was an after school project that had 40 to 50 students each that were provided a $20 incentive each week for participation.

The Crow Creek Sioux Tribe Reservation is also the poorest county in the nation with poverty levels reaching 80%.

I have heard many complaints from people about providing an incentive for participation but if I didn't provide the incentive there probably wouldn't have been participation. My goal was to stop the suicides and incentives worked because of the poverty. The students in the school have no financial income at all. The ones involved during the summer have no financial income and their families have no income and yes poverty plays a huge role. Many of the people who came to the safe house had no food to eat during the holiday season and a meal, a place to be safe and someone to talk to was very inviting and very successful.

I am on contract through emergency grant funding and my grant will run out after the end of September of 2005. I was given no resources and was asked to stop the suicides in what ever possible way. I had no available funding, no budget to work with and was told to write grants besides do all the things I have mentioned so far. In this position I also provided coordination between many services that meant meeting with agency after agency, working after hours and weekends, I also provided debriefings to the EMS, Police and schools from the other traumatic deaths.

The last historical event of things that I need to mention that is so crucial to understand is that besides the suicides there are usually many other traumatic deaths that are occurring and there is very little grief counseling happening and there are very few to no spiritual leadership that are helping persons to deal with the grief.

This type of data must be tracked. On this reservation in the past 5 years there were nearly 200 deaths this is an average of 40 deaths a year for a population of a little over 2000 people. What types of death play a large part in suicides but especially deaths of persons who are the leader figures in their families? We had over 120 grandparents that died in the last 5 years but those elderly were raising their grandchildren they were also the ones who were financially stable in their family and now that they are gone the

financial part is also gone and many of those grand children are now displaced. That's 120 families who are not only dealing with grief but are in great crisis.

My other concern is that of funding that is available. I haven't found available funding for suicide prevention. And having to submit for funding in a competitive grant process is unrealistic and foolish. We are in a crisis. I have been involved with times when we have had sometimes 5 to 10 severe attempts in one day and in some weeks there have been 15 to 20 attempts. And to have to write a grant and to be competitive deeply concerns me. Why can't the crisis be acknowledged and there be funding for places that need the help. I am in no position to be competitive and don't have the time to compete its ridiculous in my opinion.

Transportation is the other issue. There aren't very many facilities in South Dakota to send people for help. And one place says it's a substance abuse issue and the other place says it's a mental health issue and every place in reality it's a funding issue. The mental health facilities aren't culturally sensitive and haven't a clue about Indian People and about their lives and the place that they come from. I doubt seriously that any of the persons working in those facilities have an understanding of poverty situations.

So this is my report in as brief form as possible so as to get an understanding of all the issues involved with suicide and clusters of suicide. But in order to have an effective prevention program there needs to be certain aspects for this reservation or it won't work and there are as follows:

- Adequate funding that isn't based on competitiveness
- School based prevention for in school session times
- Holiday season prevention
- Summer time out of school session time
- Prevention model that functions using data from agencies that show youth and children crisis and monitor of child youth
- Prevention projects that target specifically those having the problem and that provides intervention training
- Prevention projects that includes referral components so persons can be helped
- Prevention projects that are joint projects that include substance abuse, violence abuse and suicide abuse prevention and intervention
- After hour coverage through use of crisis response training and teams from the community/compensation for crisis response team members
- Transportation funding for emergency treatment
- Cultural and historical awareness of suicide

It takes people and not just one as coordinator but it takes a crew of suicide prevention staff to deal with the problems and to meet the community needs.

And my last thought is this. I have submitted recommendations to Indian Health Service over and over but to this data there hasn't been one iota of support for the

recommendations that I have offered in regards to suicide prevention. As long as the suicides have stopped that's all that is cared about and as long as reports reflect kindly on Indian Health Service. I have been told over and over that I am just a contractor and what I say doesn't matter. While it does matter. And just because I am not an Indian Health Service full time government employee Indian Health Service should heed the advice of someone who has great knowledge of the suicide problem. And if we continue to go in the same direction that we are going there will be many more clusters of suicide attempts and there will be many more clusters of suicides.

I feel that I understand the whole situation involving suicide and I also feel that I have the knowledge and skills to bring the suicide problem to a level of understanding and resolve but with the present structures in place and leadership I feel that the problem will only be given token importance until the next suicide crisis rears its head and persons are asking questions of why once again.

I don't feel that Indian Health Service is committed to a total suicide prevention plan that works because that would involve a financial commitment toward prevention that Indian Health Service isn't willing to commit or has the resources to commit. And until that happens the fears, pain, anxieties and families living in fear of the next suicide will continue to plaque Indian Tribes for years to come.

This is my testimony as to the suicide crisis on the Crow Creek Sioux Tribe Reservation.

Sincerely,

Tolly Estes, Suicide Prevention Coordinator
Indian Health Service

United Native America
7-23-05
Call For Senate Hearing

I want to thank you for accepting our request to send you information on Native American issues that we strongly feel should be addressed by the Indian Affairs committee. Below is our petition calling for a national holiday for Native Americans, we have incorporated other issues into the petition that are of great concern to the Native American community as to obvious racial exclusion of Native Americans and misuse of our heritage.

At this time 7-23-05 over 41,000 people have signed United Native America on line petition, nation wide we have over 100,000 signed petitions calling on the federal government to address these issues by calling for senate hearings.

We are aware that the senate has in the past addressed a wide range of social issues concerning other ethnic groups. We expect no less in the handling of the Native American community issues before this governing body.

United Native America requests after reviewing all information sent to the senate Indian Affairs Committee that this governing body would call for senate hearings to address these issues by calling in top industry executives to include federal, state, local and appointed officials, tribal nations representatives should be included in this group.

The scope of these hearings should cover but not limited to, all television networks (Total lack of Native American presence in their programs) Movie industry (again total lack of Native American presence) National sports Industry (Non recruiting of Native Americans as players and misuse of Native American heritage).

National media industry failure to report on Native American community issues, heritage events to include (American Indian Heritage Month of November) As they do for all other ethnic groups. National music Industry failure to incorporate Native Americans as to their musical heritage and performing groups, all other ethnic groups are well represented in this Industry nationally to the public.

National Advertising companies failure to incorporate Native Americans appearing in their commercials promoting their products, this is visually present from day to day. Native Americans incarcerated by, federal, state, county, city and juvenile detentions are subject to racial attacks, slurs and inhuman treatment by staff members. They are deprived of practicing their religion by law, prolonged solitary confinement and segregation from Native American group activities within the system.

County school systems that allow racial harassment of Native American students by staff and faculty, racially biased punishment, racially forced out of schools and incarcerated over trivial infractions of school rules. This is a sad but true fact concerning Native American students in our country.

United Native America asks that the Indian Affairs committee conduct their own investigation into issues stated above. Each of these issues address the health, education and poverty of Native Americans. It is obvious to the Native American community and others that they are being racially excluded and disenfranchised as a race, It's time for our federal government to deal with these issues in a respectful manner and to state their recommendations and orders as to resolving these issues.

On line petition:
http://www.petitiononline.com/indian/petition.html

Report sent by:
Mike Graham, member Oklahoma Cherokee Nation
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US Senate Committee On Indian Affairs
Oversight Hearing On Indian Youth Suicide Prevention

ACLU intervenes at high school

Posted: July 04, 2005
by: David Melmer / Indian Country Today

RAPID CITY, S.D. - Seventeen-year-old Zack Eagle Hawk will not return to school in Winner, S.D. He has had too many suspensions, court appearances and racially motivated harassments to allow continued learning in the public school.

Eagle Hawk moved with his mother from Indiana to Winner in 2003. Prior to that time he had never been in trouble at school; in fact, he loved math and reading mysteries, dramas and sports autobiographies.

But once in Winner, he was suspended for drawing a medicine wheel and writing "Native Pride" in his notebook - symbols of gang activity, the school administration said. Law enforcement authorities in Winner said there was no gang activity in the small border town, which abuts the Rosebud Sioux Reservation.

In January, Eagle Hawk, while in a physical education class overheard one white student say, "I guess it is time to throw rocks at greasy Indians." The boy admitted he said that to Eagle Hawk and called him a dirty Indian.

Eagle Hawk was suspended for harassment.

Eagle Hawk's adversary also used racial slurs and curse words. School records do not show Eagle Hawk's harasser was ever punished.

At a press conference, Eagle Hawk said the students at Winner kept insisting he was a member of a Rapid City gang. Eagle Hawk said he had never been in Rapid City until the day of the press conference. Rapid City is 220 miles from Winner.

The Rosebud Tribal Council teamed up with the American Civil Liberties Union to file a complaint to the U.S. Department of Education on behalf of 14 American Indian families. The complaint asks that an investigation, which in 1997 revealed misconduct against the American Indian students in the middle and high schools, be reopened on the Winner School District. An agreement was worked out in 2000, and by 2004 the Education Department was satisfied the district had solved the problems and closed the case. The complainants want the case reopened.

The school asserts that there is no difference in the discipline policy for non-Indian and American Indian students and stands by the report it gave the Department of Education.

The ACLU investigation turned up evidence that - in practice - there is a major difference. Most of the data collected by the ACLU came from school and court records.

The American Indian student population in middle and high school is 25 percent. The out-of-school suspension rate for American Indian students is 59 percent and in-school suspension is at 85 percent.

The Rosebud Sioux Tribal Council, the Rosebud Department of Education and the ACLU charge that the Winner School District manipulated its records to present the Office of Civil Rights with a grossly distorted picture of its disciplinary practice and racial relations.

"Through its discriminatory practices, the Winner School District systematically pushes Native American children out of its schools, often into the juvenile justice system.

"To permit Winner Schools to remain above the law will encourage other school districts to engage in the same illegal activities with the same impunity," said Robin Dahlberg, senior staff attorney with the ACLU.

School officials declined requests for comment.

The problems found in Winner are part of a national trend toward get-tough policies on school misconduct, the ACLU stated. That policy leads to increased suspensions for trivial conduct and the use of law enforcement to handle minor school discipline.

"We found that the Winner School District is systematically forcing Indian children out; forcing them to go to school elsewhere, far from home;

forcing them to drop out and increasingly forcing them to juvenile detention facilities," said Catherine Kim, attorney for the ACLU.

She said that one-quarter of the students in the middle and high school are American Indian, but only two graduated from high school in the last year the statistics are available.

The No Child Left Behind Act was supposed to stop that practice, but educators said it is encouraging more suspensions to keep the students with higher test scores in class while turning out the lower-achieving students.

Jennifer Ring, executive director for the ACLU of the Dakotas, said Winner is not the only border town accused of racial harassment with discipline. She said complaints come to her office from larger cities and smaller towns, mostly bordering the reservation.

More and more children are leaving school with criminal records instead of high school diplomas, Kim said. A number of problems in Winner point to the misuse of the school board's gang policy, which defines gang activity as a group of individuals involved in two or more felonies or misdemeanors.

"When a Native American kid writes 'Native Pride' in his notebook or draws pictures of coyotes or peace pipes, this rule punishes them for gang-related activity and sends them to the authorities," Kim said.

Another complaint about Winner is that Caucasian

students harass American Indian students and school officials do nothing to stop the activity. "If a Native American kid fights back, though, he is taken away by police and is prosecuted for assault."

Rodney Bordeaux, tribal council member and chairman of the education committee, said when children are harassed every day they get tired of it. They just want to go home to their families and be happy, and get up the next morning and go to school. If they can't, he said, it affects their education.

"We want our children to have the best education opportunities possible, but if public schools maintain a hostile environment, our children will only suffer," Bordeaux said.

Boarding schools in the state are an option for these students, but they are located hundreds of miles away from home. St. Francis School on the Rosebud Reservation arranged to send a bus to Winner to pick up the students and take them to school, but the students have to get up as early as 4 a.m.

The Todd County school system on the Rosebud Reservation is 90 percent American Indian and has a dormitory. Many students come from Winner to attend school at Todd County, but the dormitory is not large enough.

Cindy Young, director of education for the Rosebud Sioux Tribe, said the tribe is working toward increasing the dormitory space at Todd County as well as the number of buses to bring children to the Rosebud.

She said attempts to put an American Indian on the board of education have met with strong resistance. For any changes to occur, she said, there has to be community

awareness. But, racial tensions have taken place for generations in the border towns in the Great Plains. Many adults remember the same treatment in Winner or other border town schools more then 30 years ago.

"The ACLU has received so many complaints over the years about mistreatment of Native American students in school districts across South Dakota that we see this as a problem that cannot be ignored.

"The government can no longer allow Native Americans to be treated as second-class citizens," Ring said.

Report sent by:
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If America is going to have national holidays, then one of them should be "Native American Day" This should be done for our Indian children.

"Internet National Holiday For Native Americans Petition"
http://www.petitiononline.com/indian/petition.html
As of June, 27 over 41,000 people have signed
UNA has over 100,000 hand signed holiday petitions

H.RES.76 Calling for National Native America Day

Congress of the United States
Senate of the United States
President of the United States

We the undersigned come together before you to request that each of these governing bodies take all necessary action to bring about a Federal Holiday for Native American Elected Leaders, To include Congressional hearings on the racial exclusion of Native Americans in movies, television, sports advertising, music companies, etc.

With the special government to government relationship between the Indian Government of America and the Federal Government it is fitting for the Federal Government to enact this holiday, and conduct Congressional hearings.

Indian governments and the people they represent are requesting that the federal government bring about a National Holiday for Native Americans to be celebrated by all citizens of America and people around the world.

This holiday would pay tribute to Indian Tribal Leaders to include Alaskan Leaders and Hawaiian Leaders. This holiday would also pay tribute to those that endured the world's longest holocaust and most costly in human lives.

It is further stated that no Indian Government nor its people find reason to celebrate and pay for Columbus Day. Seventeen states do not recognize Columbus Day. The state of South Dakota has changed Columbus day to Native American Day.

Therefore be it resolved that the Federal Government should reevaluate Columbus Day by moving it back to its original day the second Wednesday of October and not be a tax paid holiday as is St. Patrick's Day and Ocktoberfest, and make the second Monday of October a Federal holiday for Native Americans.

The polls we conducted across the country show that the vast majority of Americans prefer changing Columbus Day as to creating a whole new holiday.

It is inappropriate for Indian children and children of America to celebrate Columbus discovering a nation of people and not having a holiday paying tribute to the people of those nations.

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Report from United Native America

1. honor all treaties made with Indian nations, ratified and non-ratified treaties.

2. Establish a permanent position on the US. Supreme Court to be held by a Native American appointed judge. This should be done to bring about a stronger government-to-government relationship and representation of First American nations on the country's highest court.

3. Establish a federal oversight committee consisting of First American Nations and federal representatives to review all arrest cases deemed to be political involving members of First American Nations.

4. Strengthen government-to-government relations between First American Nations, Federal and State governing bodies through negotiations, stopping state governments from filing frivolous lawsuits on Indian nations, and closing of First American Nation businesses without federal oversight before such closings take place.

5. Support and assist in all areas to reinstate the Native Hawaiian's government, to establish a government-to-government relation with the Native Hawaiian people's government with full sovereignty and self-determination before the United States Government, and to recognize all land claims and restitution to the Native Hawaiians to said land claims.

6. Increase funding for Native American health care centers and educational institutions. In doing so America as a whole will benefit; at the present time most Native American health care centers and schools are operating at third world level or are nonexistent within their communities.

7. Increase Native American housing funding since there is a critical housing shortage in the Native American community; this issue needs to be addressed now! Failure to address this issue results in the deaths of Native American men, woman and children each year unnecessarily.

8. Implement truth in education regarding Native Americans in our nation's school system, and establish a nationwide guideline with the support of tribal nations on educational information concerning Native Americans for all schools to base their curriculum.

9. The Native American community calls upon the Federal government to rescind all Medals of Honor issued to US military personal for the massacre of 350 men, women and children at Cankpe Opi (Wounded Knee). Medals of Honor issued to US military personal for all other historically documented American Indian massacres should also

be rescinded.

Be it resolved; that the federal and state governments work with all Native American governments and their peoples to resolve all issues stated above, and

Be it further resolved; that federal and state governments show the Native American community and people around the world that they are in full support of bringing about this much needed change for the Native American community.

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**TESTIMONY OF CHAIRWOMAN KATHLEEN W. KITCHEYAN
OF THE
SAN CARLOS APACHE TRIBE**

**FOR THE OVERSIGHT HEARING ON
YOUTH SUICIDE PREVENTION**

BEFORE THE COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ROOM 485, RUSSELL OFFICE BUILDING

JUNE 15, 2005

I thank you, Chairman John McCain, Vice-Chairman Byron Dorgan, and other Members of the Senate Indian Affairs Committee, for allowing me to submit this testimony for the record. My name is Kathy Kitcheyan, Chairwoman of the San Carlos Apache Tribe based in San Carlos, Arizona. My testimony provides the views of the San Carlos Apache Tribe. We commend the Committee for holding this important hearing on youth suicide prevention. We appreciate the dedication to this serious issue you have shown by the fact that this is the second hearing that the Committee has held on this serious topic during this session of Congress.

The problem of teen suicide on the San Carlos Apache Indian Reservation is, like so many other tribal communities across the country, quickly reaching epidemic proportions. Our Reservation youth are in pain and are suffering, and we must collectively work together to address and solve this tragic problem.

In his testimony before the Senate Indian Affairs Committee on youth suicide prevention in North Dakota on May 2, 2005, Dr. Charles Grim, Director of the Indian Health Service, provided the following national statistics that we restate here for purposes of comparing the national suicide-related rates among Native Americans with the suicide-related rates at San Carlos:

- Suicide rates for Native Americans range from 1.5 to over 3 times the national average for other groups (*Trends in Indian Health*, 2000-2001).

- Suicide is the second-leading cause of death for Indian youth aged 15 – 24, and the suicide rate for Indian youth in this age range is 2.5 times higher than the national average (*Trends in Indian Health*, 2000-2001).

- Suicide is the fifth leading cause of death overall for males and ranks ahead of homicide (*Trends in Indian Health*, 2000-2001).

- Young people aged 15-34 make up 64% of all suicides (*Trends in Indian Health*, 2000-2001).

- While suicide rates for all other racial groups declined from 1990 through 1998, they continued to increase for Native Americans.

- In a 1999 study of 11,666 7-12th grade Native American youth, 22% of the girls and 12% of the boys reported attempting suicide at some point in their young lives.

These statistics are certainly alarming on a national level. Unfortunately, on our Reservation, the numbers are tragically even higher. Our Tribal Emergency Medical Services (EMS) program compiled the following suicide-related statistics for this testimony:

- In 2004, there were 101 suicide attempts. The age range was 15 to 54 years old with 50 individuals being females and 51 being males. Of the suicide attempts in 2004, 25 of the individuals were 18 years of age or under, 13 were between the ages of 19 and 21, and 17 were between the ages of 22 and 25. Of the 101 suicide attempts, two resulted in death. One death was that of a 26-year old male and the other death was that of a 28-year old female.

- Since January of 2005, there have been 21 suicide attempts. The youngest attempt was a 10-year old and the oldest was a 53-year old. 4 of the attempts were committed by persons 18 years of age or younger, 6 were between the ages of 19 to 25, and the remaining 11 were 26 years old or older. Of the 21 suicide attempts, 2 resulted in death. Both were males who were 25 years old and 34 years old.

These suicide-related incidents and deaths have had a severe and adverse impact on my community. We live in a rural area and our community is tight-knit. We all know one another or know of each other's families, so tragedies like this touch and sadden us all. Our total tribal membership population is 13,034. 30% of the population (or 4,297 members) are under the age of 18 years; 60% are between the ages of 18-54; 4% are between the ages of 55-61; and 6% are 62 years of age or over. A high majority of our members, 84%, live on the Reservation. We worry about the psychological, mental, and physical effects that these suicides have on our people, especially our youth, when suicide clustering is a documented phenomenon, such as in the case of the Standing Rock Reservation.

Given the high rate of suicide on our Reservation and its rippling effects on small communities, we are extremely concerned about this problem. The high suicide rates are due to many problems on the Reservation. Our youth, at every turn, are confronted with many obstacles and hindrances. They are faced with gang involvement, alcohol, drugs (methamphetamine use is increasing), teen pregnancy, familial dissolution, and other disadvantageous factors. Also, while we have worked hard to develop our Reservation economy, 76% of our Reservation population is unemployed compared to the national unemployment rate of 5.7% and the state of Arizona rate of 5.3%. Further, we suffer from a poverty level of 77%, which must be unimaginable to many people in this country who would equate a situation such as this as one found only in third world countries.

As a result of these circumstances, our youth feel a sense of hopelessness and isolation as there are little, if any, opportunities for jobs, careers, or personal advancement. Dr. Charles Grim summed up the situation best in his testimony before the Senate Committee on Indian Affairs recently when he stated, "Suicide is not a single problem; rather it is a single response to multiple problems. Neither is it a strictly clinical or individual problem, but one that affects and is affected by entire communities." According to Ulonda Shamwell, Director of the Division of Policy Coordination at the Substance Abuse and Mental Health Services Administration (SAMHSA), in her testimony before the Senate Indian Affairs Committee, Native youth are at heightened risk of suicide due to factors such as high poverty and unemployment rates and lack of opportunities on reservations, which can contribute to depression and lead to substance abuse. Ms. Shamwell also noted that depression and substance abuse are the most common risk factors for completed suicide among American Indian and Alaska Natives.

The goals and objectives of the National Strategy for Suicide Prevention, which is a collaborative effort of agencies within the U.S. Department of Health and Human Services, encompassing the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the National Institute of Mental Health (NIMH), the Office of the Surgeon General, and the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Suicide Prevention Advocacy Network (SPAN), are well-stated for the nation. However, there needs to be greater focus and action taken to address the suicide crisis in Indian Country where it is most prevalent.

Mental health programs in Indian Country are grossly underfunded and cannot adequately address these mental health issues. For example, at San Carlos, an IHS psychiatrist is limited to seeing patients for only 4 hours once a month and this includes both children and adults. This psychiatrist must travel a two-hour distance to San Carlos and accessibility to services is further complicated by the lack of transportation for many community members.

In order to adequately implement suicide prevention efforts in Indian Country, there must be a comprehensive approach that is culturally anchored with interventions that are evidence-based. The following are recommendations the San Carlos Apache Tribe respectfully submits:

1) Invest in programs in tribal communities that restore hope in our youth and encourage them to be optimistic about their futures, such as economic development initiatives, vocational training, educational programs, mental health services, community development programs, and family support groups.

2) Increase what we know about suicide in American Indian communities by promoting and supporting research from national research institutions such as the National Institutes of Health and the Centers for Disease Control. However, Tribes MUST be involved in the planning process of this research simply because they know their communities best and know where and how to obtain relevant data.

3) Based on this research, secure resources to develop and implement prevention strategies/programs that are culturally relevant.

4) Establish a tribal technical support center to build the capacity across tribal nations to implement and evaluate tribal suicide prevention programs.

5) Additional funding MUST be provided to support mental health services in tribal communities.

6) Promote and support a concerted and coordinated effort among federal, tribal, state, and local community agencies to address this crisis. Partnerships will be key to the success of eliminating this "silent epidemic."

7) Develop and establish an American Indian suicide surveillance and prevention system to collect information from IHS, law enforcement and medical examiner databases.

All of these recommendations are geared toward seeing what methods and systems can be put in place so that our youth feel that life is worth living and that they can dream and that their dreams can come true. As our kids are our future, I hope that we can work together to solve this grave problem. Again, thank you for allowing me the opportunity to submit this testimony.

STANDING ROCK SIOUX TRIBE

A Prepared Statement from Chairman Charles W. Murphy
For The Senate Committee addressing Teen Suicide in Indian Country
Washington D.C. June 15, 2005

Greetings from the Standing Rock Sioux Tribe I would like to take this opportunity to express our appreciation for the opportunity to submit testimony at these important hearings.

The Standing Rock Sioux Tribe is experiencing an alarming number of deaths by suicide among our youth. The following testimony will illustrate the need for increased funds for additional personnel to improve the I.H.S. Behavioral Health (mental health) services and B.I.A. Law Enforcement departments on the Standing Rock Reservation. These agencies contribute a vital function to the delivery of services geared to protect the well being of our youth and families. Upgrading the programs is essential for the development of safeguards for our future, the youth.

The Standing Rock Sioux Tribal members are descendants of the Teton and Yankton Bands of the Lakota/Dakota nations. The total land area of the Standing Rock Reservation is 2.3 million acres and of that 1,408,061 million is tribally owned.

The Standing Rock Reservation is located within the Great Plains Regional Office, where the line of authority is regulated for the local Indian Health Services as well as the Bureau of Indian Affairs Law Enforcement agency. The I.H.S. operates a hospital on the North Dakota side and a clinic in South Dakota. The hospital is a 16-bed facility at Fort Yates, North Dakota. Law enforcement is provided by the Bureau of Indian Affairs with a force of (8) officers.

From November 2004 to May 2005 there have been (12) completed suicides on the Standing Rock Reservation. The age range for the completed suicides is (14) to (26). Out of these (4) were females and (8) males. The 2000 U.S. census data show the age group under (24) to be (49.4%) of the total population on the Standing Rock Reservation and those under (19) were (43.2%) of the same total. All the completions were by hangings and all with the exception of (1) occurred in their homes. At this time there is no profile which fits the youth at risk.

Statistics from the past and the present demonstrate the distressing increase of completed suicides. Though the years of 1956 to 1997, a span of (41) years there were (18) suicides recorded on the Standing Rock Reservation. In the past (17) months, (18) completed suicides have occurred. These number illustrating the tremendous loss to the Tribes' most precious resource.

The largest school system on Standing Rock is reporting the following "In January, we have had (29) students – 13% of our entire student body in Bismarck psych wards, as there is no services for them here in Fort Yates. Of the (29) I show (28) of the students were admitted for suicide attempts of one kind or another" written by John Gartner, Assistant Principal Standing Rock High School. Judge Lola Agard, Children's Court reports that two(2) or (3) times a day their department has had to deal with the attempted suicide of a juvenile or young adult on the reservation, I.H.S. reports they are also dealing with suicide attempts 10-12 times per week.

The youth are respected and their input is critical for formulation of strategy to immobilize the crisis of suicide among the teen on Standing Rock. In attempt to collect the youth view point a survey was given out at the April 2005 annual youth conference in Fort Yates, North Dakota on the Standing Rock Reservation. The surveys were returned by (250) students from the grades of 7th to 12th. These are youth who attend the area schools. The following are responses to the surveys.

Why are youth harming themselves?

*Majority of concern is that no one is listening to the youth.

Category 1 Parent issues (81)

1. Neglect/Abuse/Alcohol Abuse.....22
2. Feeling no love from parent and not listening to youth 34
3. Youth are not told suicide is wrong..... 2
4. No supervision.....10
5. Lack of parental involvement.....13

Category 2 Mental Health issues (144)

1. Depression.....45
2. Hopelessness.....48
3. Low Self Esteem.....9
4. Lonely.....1
5. Anger.....7
6. Stress..... 5
7. Attention seeking.....27
8. Trusting issues of adults..... 2

Category 3 External issues (112)

1 Bullying-teasing from peers.....24
2 Drugs, Alcohol, Tobacco use.....43
3 Gangs..... 3
4 Peer Pressure.....20
5 Music..... 2
6 Idleness.....10
7 Relationships.....10

Category 4 Other issues (19)

1. Drop outs.....3
2. Funerals 2
3. No role models..... 1
4. No Spirituality.....13

What are your ideas for assisting youth in crisis?

Category 1 Parent issues (62)

1. Parent/Child listening and talking sessions.....60
    - Grief
    - Child feeling supported by parent
    - Views of Suicide, that it is not an option
    - Parent is listening to their children
    - Spirituality
2. Parental treatment needs, drug and alcohol.....2

Category 2 Mental Health issues (134)

1. Counseling.....67
2. Peer Mentoring.....35
3. Drug and Alcohol programs.....14
4. Support groups.....16
5. Grief counseling.....2

Category 3 Community issues (84)

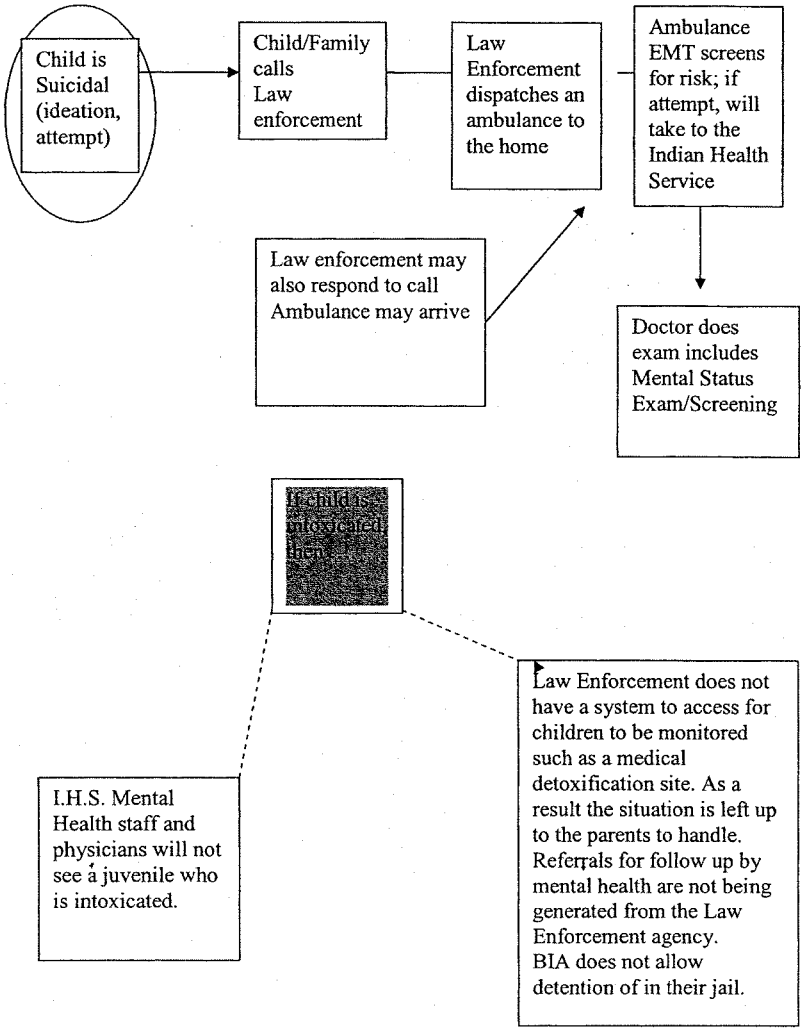
1. Youth Activities.....5
    - Evening activities
    - Dances
    - Tournaments
    - Cultural
    - Talent
2. Youth Centers.....18
    - Counseling services/support groups
    - Cultural activities is
3. Hot lines.....10
4. Law Enforcement.....1

The survey results emphasize areas the Tribe has examined and is initiating long range improvements. Community involvement is recognized as a requirement to develop a well rounded approach to the safety and continued well being of our families. Plans are currently in motion for the Tribe to develop community action to meet the areas of need the youth have highlighted.

The Standing Rock Sioux Tribe has reestablished a coalition of educators, spiritual leaders, health care providers, law enforcement officials and community leaders to address and develop an approach to abate the crisis.

The subsequent flow chart has been created to illustrate the course of events and the response of the mental health, law enforcement and ambulance service when a suicide attempt crisis happens.

FLOW CHART OF EVENTS INVOLVING SUICIDE ATTEMPT



A visible area of concern is the lack of any safeguard for children who are intoxicated and exhibiting suicidal ideations. At this time the ambulance services is the **only** program conducting limited assessments and are documenting referrals to mental health.

Statistics from Standing Rocks' ambulance services reflect the following: January though May 2005 a (5) month period, ambulance personnel have been dispatched to (69) calls involving suicide attempts. Compared to (98) calls in the calendar year of 2003 and (118) for 2004, the potential for increasing attempts is a reality.

I.H.S. is the primary mental health provider for the majority of families residing on the Standing Rock Reservation, accessing other services requires a drive up to 75 miles. Families have little choice but to depend on the limited services of the Indian Health Services.

There are several discrepancies of services in the area of mental health services. One such gap includes the absence of an on-call mental health liaison mechanism to assist families during emergency situations involving a suicide episode. The lack of a support service compounds the event with additional trauma to family members. (The majority of the incidents which require intervention occur after working hours.) Dr. Kevin First, SRIHS gives the following explanation for the policy, "There are not enough qualified mental health providers to provide adequate coverage. We only have one doctoral level professional." Dr First also reports here on Standing Rock there is one psychologist for every 3740 mentally ill persons. They have (2) bachelor level staff but they are not qualified to do suicide assessments although they have done them in the past.

Therapy is a valuable commodity. Due the limited availability and with large patient cliental the quality of services to families is questionable. At this time Dr. Kevin First, SRIHS psychologist travels to the South Dakota clinic once a week to treat as many families as he has time to see. The remainder of the time, he is located in the Fort Yates hospital.

Families who are referred for an in-patient psychological evaluation must travel off-reservation and 42% do not have follow up services upon discharge. The referrals are received by the mental health department however. Families do not have a support service which could improve follow up. Transportation to the clinic is a major barrier for many of the families. An out reach program would be an asset in addressing this area.

I.H.S. statistics reflect the following on attempts in correlation with completions, no previous attempts (36%), or one attempt (20%) or two attempts (14%). According to SRIHS, (62%) of the families of completed suicides are receiving some type of follow up, (38%) are not receiving services to deal with grief issues as well as trauma. These families are statistically at high risk, an adequate follow up system would again be beneficial.

There is an immediate need for medication management of diagnosed patients. Without the proper follow up many do not continue on their recommended medication prescriptions. Estimations indicate that approximately 75% of the current patients receiving care are also prescribed medications. Out reach services would assist the families with the proper follow up for medication check and therapy.

Testimony was presented by Dr. Charles W. Grimm, D.D.S. M.H.S.A. during the public hearings for the Senate Committee on Indian Affairs on Teen Suicide Among American Indian Youth in Bismarck, North Dakota May 02, 2005. Dr. Grimms' testimony referred to the responsibility of the Indian Health Services in the Behavioral Health area, and cites different approaches to find

data on teen suicides. Noteworthy is the mention of out reach workers which not available at the current time on Standing Rock. Even the reference of providing acute crisis-oriented out patient services is not available on a level which is effective as it relates to suicide attempts and completions.

With the large land base and number of districts which are spread through the reservation traveling from the South Dakota portion of the reservation to the North Dakota side takes nearly two hours of driving time. Yet the BIA Law Enforcement Agency employ only (8) officers and has (4) police vehicles. Officers are over-worked and have little time to proactively work with local mental health officials on suicide prevention activities as they are trained to do. Law enforcement presence in our local communities simply does not exist due to travel time and the lack of officers on the reservation.

Documentation of proper Q.P.R. (Question, Persuade and Refer) procedure of the law enforcement officer is absent, which should be happening when they encounter children and teens exhibiting suicidal gestures.

The luxury of a medical detoxification within I.H.S. is absent on Standing Rock. A medical detoxification unit would create an indispensable service. Law enforcement, mental health and chemical prevention programs would be able to perform their duties when the child is medically cleared for services. As opposed to the non-existence of services we are witnessing at this point.

Chemical abuse and dependency issues arise as factors to the on-going crisis of teen suicide. Standing Rock has one (1) youth counselor for the entire reservation juvenile/teen population who are in need of evaluation, counseling, treatment as well as aftercare services. The program available is focused on education in relation to the above mentioned services. Statistics provided by the Childrens Court (CY2004) show that minor in consumption charges were (15%) of the 798 offenses committed by juveniles within the reservation boundaries. Sentencing include referrals to the Youth Services program, voluntary referrals from families increase this programs caseload.

Appraisal of the mental health, chemical prevention and law enforcement services has depicted an inadequate funding program for the respective departments which affects their ability to provide quality care, safety and prevention to families as well as post trauma services.

Standing Rock I.H.S. is in dire need of Psychologists and out reach mental health personnel to insure proper follow up for patients and their families. Revival of the availability of an on-call procedure would assist families in dealing with the trauma of securing mental health services for a loved one and would provide the basic need of comfort to them at an extremely stressful time.

The Standing Rock Reservation is need of immediate financial assistance for the Indian Health Services which at this point of time is struggling to provide minimal counseling needs. The suicides are, we fear, creating an attitude of acceptable behavior by the youth and with the lack of therapy and follow up the crisis may continue to plague the Standing Rock Nation.

The Standing Rock Nation is requesting a financial increase for the Indian Health Services on our reservation in the amount of $500,000 per year to provide (2)Psychologists, out reach workers and training for staff to provide follow up to families in crisis. Additional funding to increase the budget of the Youth Services program is also a necessity. The Law Enforcement presence in the development of an adequate safeguard for the community is essential. It is currently under funded.

Quality therapy services are required to address the areas of prevention, intervention and post trauma not only dealing with the recent suicides but with the factors contributing to suicide.

The Standing Rock Sioux Tribe would like to express our gratitude for being allowed to submit this testimony. We would appreciate an immediate response in the near future.

STATEMENT OF THE

NATIONAL INDIAN CHILD WELFARE ASSOCIATION

SUBMITTED TO THE SENATE COMMITTEE ON INDIAN AFFAIRS

Regarding

SUICIDE PREVENTION AMONG NATIVE AMERICAN YOUTH

JUNE 22, 2005

The National Indian Child Welfare Association submits this testimony to the Senate Committee on Indian Affairs on suicide prevention among Native American youth. The focus of our testimony will be a national look at the needs within Indian Country and strategies for suicide prevention among Indian youth. A brief description of the National Indian Child Welfare Association is provided below.

National Indian Child Welfare Association – The National Indian Child Welfare Association (NICWA) is a national, private non-profit organization dedicated to the well-being of American Indian children and families. We are the most comprehensive source of information on American Indian child welfare and work on behalf of Indian children and families. NICWA services include: (1) professional training for tribal and urban Indian child welfare and mental health professionals; (2) consultation on child welfare and mental health program development; (3) facilitation of child abuse prevention efforts in tribal communities; (4) analysis and dissemination of public policy information that impacts Indian children and families; (5) development and dissemination of contemporary research specific to Native populations; and (6) assisting state, federal, and private agencies to improve the effectiveness of their services to Indian children and families.

In order to provide the best services possible to Indian children and families, NICWA has established mutually beneficial partnerships with agencies that promote effective child welfare and mental health services for children (e.g., Substance Abuse and Mental Health Services Administration, Indian Health Services, Administration for Children, Youth and Families, National Congress of American Indians, Federation of Families for Children's Mental Health, and the Child Welfare League of America).

Introduction

Although the overall rate of suicide among youth has declined slowly since 1992, rates remain unacceptably high (Lubell, Swahn, Crosby, and Kegler, 2004 as cited in National Center for Injury Prevention and Control, 2004). Compared to other non-white groups, the suicide rate for American Indians/Alaska Natives is the highest (American Association of Suicidology, 2004). More specifically, between 1981 and 2000, suicide was the second leading cause of death for American Indian/Alaska Native youth aged 15 – 24 (May, Serna, Hurt, & DeBruyn, 2005). Additionally, according

to recent data from the Indian Health Service (IHS), the suicide rate for American Indian/Alaska Native youth in this age group is 3.3 times higher than the national average (IHS, 2004). It is obvious that youth suicide is a crisis in Indian Country that must be addressed.

One of the main barriers to addressing this issue in Indian Country is the lack of access to culturally appropriate, family-focused and community-based mental health services. Across the country, more than half of Indian youth who commit suicide have never been seen by a mental health professional. This may be attributable to a lack of trained therapists or counselors on reservations or that the youth do not trust counselors, who are often outsiders (Gunderson, 2005). This testimony will address the above-listed issues by providing information on the following items:

- Suicide risk factors and protective factors
- The benefits of utilizing the systems of care philosophy for children's mental health services
- Successful approaches to addressing mental health needs in Indian Country
- Recommendations for preventing youth suicide among American Indians/Alaska Natives

Summary of Recommendations

- Increase the number of trained child therapists and mental health professionals in Indian Country.
- Require the Indian Health Services to expand their children's mental health programming to include promising practices in Indian Country such as the Systems of Care approach.
- Increase funding for Systems of Care and Circles of Care grants to allow more tribal access to these important programs.
- Require Indian Health Services to regularly report data that describes how many American Indian/Alaskan Native children are being provided mental health services through IHS or IHS contractors, types of services provided, number of mental health referrals received and other significant data developed in consultation with tribes to help inform policymakers and service providers.

Suicide Risk Factors

Recent evidence suggests that over 90% of children and adolescents who commit suicide have mental health needs before their death (Shaffer &

Craft, 1999). For American Indian/Alaska Native people, severe life stresses often place them at high risk for mental health problems. On a national level, Indian communities are affected by very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, child neglect, and suicide (Swinomish Tribal Mental Health Project, 1991). According to a 1998 study by the Centers for Disease Control and Prevention, American Indians/Alaska Natives reported much higher rates of frequent distress than the general population (13% and 9% respectively). The findings of this study suggest that American Indians/Alaska Natives experience greater psychological distress than other populations, which could contribute to the high rate of suicide attempts and completions within tribal communities (DHHS, 2001).

Further substantiating the above-listed information, a 1999 Surgeon General's report identified several risk factors for suicide, including but not limited to the following items:

- History of mental health needs, particularly depression
- History of alcohol and substance abuse
- Barriers to accessing mental health services
- Unwillingness to seek help based on the stigma attached to mental health and substance abuse disorders or suicidal thoughts.

Protective Factors

The 1999 Surgeon General's report also identified several protective factors that buffer people from the risks associated with suicide. These include, but are not limited to:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Family and community support
- Support from ongoing medical and mental health care relationships

All of the above-listed risk and protective factors can be addressed through programs built around the systems of care philosophy of culturally competent, community-based, child-centered and family-focused services. This philosophy has been utilized successfully by tribal communities since 1998 and is a critical component of effective mental health services for American Indian/Alaska Native children and families.

Systems of Care as the Cornerstone of Behavioral Health

What is a system of care?

Within the field of children's mental health, a system of care is collaboration among the family members, community members, professional organizations, and others committed to enhancing the lives of emotionally disturbed children and their families. The purpose is to bring cohesion to the strategies and services aimed to rehabilitate these children. Specific values set the principles that drive a system of care and evolve into specific practices that create change. The core values of a system of care include a system that is child-centered and family-focused, community-based, and culturally competent.

Systems of care have evolved over the past several years from the growing awareness of the absolute need for all parties involved in children's well-being to work together. Service providers now recognize that simply dispensing medication and providing adjunctive psychotherapy services falls short of what children and their families need to recover from or cope with mental illness. They recognize that the causes of mental health disorders are complex and that the impact of mental illness requires collaboration and partnerships among many individuals and organizations.

Systems of care include formal partnerships between tribal, state, or county agencies (*partnerships)*, multi-disciplinary teams (*collaboration)*, deep *family involvement* and the accessibility to service providers far beyond the typical 8 a.m. to 5 p.m. workday. In addition to professionals, effective systems of care bring into this planning the significant persons involved in the child and his/her family's life, such as spiritual healers, extended family, and community elders. Professionals may include educators, child protection services, the juvenile justice system, and mental health professionals (Cross, Earle, Echo-Hawk Solie and Manness, 2000).

Collaborative efforts of which successful systems of care are comprised are enhanced through the use of a *wraparound service model*. Wraparound is a model of care in which all aspects of care for a child are fully integrated with that child's environment. Within the wraparound service model, *case management* or *care coordination* services connect all parties providing this full array of services into a collaborative web.

Indicators of Need for Improved Mental Health Services to Children in Indian Country

In general, mental health services are scarce for all children. For Indian children, however, access is more problematic. The disparity in available resources parallels the scarcity of data relevant to Indian children and mental health.

There is very little data on the mental health needs of Indian children and adolescents (Deserly and Cross, 1996; U.S. Congress, Office of Technology Assessment, 1990). We can make some extrapolations about the level of need for Indian children and the importance of addressing those needs from statistics pertinent to the general population, particularly since we know that minorities with mental health disorders are less likely to receive treatment and more likely to be placed in correctional facilities (Knitzer, 1982). We know the following to be true:

1. Mental disorders account for four of the ten leading disabilities in established market economies worldwide (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

2. The cost of mental illness in the United States was $148 million in 1990 (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

3. Worldwide, depression is the leading cause of disabilities among persons *aged five* and older (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999); and

4. The estimated national incidence of emotional disturbance is 11.8% of the population under the age of 18 (Gould, Wunsch-Hitzig & Dohrenwend, 1980).

We can see that the cost of mental illness is extraordinary. In Indian Country, where mental health services are extremely scarce and the need is, we can assume that both the life-long personal and financial costs of not providing adequate mental health services to our children will be enormous.

The 2000 Census reports that about 2.5 million[1] American Indian people are living in the United States. Of this number, 38% are under the age of twenty. Research estimates that there are approximately 93,000 emotionally handicapped Indian children in the United States (Deserly & Cross, 1996).

Although epidemiological research is scarce, we know that Indian children suffer from catastrophic rates of posttraumatic stress, which, if untreated, creates a generation of adults who suffer from severe, chronic mental illness. Boarding school surveys have identified Indian youth as being at high risk for mental health disorders. According to an unpublished paper by the Bureau of Indian Affairs (1995), *Therapeutic Residential Schools - Promise of the Future*, off-reservation, residential school students are either "at risk" or are "very high risk" students. Most of these students have suffered sexual, physical and emotional abuse, abandonment and/or rejection and have been involved in self-destructive behaviors. Supporting documentation shows that many students with mental health problems are on probation from the juvenile court system. In addition, the scope of alcohol and drug abuse among entering students is overwhelming, falling between 80% to 100%. Over 80% of these students come from home environments where one or both parents have been identified as having a substance abuse problem. The paper further reports increasing symptoms and behaviors in all areas investigated in mental health screenings. The majority of students screened (approximately 95%) reported critical medical, social, mental, and educational needs that are not being met.

Promising Practices

Given the high prevalence of mental health need and the effectiveness of the systems of care philosophy in tribal communities, it is important to look at how this philosophy has been incorporated into tribal practices to address the needs of their children and families. Since 1998, 16 tribal and urban Indian communities have been involved in the Circles of Care grant initiative through the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration Center for Mental Health Services. Circles of Care is a children's mental health planning and evaluation grant that is based on culturally competent and community-based efforts to develop a model system of care for children's mental health. As

[1] This number depicts those individuals who reported American Indian/Alaska Native as their only race. An additional 1.6 million people reported being American Indian/Alaska Native in combination with one or more other races.

a planning grant, the effort is not on providing direct services but building community relationships and a vision for children's future. There are several examples of work done by these communities that could easily be seen through the perspective of suicide prevention, in that the primary approach to prevention in Indian Country is based on developing cultural identity and establishing and strengthening relationships.

One approach, which appears to have good results, is the use of the Gathering of Native Americans (GONA) process in these Circles of Care communities. This is a 4-day community-based event that leads participants through a series of self-awareness activities and group relationship building activities that build on community culture and strengths. The GONA was developed for the purpose of substance abuse prevention by a group of American Indian trainers for the Center for Substance Abuse Prevention and has an established manual that is available to the public. One of the many Circles of Care projects that made extensive use of the GONA was the Ute Tribe in Fort Duchene, Utah. They had a series of GONA events that were targeted at different population groups in the community. The youth GONA event had nearly 200 young people from the community participate. As a result of participating, these youth (most of whom would qualify as "high risk") left the four-day event with a new connection to other youth and to their sense of responsibility as a member of their tribe and with a greater sense of their own identity as an Indian person. The Ute Tribe also had GONA events with groups of men, women, and elders who were each successful in building relationships and sense of community.

The Passamaquoddy tribe in Indian Township, Maine, is one of 10 tribal communities that have received funding through the Comprehensive Community Mental Health Services for Children and Their Families Program initiative of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The tribe has implemented mentorship and respite care services whose primary function is to provide culturally appropriate services to children with emotional disturbance and their families. The secondary effect is one that can be viewed as a suicide prevention strategy. Children who are "at risk" are paired with tribal community members (often respected tribal elders) based on the youth's interest in developing a certain talent or skill. For example, some youth have spent time with elders learning how to do wood carving, basket making, and beadwork. In addition to learning a skill that may lead to the young person being able to have an avocation,

the increased self-esteem, positive cultural identity and relationship with respected community members serves to build strong resilience in these youth. The community as a whole benefits, because they have been able to see these "at risk" youth as contributing members of the community.

Recommendations

- **Increase the number of child trained therapists and mental health professionals in Indian Country.**

The disparity in distribution of human resources is higher when one considers that mental health providers working with children and families spend much of their time working with adults. The greater need is to bridge the gap in availability of services for children.

Additionally, training more individuals in working with children would address problems of misdiagnosis, poor assessment of need, and inappropriate intervention due to workers who lack specialization in these areas. When mental health service providers are unfamiliar with children's issues, there is a greater likelihood that they will misdiagnose the child, resulting in lifelong consequences, such as inappropriate services, side effects of unnecessary medication, and denial of health benefits.

- **Require the Indian Health Service to expand their children's mental health programming to include promising practices in Indian Country such as the Systems of Care approach.**

Systems of care is consistent with federal policy for mental health services to children and families. It involves the family and natural, indigenous systems of care that facilitate the empowerment of children and families as well as expanding resources. It helps avoid duplication of services and contributes toward sustainability of behavioral health services within an economy of dwindling resources. Systems of care reduce costs by lowering the numbers of children placed out of the home (juvenile detention, foster care, residential treatment). They promote great success in prevention and treatment of mental health disorders by engaging the community in developing prevention and treatment strategies. The community becomes part of the treatment plan, thereby

increasing the number of people supporting the child and the family in need.

Currently, the reauthorization of the Indian Health Care Improvement Act (S. 1057) provides an opportunity to focus on these troubling issues and provide support to promising practices that are operating in Indian communities today through the Systems of Care approach. Indian Health Services, a primary federal agency with responsibility for mental health services to American Indian/Alaskan Native children, is currently funding three tribal community sites to develop Systems of Care based models of mental health services, but obviously many more tribes need this opportunity. Adding language to S.1057 that would reinforce IHS's efforts to fund and provide support to this proven model could help leverage relationships and program efforts with other federal agencies that are currently engaged in Systems of Care work, such as the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Children's Bureau. This additional language would ensure that promising practices are being developed and implemented within tribal communities and encourage culturally relevant and effective approaches to wellness. The language would also provide consistency between the current legislation and other Department of Health and Human Services (DHHS) policy regarding systems of care. Below is an example of language that is being recommended:

1) Section 703(a)(1): IN GENERAL.-The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations consistent with section 701, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including **Systems of Care and** Traditional Health Care Practices, which shall include-
2) Section 707(c)(1): IN GENERAL-The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services, which may incorporate **Systems of Care and** Traditional Health Care Practices, to Indian children and adolescents, including-
3) 707(c)(2)(E): "for intensive home- and community-based services, **including collaborative systems of care.**
4) Section 709(c)(3): "(3) community-based and multidisciplinary strategies, **including Systems of Care,** for preventing and treating behavioral health problems.

5) Section 714: **(10) SYSTEMS OF CARE.-The term 'Systems of Care' means a system for delivering services to children and their families that is child-centered, family focused and family driven, community-based and culturally competent and responsive to the needs of the children and families being served. The system of care values prevention and early identification, smooth transitions for children and families, child and family participation and advocacy, comprehensive array of services, individualized service planning, services in the least restrictive environment and integrated services with coordinated planning across the child-serving systems.**

- **Increase funding for Systems of Care and Circles of Care grants to allow more tribal access to these important programs.**

The Center for Mental Health Services (CMHS) under SAMSHA recognizes that many Indian communities have gone too long without mental health services and that these communities lack the infrastructure to support a mental health system that can address the needs present within their populations. In its commitment to bridging the gap in services to Indian children, CMHS has funded 16[2] tribal and urban Indian programs whose mission is to design systems of care (planning grants). These projects, called Circles of Care, are in addition to the nine Systems of Care tribal sites that are providing services.

Although both the Systems of Care and Circles of Care programs have been very beneficial to tribal communities, it is important to increase the level at which they are funded so that more tribes are able to access these important grants. Currently, only 25 out of 563 federally recognized tribes in the nation have been able to access this funding for planning or implementing local systems of care.

Those sites that have received Circles of Care and/or Systems of Care grants have reported that the level of involvement required from both the Indian and non-Indian communities has resulted in saving lives of suicidal adolescents, reducing school absenteeism and expulsion, improving school grades, decreasing the rate of recidivism into the

[2] Nine tribal Circles of Care sites were funded for this three-year grant in 1998 with seven more sites being funded in 2001. The first round of grantees has completed the grant activities with several securing funding for implementation of their plans.

juvenile criminal justice system, increasing self esteem, preventing child abuse, and keeping children within their homes as opposed to placing them into foster care or residential treatment (Cross, Earle, Echo-Hawk Solie, & Manness, 2000). These changes transform the lives of children and families. One can speculate that the cost savings would be enormous by providing extensive services at the front end versus the exorbitant costs of back end services such as incarceration, protective placement, and in-patient psychiatric hospitalization, as well as general assistance. Providing effective services to children will likely also save costs from social security disability benefits, since chronic, severe mental illness often renders people unemployable.

- **Require Indian Health Services to regularly report data that describe how many American Indian/Alaskan Native children are being provided mental health services through IHS or IHS contractors, types of services provided, number of mental health referrals received and other significant data developed in consultation with tribes to help inform policymakers and service providers.**

While we continue to understand much better what the problems and risk factors are, we do not have sufficient data describing what is occurring when services are provided. Currently, IHS provides basic data on the numbers of American Indian/Alaskan Native *people* receiving services but does not identify how many are children or adolescents. Data describing services provided and referrals is also not readily reported. Without this data, it becomes more difficult to develop either a local or national picture of the need and where resources should be targeted. Our understanding is that the IHS client data system, Resource Patient Management System (RPMS), does collect this type of data, but it is not easily accessible or reported to tribes and policymakers.

Conclusion

The need for mental health systems of care for Indian children, although inadequately documented, is expected to be substantially higher than that of the general population. Access to services is poor for a variety of reasons, including cultural issues, funding, isolation, and the need for human resource development.

Overall, data collection and analysis is vital to comprehending the extent of the mental health needs of Indian children, as well as to justify requests for funding and developing intervention strategies. Indian communities have long been hampered by the lack of supporting statistics in their attempts to pursue funding, which often allows state and county agencies to avoid developing culturally specific programs for Indian children and impedes Indian tribes and urban organizations from successfully competing for grants.

Mental health services for Indian children are currently provided in a hodge-podge fashion, often only in crisis situations and by several different systems, many of which remain inaccessible for most Indian nations' members. Most Indian programs have only a modest capacity for evaluation and treatment, but few non-Indian programs have strategies for serving Indian children appropriately.

In order to address the mental health needs of tribal communities, tribes should be given the opportunity to provide services for their own members through an increase in funding for planning and implementing mental health programs. This would allow the services to be tailored to fit the individual and would also provide tribal members with access to community-based, culturally competent programs to heal their children and families.

References

American Association of Suicidology. (December 2004). *USA suicide: 2002 official final data*. Retrieved June 22, 2005, from http://www.suicidology.org/associations/1045/files/2002datapgv2.pdf

Bureau of Indian Affairs. *Therapeutic residential schools—Promise of the future*. Unpublished manuscript distributed at August 1995 Indian Mental Health Advisory meeting, Washington, DC.

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K. (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I*. Washington, DC: Center

for Effective Collaboration and Practice, American Institutes for Research.
Gunderson, D. (2005). Minnesota Public Radio

Deserly, K.J., & Cross, T.L. (1996). *American Indian children's mental health services: An assessment of tribal access to children's mental health funding*. Portland, OR: National Indian Child Welfare Association.

Gould, M., Wunsch-Hitzig, R., and Dohrenwend, B.P. (1980). Formation of hypotheses about the prevalence, treatment and prognostic significance of psychiatric disorders in children in the United States. In Dohrenwend, B.P., Dohrenwend, B.S., Gould, M.S., Link, B., Neugecauer, R., & Wunsch-Hitzig, R. (Eds.), *Mental illness in the United States* (pp. 9-44). New York, NY: Praeger Press.

Gunderson, D. (2005). *Indian tribes 'losing kids every day' to suicide.* Retrieved June 23, 2005, from http://news.minnesota.publicradio.org/features/2005/06/10_gundersond_indiansuicide/

Indian Health Service. (2004). *Trends in Indian Health, 2000-2001.* Retrieved June 22, 2005, from http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/Trends00.asp

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

May, P.A., Serna, P., Hurt, L., & DeBruyn, L.M. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation. *American Journal of Public Health, 95* (7).

National Institute of Mental Health. (1999). *Science on our minds: The numbers count*. Bethesda, MD: Author.

Shaffer, D., & Craft, L. (1999). Methods of adolescent suicide prevention. *Journal of Clinical Psychiatry*, 60, (Suppl. 2), 70-74.

National Center for Injury Prevention and Control. (December 2004). *Suicide: Fact sheet*. Retrieved June 21, 2005 from http://www.cdc.gov/ncipc/factsheets/suifacts.htm

Swinomish Tribal Mental Health Project. (1991). *A gathering of wisdoms, Tribal mental health: A cultural perspective*. Mt. Vernon, Washington: Veda Vanguard.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity*. Rockville, MD: Author.

U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide*. Washington, DC: Author.

Statement for the Record
Committee on Government Reform
U. S. House of Representatives

Steroid Use Among Females: Results of the Youth Risk Behavioral Surveillance System (YRBSS)

Centers for Disease Control and Prevention
U.S. Department of Health and Human Services

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The Centers for Disease Control and Prevention (CDC) developed the Youth Risk Behavior Surveillance System (YRBSS) in 1989 to monitor six categories of priority health-risk behaviors among youth -- behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity -- plus overweight. These risk behaviors contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. Steroid use among youth is captured in one of the survey questions. The YRBSS is used to determine the prevalence of health-risk behaviors among youth; assess whether these behaviors increase, decrease, or stay the same over time; and examine the co-occurrence of health-risk behaviors among youth. The YRBSS also is used to monitor progress toward achieving national health objectives for 2000 and 2010 as well as other program indicators (e.g., CDC's HIV Prevention Strategic Plan).

The YRBSS includes a national school-based survey conducted by CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies. In these surveys, conducted biennially since 1991, representative samples of students in grades 9 through 12 are drawn. In 2003, a total of 15,214 students completed the national survey, and 32 states and 20 school districts also obtained data representative of their jurisdiction.

The national Youth Risk Behavior Survey is conducted from February through May of each odd-numbered year. All except a few states and cities also conduct their survey during this period. Separate samples are used in the national survey and state and local surveys. The national sample is not an aggregation of the state and local surveys, and state or local estimates cannot be obtained from the national survey.

Data-collection procedures are similar for national, state, and local surveys. Local procedures for obtaining parental permission are followed before administering a Youth Risk Behavior Survey in any school. We think it is worth noting that Federal law (the Protection of Pupil Rights Amendment 20 U.S.C. § 1232h) requires that parents be notified of the survey, be provided an opportunity to review the survey, and be provided an opportunity to opt their child out of participating in the survey.

For the national survey and the majority of state and local surveys, trained data collectors travel to each participating school to administer the questionnaire to students. These data collectors read a standardized script to participating students. The script includes an introduction to the survey and directions on how to complete the questionnaire.

Survey procedures for the national, state, and local surveys are designed to protect student privacy by allowing for anonymous and voluntary participation. In all surveys, students complete the self-administered questionnaire during one class period and record their responses directly in a computer-scannable booklet

or on an answer sheet. To the extent possible, students' desks are spread throughout the classroom to minimize the chance that students will see each others' responses. Students also are encouraged to use an extra sheet of paper or an envelope, provided by the data collector, to cover their responses as they complete the questionnaire.

In the national survey, students who are absent on the day of data collection still can complete questionnaires if their privacy can be maintained. These make-up data-collection efforts sometimes are administered by the data collector; however, if the data collector cannot administer the questionnaire, school personnel can perform this task. Allowing students who were absent on the day of data collection to take the survey at a later date increases student response rates. In addition, because frequently absent students are more likely to engage in health-risk behaviors than students who are not frequently absent, these procedures help provide data that are representative of all high school students. In the 2003 national Youth Risk Behavior Survey, questionnaires from 664 students (5 percent of all participating students) were completed during a make-up data collection.

The national Youth Risk Behavior Survey uses a three-stage, cluster sample design to obtain a nationally representative sample of students in grades 9 through 12 in the United States. The target population comprises all public and private high school students in the 50 states and the District of Columbia. U.S. territories are excluded from the sampling frame. Sample sizes from the national Youth Risk Behavior Survey are designed to produce estimates that are accurate

within ±5 percent at 95 percent confidence. For each national survey, the first-stage sampling frame includes primary sampling units (PSUs) consisting of large-sized counties or groups of smaller, adjacent counties. In the second stage of sampling, schools are selected from PSUs with probability proportional to size. To enable separate analyses, black and Hispanic students are over sampled. The final stage of sampling consists of randomly selecting, in each chosen school and in each of grades 9 through 12, one or two entire classes. Examples of classes include homerooms or classes of a required discipline (e.g., English and social studies). All students in sampled classes are eligible to participate. Sampled schools, classes, and students who refuse to participate in the survey are not replaced. Sampling without replacement maintains the integrity of the sample design and helps avoid the introduction of non-measurable bias into the sample.

DATA ON STEROID USE

Before each biennial survey, sites (states and districts) and CDC work together to revise the questionnaire so that it reflects site and national priorities. One question on illegal steroid use has been asked since 1991 – "During your life, how many times have you taken steroid pills or shots without a doctor's prescription?" Since 1991, illegal steroid use has increased among high school students from 2.7 percent to 6.1 percent in 2003. Between 2001 and 2003, no change was noted in lifetime illegal steroid use. See the table below for more detailed 2003 national Youth Risk Behavior Survey results.

Lifetime Illegal Steroid Use			
	Female	Male	Total
Race/ethnicity			
White	5.6% +/-2.1	6.8% +/-1.6	6.2% +/-1.8
Black	1.9% +/-1.3	5.4% +/-2.2	3.6% +/-1.6
Hispanic	6.6% +/-2.1	7.8% +/-3.2	7.2% +/-2.5
Grade			
9	7.3% +/-2.6	6.9% +/-3.0	7.1% +/-2.6%
10	5.1% +/-2.3	7.0% +/-2.3	6.1% +/-1.8
11	4.3% +/-1.7	6.8% +/-2.5	5.6% +/-1.8
12	3.3% +/-1.5	6.4% +/-2.3	4.9% +/-1.7
Total	5.3% +/-1.6	6.8% +/-1.7	6.1% +/-1.5

For more information on the methodology of the YRBSS see -- CDC. Methodology of the Youth Risk Behavior Surveillance System. *MMWR.* 53(RR-12):1-13, 2004. For the latest national, state, and local results see -- CDC. Youth Risk Behavior Surveillance – United States, 2003 *MMWR.* 53(SS-2):1-96, 2004.

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