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INDIAN YOUTH SUICIDE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

ON

OVERSIGHT HEARING ON THE TRAGEDY OF INDIAN YOUTH SUICIDE

MAY 17, 2006
WASHINGTON, DC

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INDIAN YOUTH SUICIDE

WEDNESDAY, MAY 17, 2006

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. John McCain (chairman of the committee) presiding.

Present: Senators McCain, Dorgan, and Murkowski.

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

Senator DORGAN. Senator McCain is delayed this morning and has asked that I convene the hearing. He will be here, however, shortly.

I want to say good morning to everyone and thank all of you for being here. This is the cOMMITTEE ON Indian Affairs third hearing on the tragedy of Indian youth suicide. It is a sensitive subject, one that some perhaps would prefer we not even discuss, but one I think that we simply cannot ignore.

Today, the committee will hear testimony about what kind of suicide prevention programs are currently available in Indian country; what programs exist that may not yet be available to certain areas in our country; whether there are recommendations to apply and tailor additional programs or resources to address the problem of Indian youth suicide on reservations and Alaska Native village communities.

I want to acknowledge the presence of the Indian Health Service. Dr. Grim is with us and Mr. Perez, and that of the Substance Abuse and Mental Health Services Administrator, Mr. Curie, is with us today. You and your staff have been very helpful to this committee as we have reflected on a good many recommendations on these issues.

Others of our witnesses have also provided valuable experience and insight. This is the third hearing that we will have held on this subject. Last week, during what was called Health Week in the United States Senate, the full Senate approved legislation that I had authored with my colleagues, Senator McCain, Senator Murkowski, and others, dealing with telemental health, one avenue to try to deal with this issue of teen suicide on Indian reservations.

I am very pleased that the Senate has moved that legislation. I thank Senator McCain, Senator Murkowski, and others of my col-

leagues for working with me to put a piece of legislation together. It was very helpful.

The legislation I think is a positive step, but there is so much more yet to be done, and that is the purpose of holding this hearing.

We have a number of witnesses today. The first panel is a panel that is composed of Jerry Gidner, the deputy director for tribal services at the Bureau of Indian Affairs, U.S. Department of the Interior. Mr. Gidner is accompanied by Chet Eagleman, acting chief, Division of Human Services; Kevin Skenandore, acting director, Office of Indian Education Programs; and Peter Maybee, aAssistant to the deputy bureau director, of the Law Enforcement Services.

We have Dr. Charles Grim, the director of the Indian Health Service, Department of HHS, accompanied by Jon Perez, the director of Indian Health Services Division of Behavior Health; and Charles Curie, administrator of substance abuse, Mental Health Services Administration.

So we want to thank everyone who has changed their schedule to be with us this morning. Mr. Curie, I understand that you were scheduled to be elsewhere, but have changed your schedule to be with us. Thank you very much.

Why don't we begin? I would like to call on Senator Murkowski if she has opening comments, and then we will begin to hear from the first panel.

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman.

I appreciate your attention, as well as that of Chairman McCain, to this very important issue. As you have pointed out, it is an issue that we don't like to talk about. It is sensitive. It is personal, but it is very, very real.

I am pleased to welcome to the committee this morning First Vice President, Bill Martin. Bill is Tlingit and Haida. He is with us today. He is a tribal leader and the chair of Alaska's Suicide Prevention Council. He has a big job in that role and we certainly appreciate all the work that he does.

In August 2003, the Centers for Disease Control reported that the Alaska region of the Indian Health Service had a higher rate of suicide among Native youth under age 19 for the period of 1989 to 1998, so a 10-year period, higher than any other IHS region in the country. Ours was 23.8 per 100,000 population. You can compare that to the next highest, the Aberdeen region in the plains, they were second at 19.1 per 100,000.

These are statistics that are terrible. These are statistics that should concern us all. Death by suicide in Alaska rose 4 percent in 2005 over the previous year. We know. We don't need to continue to listen to the stories about how they affect the communities, the families, but it is important to hear those stories and understand the devastation that the suicide is causing in too many of our Native villages in our communities on our reservations.

Mr. Chairman, I want to commend you for your efforts and all that you have done to bring attention to this issue. The passage of

the Indian Youth Telemental Health bill now pending in the House of Representatives, I think that is something that we all want to continue to encourage to make positive steps in the direction that that legislation leads us.

We have some issues in Alaska that present great challenges, our distance, our geography, but we share many characteristics with Indian country in the lower 48. We are isolated in terms of our road infrastructure. In many cases, our telecommunications infrastructure needs improvement. We have serious needs for medical professionals in the areas, particularly in the behavioral health area. It is tough to get professionals to move out there to provide the services that we so desperately need.

We recognize that for the rural telemedicine project, we can help bridge this gap that is so necessary. The Native health system in the State I think has proven to be a pretty innovative. This has been helpful to us, training the community members as behavioral health aids providing this bridge between the Native people needing the services and the professionals in the cities.

So we are making serious headway there, but we recognize that we have so very hard to go. So I appreciate the good works of most of you at the table, those of you in the room, that are focusing on this, and the focus that this committee has placed on this issue that is such a concern.

With that, Mr. Chairman, I just want to welcome everyone and look forward to their testimony.

Senator DORGAN. Senator Murkowski, thank you very much.

At a recent hearing dealing with methamphetamine addiction, we had a tribal chair come to this committee and describe the devastation of addiction to methamphetamine, but also the number of attempted suicides on her reservation. As a tribal chair, she described it in some detail, and it was startling, absolutely startling. What got me interested in this issue was a rash of suicide or a cluster of teen suicides on the Standing Rock Sioux Reservation in North Dakota. Even prior to that, I have used on the floor of the Senate, with the consent of relatives, the name of a young woman. I understand it is sensitive, and that is why I asked the relatives if I could do it, but a young woman, 14 years old, named Avis Little Wind. Avis Little Wind killed herself. She was 14. Her sister had killed herself, taken her own life 2 years before.

At age 14, she had missed 90 days of school, lay in her bed in a fetal position, with obviously serious emotional issues, and somehow no one caught it. This young girl lay in her bed for 3 months, not going to school, at age 14, and it didn't raise any red flags anywhere, apparently.

And so I went to meet with the school administrators, with the tribal council. I met with the classmates of this young women. And then just recently I went to the Standing Rock Reservation and had a meeting with Indian kids, high school kids, just us, nobody else was around, just myself and about 1 dozen or 1½ dozen Indian kids, just talking for about 1 hour about their lives, about what they see in their school, about the issue of teen suicide, teen pregnancy, methamphetamine.

What is happening is pretty unbelievable in many areas. This issue of suicide is so tragic, particularly with respect to youth. It

is young people I think feeling that their life is hopeless; that they are helpless. They decide that the only way out is to take their own life. Some young kids have told me that some of their acquaintances who took their lives really didn't want to die, they just wanted attention, and they were trying to get attention, to scream out and beg for attention.

I think as a result of all of this, in our region Indian teens are 10 times more likely to take their lives than in the population as a whole. I think my colleague just described the circumstance in Alaska.

So the purpose of this is not to exploit or to be sensational. The purpose of this is to see if we can find some way that is going to save some lives; that is going to say to these kids that things are not hopeless and there are people that want to help. That is the purpose of having these discussions and trying to think through what are the policy choices for us to address what is a very serious issue.

Let me begin the first panel. Jerry Gidner is the deputy director for tribal services at the BIA. Mr. Gidner, your entire statement will be part of the record. You may proceed with your testimony.

STATEMENT OF JERRY GIDNER, DEPUTY DIRECTOR FOR TRIBAL SERVICES, DEPARTMENT OF THE INTERIOR, ACCOMPANIED BY CHET EAGLEMAN, ACTING CHIEF, DIVISION OF HUMAN SERVICES; KEVIN SKENANDORE, ACTING DIRECTOR, OFFICE OF INDIAN EDUCATION PROGRAMS; AND PETER MAYBEE, ASSISTANT TO THE DEPUTY BUREAU DIRECTOR, LAW ENFORCEMENT SERVICES

Mr. GIDNER. Thank you, Mr. Chairman, Mr. Vice Chairman, members of the committee. With your permission, I will put the testimony in the record and just give a brief statement.

My name is Jerry Gidner. I am the deputy bureau director for tribal services at the BIA. You mentioned my colleagues who are here today with me. I did want to mention that Bureau Director, Pat Ragsdale, is here today in the audience because of his interest in the topic.

As the committee knows, Mr. Chairman, teen suicide is a serious problem in Indian country. The suicide rate is 2.5 times greater than the nationwide rate. IHS statistics show that it is the third leading cause of death in Indian children 5 to 14 years old and the second leading cause of death among teens and young adults 15 to 24 years old.

Every 2 years, our Office of Indian Education Programs does a youth risk behavior survey, and that survey shows some fairly startling results. The last survey results that are available are those from 2003. Those results show that one-third of Indian children and teens feel sad or hopeless at some point in a given year, and that of course is a beginning stage in those children who might commit suicide.

In high school, the surveys show that 21 percent seriously considered suicide in the last year and 18 percent actually attempted, made some attempt in the past year. I invite you to think about that for just 1 minute. That is a very stunning statistic. It means

that nearly one-fifth of students in BIA schools or BIA-funded schools made some attempt at suicide.

Senator DORGAN. Mr. Gidner, tell us again where that data comes from?

Mr. GIDNER. That comes from a survey conducted by our BIA's Office of Indian Education Programs, which is conducted every 2 years in high schools and middle schools. As I said, that data is from 2003 and I understand the survey was conducted again in 2005. That data is not yet available. In middle school, the younger children, 26 percent seriously considered suicide and 15 percent actually attempted it. Mr. Chairman, as you pointed out, the youth of Indian country are crying out for help.

Research shows that many social factors such as poverty, alcohol, and substance abuse can lead to suicidal behavior and these social factors as we all know are present in Indian country. So the question you are rightfully asking is what can be done about this. Our colleagues here at the table from HHS provide most of the suicide prevention and treatment behaviors.

The role of the BIA is somewhat less than that. We do work on some of those societal factors. We help tribes develop the infrastructure of government, the infrastructure of schools and law enforcement, where that does not otherwise exist. We participate in several multiagency efforts. For example, in the Rocky Mountain region, there is a Native American youth suicide prevention initiative where we partner with IHS and others in that effort.

Our law enforcement office, where they have jurisdiction, are very often the first responders to suicides and investigate the suicide. We also train our detention center staff, particularly for the youth detention facilities, in suicide prevention efforts.

Our Office of Indian Education programs again receives funding. All bureau-funded schools receive funding through the Department of Education to operate safe and drug free school programs, and those are used to prevent violence and substance and alcohol abuse, which of course can be precursors to suicide attempts.

In 2004, our education program launched a suicide prevention initiative using the question, persuade and respond model, where people are trained to question students that may be harboring ideas about suicide, persuade them to get help, and refer them to the appropriate help if they will go. All 184 BIA-funded schools and dormitories received this training, and the administrators were instructed to ensure that all of their staff had that training as well.

With that, I will conclude my statement. I will be happy to take your questions.

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

Senator DORGAN. Mr. Gidner, thank you very much for your testimony.

Next, we will hear from Dr. Charles Grim, the director of the Indian Health Service at the Department of Health and Human Services. Dr. Grim, thank you for joining us again.

STATEMENT OF CHARLES W. GRIM, DIRECTOR, INDIAN HEALTH SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JON PEREZ, DIRECTOR, INDIAN HEALTH SERVICE DIVISION OF BEHAVIOR HEALTH

Mr. GRIM. Thank you, Mr. Vice Chairman, and Senator Murkowski. I continue to appreciate working with this committee and your willingness to raise issues like this that we in Indian Health deal with on a daily basis. This is a very important issue, and we are very appreciative that you have chosen to hold another hearing about it. I applaud you for getting the bill that you all introduced passed. I think telehealth is one of the ways that we are going to be able to get into some of the most rural parts of the country the kind of care that you receive in urban areas.

Today, I am accompanied by Dr. Jon Perez, our national behavioral health consultant, who has been before you as well today. I am honored to be able to testify on behalf of Secretary Leavitt on suicide prevention programs in Indian country.

I am also honored to testify alongside Charlie Curie, a strong supporter of addressing substance abuse and mental health issues in Indian country, something that I personally witnessed and watched him do during his tenure at SAMHSA. It is also always a privilege for me to testify alongside my colleagues at the BIA, today Jerry Gidner, because our two agencies play such a large role in Indian country.

I would ask that my written testimony be made a part of the record. In it, you will find a much more detailed analysis of the statistics and some of the partnerships and things going on in Indian country. Today, I am just going to summarize a few things in my oral comments.

Suicide in Indian country, as I have said before, in contrast to most of the rest of the United States, is characterized by higher rates for younger people, and affecting entire communities because suicide, much like an infectious disease, often spreads rapidly among families and peer groups in what you and others have called suicide clusters in Indian country.

The latest information that we have, which has been cited by yourself, Senator Murkowski and the BIA, I won't go through all those statistics, but suffice it to say they are startling. I am glad that we, that the Senate, that the tribal leadership have brought this issue to the forefront and talked about it.

I am also appreciative that the Surgeon General was here at the last hearing held here in Washington to raise the issue not only in the Nation, but the high rates in Indian country.

The most important thing to remember is that suicide is not a single problem. It is a single response to multiple problems. Neither is it strictly a clinical or an individual problem, but one that is affected by the entire community. I think the panel that you have put here today is going to bring all those perspectives into play.

Let me quote from the Institute of Medicine's landmark 2002 publication called "Reducing Suicide." They stated that suicide may have a basis in depression or substance abuse, but it simultaneously may relate to social factors like community breakdown, loss of key social relations, economic depressions, or political vio-

lence, much of which we know occurs in many of our Indian communities.

To address it appropriately, we have worked on both public health and community interventions as much as we have the direct clinical ones. As you know, much of the Indian Health Service budget in alcohol and substance abuse and in mental health goes directly to clinical care.

In late September 2003, I announced the Indian Health Service National Suicide Prevention Initiative. It was designed directly to support our Indian Health Service tribal and urban programs in three major areas associated with suicide in our communities: First, to mobilize tribes and tribal programs to address suicide in a systematic evidence-based manner; second, to expand and enrich research and program bases around suicide in Indian country, something that is lacking; and third, to support and promote programmatic collaboration on suicide prevention.

While we have made progress in developing plans and delivering programs to Indian country, we all realize that this is only the beginning of a long-term concerted and coordinated effort among not only the Federal programs here at the table, but tribal communities, states, and other local and county community efforts around the country that we need to address the crisis.

The initiative that we put together, along with tribal leadership and tribal providers, addressed all 11 goals around HHS's national strategy for suicide prevention. That work represented the combined work of advocates, clinicians, researchers and survivors of suicide and their families all around the Nation. It lays out a framework of action to help prevent suicide and also guide us in the development of an array of services that we are developing.

In our headquarters office right now, we are currently working with the areas, tribes and communities, as well as States, to establish area-wide suicide surveillance and prevention systems, in collaboration with the BIA and States to collect information from law enforcement and medical examiner databases. We are also establishing partnerships between IHS and BIA to increase access to health and mental health care for children attending BIA-funded schools, and strengthening partnerships between State and Federal agencies in the area of suicide prevention.

We have also been working closely over the last several years in collaboration with SAMHSA and other HHS agencies and nongovernmental organizations and States to address and reduce suicide. We continue to train community members in the QPR model that was mentioned by Mr. Gidner, to involve American Indian and Alaska Native youth in suicide prevention efforts primarily through school products and Boys and Girls Clubs. We have been utilizing tribal colleges to provide suicide prevention training and programs that are culturally appropriate to our population.

For the first time, we have far more accurate data that is being gathered and shared from our clinicians in our communities, and those national policymakers and programs, all of which are extremely important to discuss the prevalence and the effects of suicide in Indian communities. No longer are we extrapolating data or estimating data, because we have data now that we feel is representative of Indian country and the communities affected.

We are continuing to upgrade those systems. For the first time, our electronic health record that we have had for many years is going to be fully integrated with the behavioral health documentation that many communities keep on suicide and other behavioral health issues.

Mr. Chairman, I will conclude my statement now by noting that, as I said earlier, my written statement goes into much more detail about the efforts that we have done. I want to thank you and this Committee again for continuing to raise this issue. I will be happy to discuss any of these issues that we have brought up today with you during the question and answer.

Thank you.

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

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

Finally, we will hear in this panel from Charles Curie. He is the administrator of the Substance Abuse and Mental Health Services Administration. Mr. Curie, thank you again for being here.

STATEMENT OF CHARLES G. CURIE, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Mr. CURIE. Thank you, Mr. Chairman and Senator Murkowski. Good morning. I am Charles Curie, the administrator of SAMHSA, the Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services. I am pleased to be here today to describe how SAMHSA is working to address the issue of suicide among American Indians and Alaska Natives.

Senator Dorgan, as you kindly mentioned earlier, I was scheduled to speak at a suicide prevention conference actually in Casper, WY today, but I am so personally concerned about suicide rates, especially in Indian country, and the work that we must continue to do there, that I wanted to provide this testimony myself.

It is a privilege also to testify with my friend and colleague, Dr. Charles Grim, director of the Indian Health Service [IHS]. SAMHSA and IHS have developed a strong partnership and a lot of collaborations that we are working on. It is reflected in our current interagency agreement to work efficiently and effectively together to help meet the public health needs of American Indians and Alaska Natives.

It is also a privilege to be here with Jerry Gidner, deputy bureau director for tribal services at the Bureau of Indian Affairs [BIA].

Suicide is not only a serious public health challenge, but it is a tragedy that is only now receiving the attention and degree of national priority it deserves. As you indicated, Senator, many people have difficulty discussing this issue and many times it is easier to put it out of the realm of consciousness. Many Americans are unaware of suicide's toll and its global impact.

Suicide makes up 49.1 percent of all violent deaths worldwide. It surpasses homicide as the leading cause of violent deaths. In the United States, suicide claims approximately 30,000 lives each year. When faced with the fact that the annual number of suicides in our country now outnumber homicides by 3 to 2, approximately 30,000 and 18,000 respectively, the relevance of our work becomes very

clear. When we know, based on SAMHSA's household survey for 2003, that approximately 900,000 youth have made a plan to commit suicide during their worst or most recent episode of major depression, and an estimated 712,000 attempted suicide during such an episode of depression, it is time to intensify activity to prevent further suicides.

The household survey data, the countless personal stories of loss and tragedy, are why we have made suicide prevention a priority at SAMHSA.

Last year, as you mentioned, a suicide cluster occurred on the Standing Rock Reservation in North Dakota; 10 young people took their own lives, and dozens more attempted to do so. The Red Lake Indian Tribe in Minnesota is experiencing high suicide rates following the deaths of 9 individuals at the hand of a 16-year old high school junior. Tragically, many other reservations have similar stories to tell. Suicide is the second leading cause of death for American Indian and Alaska Native youth ages 15–24. In 2003, the suicide rate for this population was between 2 and 2½ times the national average, and the highest among all ethnic groups in the United States, with a rate of 18 suicides per 100,000 individuals.

SAMHSA's policy is to level the playing field and to ensure that tribal entities are eligible for all competitive grants for which States are eligible, unless there is a compelling reason to the contrary. Currently, SAMHSA consistently is funding around $34 million of grants to award tribal behavioral health issues.

In 2005, we made the first cohort of awards, 14 in all, including a grant to Arizona under the Garrett Lee Smith Memorial Act. These funds are available to help States and tribes implement effective suicide prevention networks. One of those first grants went to the Native American Rehabilitation Association in Oregon. Today, I am announcing almost $9.6 million in funding for eight new grants, each for approximately $400,000 per year for 3 years under this program to support national suicide prevention efforts.

Grants have been awarded to programs in Oregon, Connecticut, Utah, Wisconsin, and Idaho. In addition, grants specifically geared to American Indians and Alaska Natives have been awarded to the Manniilaq Association of Alaska, the United Indian Involvement, Inc., and the Montana-Wyoming Tribal Leaders Council. An announcement for a third cohort of grants under this program closed yesterday. SAMHSA again invited all tribes to apply and provided technical assistance to tribal organizations to encourage more applicants.

The Garrett Lee Smith Memorial Act also authorized a National Suicide Prevention Resource Center. We are requiring the center to address how they would expand the current youth suicide prevention technical assistance to go toward tribes and tribal organizations.

SAMHSA has long supported a national suicide hotline, 1-800-273-TALK. Funding for the current hotline grantee was increased by $369,000 in fiscal year 2006, and the grantee has been asked to submit an application that indicates how they will expand their access to tribes.

In the Administration's request for the fiscal year 2007 budget, the one currently in front of Congress, SAMHSA is asking for near-

ly $3 million for a new American Indian-Alaska Native Initiative to provide evidence-based programming to prevent suicide and reduce the risk factors that contribute to youth suicide and violence.

SAMHSA has also transferred $200,000 to IHS to support programming and service contracts, technical assistance, and related services for suicide cluster response and suicide prevention. One example is the development of a community suicide prevention tool kit. This tool kit includes information on suicide prevention, which can be made readily available via the web.

SAMHSA also has issued emergency response grants in the aftermath of suicides, both on the Standing Rock Reservation as well as at Red Lake. Those dollars are still available to those two entities and we are still working in close collaboration to ensure those dollars are used in the best way possible.

SAMHSA is proud of what we have done, while knowing that this is not nearly enough. There is much more to do. The problems confronting American Indian and Alaska Native youth are taking their toll on the future of tribal communities.

I ask also that my written testimony be made part of the record, which does go into much more detail. I want to thank you again for the opportunity to appear today and I would be pleased to answer any questions you may have.

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

Senator DORGAN. Mr. Curie, thank you very much.

The Senate now has a vote in progress. I understand there are about 6 minutes remaining, so I think we will have no choice but to have a brief recess. We do want to ask some questions, and I believe Senator McCain will be joining us as well. But I think in the interest of time here, we will take about a 10-minute recess, and we will reconvene, we expect, at 10:15.

[Recess.]

Senator DORGAN. The hearing will come to order again.

Let me thank the panel for their testimony, and let me ask a few questions, if I might.

The hearings that I have held and the discussions that I have had paint a pretty dismal picture in most areas and with most reservations. The resources available, for example, when I went to the Spirit Lake Nation Tribe and talked to the school administrators, the tribal council, parents, students, and others, what I discovered with respect to the death of Avis Little Wind and others who had committed suicide is that they had very few resources. Mental health resources were virtually nonexistent. To the extent that they were accessible, they were accessible only with great difficulty, only then if you were able to borrow a vehicle from someone, if someone would loan you a vehicle that you could use, then the transport. It was unbelievable to me to see how few resources area available.

Now, Mr. Curie, today you have described grants and I appreciate your announcement today of those grants. I think it is going to be helpful. But I would like all three of you to tell me, you know, you have told us what is happening; tell us what isn't happening that has to happen in order for us to fully address this.

Let me describe why I say that. Dr. Grim, you talked about the resources that are important in rural areas to address this. But

you know, the President's budget recommends zeroing out the Indian Urban Health Centers in urban areas, zero them out. So even in urban areas, we have problems with the resources.

So I appreciate all that you say that you are doing. Tell me, as professionals, and as people who visit reservations and understand these issues, what is not being done that has to be done in order to really address this issue? Mr. Curie, would you go first?

Mr. CURIE. Yes; I will. Senator, I couldn't agree with you more that the issue around resources and accessibility to care is really part of the fundamental problem that we are seeing here. In fact, when we take a look at suicide rates, whether it is in Indian country or in general, untreated depression, lack of intervention many times is the root cause.

I think when we look at Indian country, we look at the remoteness of many of the reservations we see especially in Alaska with the Alaska Native villages, and this is an ongoing problem. We need to be thinking in terms of how to have the resources available to people where they live. There are models that are now being developed.

One, I would point out, is at the University of Alaska in which individuals who are from the tribe, young people in particular who are looking for a potential career, are trained as behavioral health, mental health, substance abuse aides and have the supervision, then, of a graduate degree professional that they would be connected with. We think this offers a pathway that we need to examine and see how we can expand and bring that to some sort of systemic level. Because again, when you have virtually hundreds of miles to go before you find a professional, it is unlikely that the interventions are going to be timely and appropriate.

This is tied, I think, to the greater workforce development issue that is facing the field as a whole, both in mental health and substance abuse, attracting people, keeping people in the field. Then again it is compounded even further when you are talking about rural frontier remote areas, and we are talking about Indian country.

So we need to be thinking in terms of how individuals themselves can be engaged and get the training and support they need.

I think it is also very critical for us to do what we can in collaboration with agencies that work not only on the treatment end of things, but in helping the young people in those villages find both an anchor, and I was discussing this with Senator Murkowski earlier, and a line of sight of where they are going to end up being someday.

I think those villages where we have seen a real focus on getting a sense of their cultural heritage, having strong youth initiatives to give them a sense of family, heritage, tradition, and helping them see what their future can hold, are establishing clear protective factors that can help address these risk factors. So we believe a public health model in identifying risk factors and increasing protective factors also will be critical in this process.

Senator DORGAN. Thank you.

Dr. Grim.

Mr. GRIM. I would agree with everything Charlie said. Let me just start out by saying that. Second, since we focus on direct clini-

cal and preventive, as well as public health care in our settings, we need to continue to do that. We need to have those sorts of services available. I think the expansion of, and we are doing this in telehealth, the expansion of tele-mental health capabilities. We don't have that across all of our areas yet. I think that will also lead to some increase in services.

We face the same thing that Charlie said at a national level, you know, the recruitment and retention of the right types of health care professionals. But also I think I want to play up the partnership issue a lot. I don't think any one agency right now has the full answer to this, nor has all the money that they need to address it. But I think we are seeing a lot of partnerships emerge around this issue.

A lot of it is coming from the Administration, asking the Indian Health Service and SAMHSA and BIA to work together. A lot of it is coming from the Congress in stimulating activity through funding or through bills like you all just passed. I think the partnerships that we have with SAMHSA, with BIA right now, are critically important partnerships.

We have also worked with Canada. My counterpart from Canada, the Director for First Nations and Inuit Health Branch, they have a very similar problem up there. We had a recent meeting in Albuquerque, New Mexico where their National Institute of Health Research, our National Institute of Mental Health, people from Indian Health Service, and First Nations and Inuit Health Branch, the Wisdom Keepers and traditional healers from communities, all got together.

We partnered to come up with a research agenda in Indian country over the next 5 or so years. We know there is a lack of information about, as Charlie said, some of the risk factors, as well as the protective factors. Ever since Charlie and I have been in our positions, we have held a joint meeting between the State block grant coordinators, the Indian programs, and the Indian Health Service and SAMHSA staff. That meeting has continued to grow in both importance, as well as in attendance. We are even having people from other countries come now. There is a part that spins off on that about suicide to a work group.

So I think partnerships with others beyond just the ones I mentioned, because the socially complex factors of housing, education, safety in the communities, all those are part of it. It is just such a complex issue that we have to have more partnerships, I believe.

Senator DORGAN. Mr. Gidner.

Mr. GIDNER. Thank you. I would agree with Dr. Grim and Mr. Curie as well. From the BIA perspective, on the micro level, I would say there are not enough trained people on the ground to observe and work with the youth, to identify those who may be thinking about suicide, and to get them into the appropriate health model to prevent that. BIA does have a cadre of social workers throughout the country. They are spread very thin and spend most of their time working with child abuse and adoptions, foster care, things of that nature.

On the macro level, though, I would suggest that what needs to happen is there has to be a way to give these children hope that there is some better future for them. That would involve more job

creation, better law enforcement, other things that are going to improve the health of their community so that they know there is something waiting for them, and that they have a reason to live.

Senator DORGAN. Mr. Chairman, welcome. We are just finishing up the first panel. Senator Murkowski has not yet asked questions.

I have to be down at an Appropriations hearing in a few minutes with the Defense Secretary to question him. I just wanted to make a point at the end of this panel. I think these partnerships are important. I especially appreciate the fact that you are all providing focus to this. I also think that we have to provide funding as well.

For example, we have an Indians in Psychology Program trying to encourage Indians into psychology in colleges. That gets zeroed out every year by the Administration and they are zeroing out the Urban Indian Health Centers. So we do have to provide funding. We need youth centers. We need trained mental health professionals and so on.

I have been sensitive to this issue of suicide for a long, long time. I walked in one morning and found a very close friend of mine had taken his life, a co-worker. I found him at his desk at 8 o'clock in the morning. With him, as it is, you say, with Indian youth, it is the single act in response to multiple causes, almost always the case regardless of age.

But especially with respect to Indian youth, there is a very serious problem, and I appreciate the partnerships. We need the funding. We need strategies. I appreciate Chairman McCain also providing focus to this issue with this committee, and Senator Murkowski's attention and interest in it as well. I look forward to continuing to work with you and exchanging views with you and developing strategies with you to address it.

Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you very much, Senator Dorgan. Thank you for your leadership. Thank you for your attention and your continued commitment to this issue.

I know that a lot has been covered. I just wanted to ask, Mr. Curie, I keep hearing from Indian country that methamphetamine is having a significant effect on this issue, not just suicide, but on a whole lot of other aspects of Indian country. Can you comment specifically on the epidemic of methamphetamine and how it has affected this specific issue?

Mr. CURIE. Yes, Mr. Chairman; Methamphetamine is undoubtedly from what we have seen the most dangerous drug that has been on the street and available. In terms of its addictive quality, one use and addiction can occur. In terms of the devastating impact it has on the individual, in terms of their brain. Their whole life begins to get focused on one thing, and that is the desire to have more methamphetamine.

The challenge and why it is in many parts of the country, while national prevalence data shows that actually opiates and painkillers are growing at a faster rate overall nationally, there are places in the country, in Indian country and rural and frontier areas in Western and Midwestern States where methamphetamine is the number one problem. That is because of the accessibility of the ingredients to make meth. It is available, of course, readily

available in hardware stores, in various retail outlets, and there are recipes, of course, available through the Internet today.

The CHAIRMAN. And some of it is coming across our Indian reservations from Mexico?

Mr. CURIE. Yes; and that is also another factor. Absolutely. So there is accessibility to it. And there is an undeniable link between substance abuse, especially when we talk about how dangerous meth is, and suicide. A high percentage of suicides are linked to drug and alcohol use.

So to approach this, we believe that it has to be a multifaceted approach to the suicide problem, that we have to consider our substance abuse treatment and prevention efforts to be part of the suicide prevention efforts. We need to be working specifically with tribes in the context of their culture and the context of what their needs are to identify those risk factors that continue to contribute to the substance abuse problem, and to develop protective factors. We are finding many of them are the same that relate directly to the suicide problem and issue. So they do go hand in hand.

We are looking very closely now in California, where the tribal organization, the California Rural Indian Health Board, received one of our access to recovery grants in which vouchers are being used and to expand their capacity for substance abuse treatment. We are going to be looking very much at the link there in terms of the impact that additional resource is having in helping address this issue.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Mr. Gidner, you mentioned in your testimony this high school, middle school youth risk behavior survey, where you have gotten some pretty compelling data about what our young people are contemplating. What do you do with that data once you receive it? I understand how these surveys work and the confidentiality aspect of the survey, but if you have statistics coming out of a middle school that show a disproportionate number of our young people are contemplating suicide, is there any opportunity through the BIA or for the school itself to have some kind of an intervention with a group of young people that are clearly at risk because they have indicated to you, they are asking for help. What do you do with the information?

Mr. GIDNER. What we have done, Senator, is launch, I believe I mentioned, the question-persuade-response model, where all the bureau-funded schools are trained, the administrators and staff, to intervene on behalf of individual students when they observe problems and to try to talk to those students and persuade them to get help and to refer them to the appropriate place to get that help.

Senator MURKOWSKI. But you are dealing with, again, you are not able to pinpoint who your students are. You just have a recognition that in this particular school we have an issue. With these surveys, you have a lag time between the time the students respond and the data is compiled and the results then get back. Are these surveys helping us do something? Or are they just an indicator of how bad the situation may be getting?

Mr. GIDNER. I actually don't know the answer to that question. I will have to make inquiries and find out exactly what we do do with that information.

Senator MURKOWSKI. I think when we ask our kids how they are feeling and how they are thinking, we need to be in a position to then respond and not respond eight or nine months after the fact in some generic way. These surveys have value, but we do want to know that we are able to get to the kids, particularly when you have statistics coming back that say one-fifth of our high schoolers have contemplated suicide at some point in time.

Mr. Curie, you mentioned a grant to Manniilaq Association, which we greatly appreciate. Can you tell me the terms of that grant, what we are talking about, and exactly how you anticipate that we will be able to utilize that to stem the suicide rate?

Mr. CURIE. Absolutely, Senator. It is a total of $1.2 million over a 3-year period, $400,000 per year. It is to be utilized to begin to implement evidence-based suicide prevention strategies that are community-wide types of strategies. Again, more clearly identifying what risk factors are contributing to the suicide issue, risk factors such as students not having enough activity, young people and families not being fully engaged. There are going to be a variety of those types of risk factors.

And then developing strategies and begin to put into place evidence-based programs that reflect the protective factors that can begin to address those particular risk factors, and of course a required evaluation of that over the 3-year period as to how effective it is working.

Again, it is to put in a prevention framework and have it be community-based engaging all elements of the community.

Senator MURKOWSKI. Which is the appropriate response, the appropriate way to proceed in my opinion. We had an opportunity to speak a little bit during the break about, it is a societal issue. It is an economic issue. There are so many things that come into it.

When I have asked young Alaskans out in the villages, are you happy, what would make your life better, it is some very simple responses. They are bored; we are looking for something to do; we have no community meeting place.

And yet when we try to address that by providing for a Boys and Girls Club or some form of a community center, that doesn't necessarily fit your model in terms of where grant funding goes. We need it to be in some form of a service, and yet we need the flexibility to work with the communities.

Manniilaq has, I was out there over the Easter break, and they have an incredible program out in the remote area where literally the whole family is taken out to be treated for substance abuse and other issues. But the family as a whole is addressed, not just the one individual that is suffering from the addiction or the depression. I don't know if we are set up to deal with a response in this broad a manner, but when we are looking at statistics like we are seeing now, it seems to me we have to do something different. The Manniilaq approach hopefully will shed some light there.

Mr. CURIE. I think that type of model has a lot of merit and applicability. In fact, I think one of the challenges and barriers that we have found in Alaska in particular is the fact that when treat-

ment is offered that someone is taken out of a village, around 200, 300, or 400 miles to residential treatment centers, spends a period of maybe a few months there even, but goes right back. There has been very little intervention for the family or the community. The results are not good.

Senator MURKOWSKI. The results are predictable.

Mr. CURIE. Exactly. So what we need to do is find resources within the community and have the supports put in place so that people have an anchor to rely on. They need, again, to be community-based. It should be no surprise to us. We believe in community-based care throughout this Nation in what we are doing. We find that those give the best results. The same would be true in Indian country.

Senator MURKOWSKI. One question for you, Dr. Grim, and then you can comment here. As far as Alaska's behavioral health aid program, it is something that has been working in the State. Do you see this perhaps as a model to be used in other areas of Indian country? And if you would comment on what Mr. Curie and I were talking about.

Mr. GRIM. If you would permit me, Senator Murkowski, to respond to his question first. I wanted to say that I think the tack that SAMHSA is taking is a very appropriate on, too. One of the things I talked about in our partnerships together that we have with them. They are taking and asking communities to use evidence-based sorts of practices and try to put them in place in real life communities and see how they work.

One of the things the Indian Health Service is doing with some of our resources is to go to the community level and ask them what needs to be done. We have been targeting communities that have some of the highest need. So we are doing basically what you said. SAMHSA is attacking it from one direction. We are using some of our resources to attack it from just the direction you said. We go into an individual community and say, okay, what is it you think you need; we have specialists that help; that can help guide the process. Then we try to tailor it for that community.

So I think, again in combination with multiple agencies working together, we are trying to tackle it from different perspectives.

To be more direct to your second question or your question to me, I have watched in awe and respect as Alaska has continued to push the frontier to try to deal with some of the issues that they have to deal with in their communities. I think the next step, the community behavioral health aid therapist that they are looking at is going to be another model program. As Charlie said, we are looking at shortages in many of the professional areas.

He also noted, as I noted, that I think we have under-diagnosed mental health issues, depression and others, in many of our communities, not just Indian communities around the country. Now that mental health care is becoming more acceptable, people are willing to seek it out. We are starting to see more chronic diseases that are being affected by some of the underlying mental health conditions people have. I think we are all becoming much more aware of it and the role that it is playing in not just mental health issues and suicide, but in chronic disease issues as well.

Senator MURKOWSKI. I appreciate your support.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I thank the witnesses. I appreciate your prioritizing this very important issue. We look forward to working with you. Thank you.

Our next panel is Donna Vigil, who is director of the Division of Health Programs at the White Mountain Apache Tribe, Whiteriver, AZ. She is accompanied by Dr. Norine Ashley, who is the director of the Apache Behavioral Health Services. William E. Martin is chairman of the Alaska State Suicide Prevention Council and First Vice President of the Central Council of the Tlingit and Haida Tribes of Alaska. Dr. Dale Walker is director of One Sky Center, Oregon Health and Science University. Jo Anne Kauffman is the project director of Native Aspirations Project in Spokane, WA.

Welcome to our witnesses. Ms. Vigil, welcome. We are glad to see you. Please proceed with your statement.

STATEMENT OF DONNA VIGIL, DIRECTOR, DIVISION OF HEALTH PROGRAMS, WHITE MOUNTAIN APACHE TRIBE, ACCOMPANIED BY NORINE ASHLEY, DIRECTOR, APACHE BEHAVIORAL HEALTH SERVICES; AND FREDERICK L. HUBBARD, ASSOCIATE DIRECTOR, COMMUNITY RELATIONS

Ms. VIGIL. Good morning, Mr. Chairman and members of the committee. My name is Donna Vigil. I represent the White Mountain Apache Tribe. I am the executive director of the Division of Health Programs. I have with me here Dr. Norine Ashley.

The CHAIRMAN. Welcome

Ms. VIGIL. She is the director of the Apache Behavioral Health Center.

The White Mountain Apache Tribe has 17,000 members with 15,000 members living on the reservation. Before I go any further, I would like to say that Ronnie Lupe, chairman of the White Mountain Apache Tribe, sends his highest regards to all the members of the committee, especially to his friend, Chairman McCain. He considers all the members of the committee friends to the Apache people.

The CHAIRMAN. Thank you.

Ms. VIGIL. Suicide is a great challenge to the White Mountain Apache Tribe, particularly among children and young adults. With very little outside funding, the White Mountain Apache Tribe has come together to address this issue. We started up in 2001 with a suicide task force established by the tribal council. It is headed by a community member who is an IHS employee and a member of the tribe. This committee, the suicide task force, has worked with Johns Hopkins University. It is working on research through the NARCH program, which stands for Native American Research Center for Health.

Through that, the tribal council passed a resolution to begin a registry of suicides, and through the suicide registry our mental health center, Apache Behavioral Health Center, sees all the people who are suicidal, or who are at high risk. Within a 1-year period, there were 300 referrals from the task force. We have two tribal members who are working on the task force, assisting and helping with case management.

Another committee we have formed is the High Risk Response Alliance through the Apache Behavioral Health Services. The Behavioral Health Alliance is really an effort to get community members involved in our efforts with suicide prevention.

With that, we started a Ministers Alliance. You know, as Apache people, we are deeply spiritual, and we wanted to include spirituality in our suicide prevention program, so the Apache Behavioral Health Center did incorporate a component of spirituality. We have over 60 Christian denominations on our reservation. The ministers had a walk recently and had prayer services in a location where we had several suicides.

Another part of the Alliance is the traditional part, our traditional healers. They formed a group and are planning a ceremony for the reservation.

These are only some of our efforts. We have limited funds and are trying whatever we can to work on the suicide issue, but we have some barriers. I am going to mention them quickly because they are very important. One is that there are not enough professionals and paraprofessionals who can provide training or skills to respond to suicidal persons. Apache Behavioral Health Services is partly funded by Public Law 93–638. It also receives funding from third-party billing, through Medicare [which is Medicaid of Arizona].

But we fear that we may not be able to continue billing for our Native American counselors, those who are not doctors. They are good workers who go out into the community and help the people in crisis. Yet our Medicaid program is in jeopardy because of the certifications and degrees that are required. So we ask that this doesnt happen; that we are able to continue to bill for services provided by these non-professional people. This is very important for the continued success of our suicide prevention program.

Another thing we need is a 24-hour response center. That would allow us to have a place where people can call any time.

Underlying our challenge with suicide is the main problem of substance abuse. Without any culturally sensitive centers to which we can send our young Apache people, it is difficult to work on the problems that they have. So we are asking that we get funds for culturally sensitive substance abuse prevention centers, to provide this much-needed service for our youth.

In conclusion, our needs are great, and our resources are few. Our suicide rate is among the highest in this country. So I am very happy and I am grateful that the Senate Committee on Indian Affairs has taken an interest in hearing about suicide in the hopes that you will help us to implement and fund suicide prevention programs.

Thank you.

]Prepared statement of Ms. Vigil appears in appendix.]

The CHAIRMAN. Thank you very much.

Mr. Martin, welcome.

STATEMENT OF WILLIAM E. MARTIN, CHAIRMAN, ALASKA STATE SUICIDE PREVENTION COUNCIL, AND FIRST VICE PRESIDENT, CENTRAL COUNCIL OF THE TLINGIT AND HAIDA TRIBES OF ALASKA

Mr. MARTIN. Chairman McCain, Senator Murkowski, other members of the committee, thank you for inviting me to testify at this hearing.

My name is William Martin and I am chairman of the State Suicide Prevention Council in Alaska. I am also first vice president of Tlingit and Haida Indian Tribes of Alaska.

The State Suicide Prevention Council serves in an advisory capacity to the Governor with respect to what actions can be taken to improve health and wellness; broaden the public's awareness of suicide; enhance suicide prevention services and programs; develop healthy communities; and develop and implement a statewide suicide prevention plans, copies of those plans I have brought with me and have distributed to your aides; and to strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the State.

Let me briefly outline the magnitude of our problem and then report on what seems to be working at preventing suicide. For the past decade, Alaska has had the second highest rate of suicide in the United States, twice the national average. Alaska Natives commit suicide two to three times that of non-Natives in Alaska. In my written testimony is an even more startling statistic.

Our Suicide Prevention Council has offered the workplans to prevent suicide. We distribute it within many diverse communities throughout the State. With no one answer that fits our many cultures, we believe there are tools that make suicide preventable. Our workplan combines analysis of the problem with words of wisdom from our Alaskan elders. It sets 13 prevention goals that a community can use to meet its specific suicide prevention needs.

I submit with my written testimony a copy of our workplan and ask that it be included in the record of the hearing.

The CHAIRMAN. Without objection, it will be made part of the record.

Mr. MARTIN. Our Suicide Prevention Council has increased its suicide prevention and awareness efforts through a media campaign and through effective use of the Gatekeeper program. Gatekeeper programs reduce suicide rates by training first responders such as emergency personnel, public safety officers, clergy and others who may be approached in a suicidal crisis, but who typically lack specific suicide prevention experience.

The Gatekeeper program results in much more effective crisis intervention. We could do far more Gatekeeper training if we could gain greater access to Federal funding for these programs. This cost-effective approach works and deserves more financial support.

As an Alaska Native leader, I have become convinced that my people must go back to study the lessons of our ancestors. They lived in a time before alcohol was introduced to our communities. Suicide then was an unheard of event, typically in rare cases where one has grievously shamed his family or has caused despicable hurt upon others. Although my stance may not make me very popular, I am convinced that tribal leaders should set an example to our

people by abstaining from alcohol. Whether or not alcohol is a problem for us as individuals, we leaders need to demonstrate to our people that alcohol is the cause of most of our social problems.

Suicides in a community tend to go in streaks and I think I know why. I believe that there is a copycat effect that is encouraged by how we talk about people after they kill themselves. For example, at a funeral for someone, we never say bad things about a person who has died, but there may be a person listening in the audience, a young person who might think to himself that this is all I need to do to gain respect for my family and my friends and for my elders. So it starts a compounding effect.

We need to talk to our young people before this happens. We need to praise their good qualities while we are living. Natives don't usually openly demonstrate day to day affection and love for our children because of some of our cultural ways. We just don't do that. We need to change this. Our Native cultures are living entities that need to be shaped by Natives alive today.

To change this culture, to change our ways, we need to find funds from outside our own private communities to support suicide prevention programs that assist our elders and leaders in changing the attitudes of our people. Native communities simply cannot compete on the same playing field for funds from SAMHSA and from the Centers for Disease Control.

One of our regions hit hard by suicide is the Yukon-Kuskokwim Delta. Through the Association of Village Council Presidents, a plan has been organized which in Eskimo means "securing a future for our children." This mission is to create a well community in which all entities work together under the direction of elders to restore healthy communities, strong in culture and language.

Like my own community in Juneau, the Tlingit and Haida community has developed a modest program that involves Native teachers in button-blanket making, weaving, and carving to pass on this knowledge to our youth. This has shown to be a great success in bringing back Native pride and Native values, the key defense mechanisms against hopelessness and depression that can lead to suicide.

To fund a program such as this in the Juneau area requires funding of approximately $15,000 to $20,000. Funds like this should be made available to our smaller communities that could bid on plans and programs that we can use to discourage suicide.

Mr. Chairman, my time has expired and I would be happy to answer questions and will be available for that.

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

The CHAIRMAN. Thank you very much, Mr. Martin.

Dr. Walker.

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

Mr. WALKER. Thank you very much, Mr. Chairman. It is a pleasure to be here.

Senator Murkowski, I also appreciate being here as a witness for you.

My name is Dale Walker. I am a psychiatrist. I am also a Cherokee. I direct a program called the One Sky Center. The One Sky

Center is the only national resource center for American Indian alcohol, drug and mental health in the country. In the last year, we have been at 59 different sites. We are a small group. We have partners across the country who work closely with us.

We have heard a little bit about the discussion of interagency support and coordination, and I would tell you that the development of partnerships at the level of a resource center is a critical next step in trying to do these issues as well.

We have been at many sites, first looking at alcohol and drug issues, but everywhere we went, it was the issue of family violence, suicide, disorganization, and disconnection with culture that were issues of great concern. You have heard already today the fact that these issues are interrelated, that indeed trying to wrestle with this issue in a pointed directive way is not as effective as working with the tribe and getting an overall plan on how to deal with the many circumstances that lead to the problems.

You have heard some discussion also about indigenous knowledge or traditional knowledge about how to keep the family intact and about how to restore values. All of these are critical and quite important. Evidence-based work is also critical, but community-based treatment and management requires that the values within the community are a part of the care.

We have been looking and working with areas also and finding out that you don't do a visit, a consult or technical assistance once; that when you visit, you stay. You work with the tribes continuously through the process.

Sometimes, that is not in sync with the funding cycles of how programs work within the system, so we are very interested in if things are set up to help develop. By the way, I want to add, you already know that there is underfunding of mental health, addictions, and education. There are three reports, two from Congress, about the underfunding. You are aware of the disparities that exist in these areas.

In order to address those, we know there needs to be more bottom-line funding to help with these problems. Then when you develop special programs with grants, you can actually advance the best practices for a community so that everybody can learn together.

Our experience has been that if we can work with and train people, the behavioral health aide program in Alaska is a very good example, they are able, the community is empowered to select their people. They decide who gets the training for triage assessment and follow-up after-care in their programs. That empowers the community to be involved.

They also have the trust and that kind of goes quickly with the process of care. We support that. I think it is a remarkable next step in training for IHS programs, as well as, frankly, third world programs that are in the same situation. These efforts are quite important.

In the proposed bill, we took a serious look at the training issues and maintaining the expertise out in the field. How you get the care there, and how you maintain the care becomes critical. You have to maintain the care for licensure so that billing and work under the logical health care circumstances. That maintenance of

license and certification to do the training is very difficult if you are in a remote area.

We think that the telemedicine is not only for clinical care, but it is for training of the people who go out into the area. It would be wonderful to have in place modules for training in addictions and mental health and suicide so that people could take courses on Web sites and be able to do that. We are working with the tribal colleges and universities to help establish that kind of approach.

The other position I would just mention is that the interagency task forces and partnerships work if the people understand that we have to look at the total funding across agencies and get together to figure out how to focus the dollars as a group. If you look at it as individual silos, that is what you get.

We have much else to say in the discussion, but I am going to end the conversation here.

Thank you very much.

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

The CHAIRMAN. Thank you very much, Dr. Walker.

Ms. Kauffman, welcome.

STATEMENT OF JO ANN KAUFFMAN, PROJECT DIRECTOR, NATIVE ASPIRATIONS PROJECT

Ms. KAUFFMAN. Thank you, Mr. Chairman. I want to thank you and Vice Chairman Dorgan for your work on this issue, and also thank you, Senator Murkowski for your presence here and your interest in this very difficult topic.

My name is Jo Ann Kauffman. I am a member of the Nez Perce Tribe. I have been involved in Indian health issues for the last 30 years. I have a master's in public health from the University of California at Berkeley.

I was invited here to testify today as a contractor for SAMHSA and the work that we are doing currently on their behalf to bring evidence-based interventions to high risk communities in prevention mode.

I must say, first of all, that this hearing is important and it was interesting coming on the heels of Mother's Day. I spent the weekend thinking about the importance of what can come out of this hearing and the work that you are doing to bring resources to communities, and my heart goes out to all of those parents for whom this issue is very personal.

We were asked last year by the Substance Abuse Mental Health and Services Administration to consider an emergency contract. As a Federal contractor, we prepared a response for them, specifically to look at nine of the highest risk communities across the United States in Indian country for purposes of preventing some of the disasters that we saw last year with regard to youth violence in Minnesota and some of the suicide clusters across the Plains States.

We pulled that together primarily as a prevention model to prevent youth violence, youth bullying and suicide. We targeted those communities most at risk through a quantitative assessment. We are engaging those nine communities in a grassroots, bottom up planning approach, and bringing the curriculum or the evidence-based interventions to those communities to implement according

to their wishes over the remainder of this contract which runs until March 2007.

The nine communities that were selected include, well first of all, in selecting the nine communities that was a quantitative analysis of mortality data related to violence for Indian youth in comparison with behavioral health funding and poverty rates. We looked at three areas primarily: The Aberdeen area, the Alaska area, and the Billings area. Then we did a series of interviews with professionals in each of those areas to identify three communities within each area to come up with the nine.

In the Aberdeen area, we have agreements to work with the Cheyenne River Reservation, Crow Creek Reservation, and the Pine Ridge Reservation. In Alaska, we will be working with the Native Village of Alakanuk, the Noorvik Native community, and the Native village of Savoonga. In the Billings area, we will be working with Fort Belknap Indian Reservation, Fort Peck Indian Reservation, and the Wind River Reservation in Wyoming.

Because youth violence is a complex historical, cultural and family issue that has economic and geographic and access to care kinds of issues overlaying that, our effort really is to reduce risks by promoting supportive and protective factors within each of those communities, and to allow each community to identify its own strategy.

We did conduct a review of evidence-based interventions and I want to note that the National Registry of Evidence-Based Programs and Practices, known as NREPP, is provided through SAMHSA as a registry of evidence-based interventions. It contains only two Native American-focused evidence-based interventions that have received that seal of approval by NREPP.

There are a host of other interventions that are called practice-based interventions. And then as you heard earlier, there are many cultural-based interventions that bring forward the traditions and values and ceremoneys of particular tribes and cultures as a way to protect Indian youth and to prevent violence.

I am happy to report that last week, we conducted our first two community engagements. We worked with the communities at Pine Ridge and at Cheyenne River. Each of those communities conducted their own planning process. They learned about the evidence-based interventions. What emerged from that was their own very unique application of cultural knowledge and values and tradition and ceremony to come up with a plan for this next year for working within their school districts and their communities to prevent youth violence.

All nine communities are very motivated. This effort is, as I described, is an emergency effort of a prevention mode to prevent further incidents like we heard of last year. But it is a short-term effort and each of the communities has been very active in seeking additional alternative resources through their States, through the Garrett Lee Smith opportunities for funding, and through other resources.

So in closing, Mr. Chairman, I have a few recommendations. First, that the committee consider expanding support for tribal communities seeking assistance through SAMHSA or IHS. It is difficult for short-term demonstration efforts to have time to prove results. Second is that in looking the quantitative data, it is clear

that many more communities require this type of preventive assistance through whatever channels are available.

Third is that the NREPP process of sanctioning certain evidence-based interventions may inadvertently be leaving out many traditional tribal or practice-based interventions. That is important only because it seems that funding now is being tied closer and closer to that status of NREPP evidence-based interventions, including Medicaid reimbursement at the State level.

So it would be important to provide whatever support to get more tribally based or culturally based interventions through that status.

I support everything that has been said already with regard to workforce development in the paraprofessional field and increased access to services.

In closing, Mr. Chairman, thank you very much for this time.

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

The CHAIRMAN. Thank you very much.

I would like to ask the witnesses how serious in the overall issue of suicide is the issue of methamphetamine, the accompanying epidemic of methamphetamine. I will begin with you, Ms. Vigil.

Ms. VIGIL. Well, in the last year we have noticed a 30-percent increase of methamphetamine use. When we recently tested our regular employees who work for the tribe there was a 30-percent use.

The CHAIRMAN. What percent?

Ms. VIGIL. Thirty percent. In the past, there was no methamphetamine abuse on the reservation; there was just alcohol. And now methamphetamine abuse is climbing even among the work force of the tribe. Methamphetamine abuse is related to alcohol abuse, and substance abuse is related to more than 50 percent of the suicide cases.

The CHAIRMAN. Mr. Martin.

Mr. MARTIN. Mr. Chairman, it is a huge problem in Alaska because it is easily made. It can be made any place. Also, the effects of it are quicker in bringing down barriers in people, even more so than alcohol. It is a problem we are focusing hard on in villages, but without law enforcement in remote villages, it is very difficult. And besides, with the secrecy involved in each of those communities, it makes it very difficult to bring it out in the open and expose it to the law enforcement people.

The CHAIRMAN. Dr. Walker.

Mr. WALKER. If suicidal intent and alcohol are a crisis, suicidal intent coupled with methamphetamine is a disaster. I say that in studying and working on suicide issues, 90 percent of the time substance use is a part of the suicide attempt, so it is a huge connection. The fact is that methamphetamine now is more and more available, and most kids use what is available. There is not a staggered way of doing it. They use what is available. Methamphetamine is everywhere in every Indian reservation. Therefore, it is used.

The reason I say it is a disaster is that methamphetamine also causes psychosis. You actually lose control of your ability to use your own logical thinking.

The CHAIRMAN. And there is a period of exhilaration and a period of depression.

Mr. WALKER. That's right. And so with all of that connected, the psychosis and the depression and the loss, all of those feelings are magnified, making risk for suicide much, much higher.

The CHAIRMAN. Dr. Walker, before I leave you, is most of this in Indian County manufactured in Indian country? We know how easy it is to obtain the materials. Or is it like in the rest of the country, where you have really this flood of Mexican methamphetamine, which is even cheaper than making it yourself?

Mr. WALKER. What I hear across the country is the import, the bringing in from out of the country and out of the area. There are users, and many times by the way, the manufacturing is not by Indians out in isolated areas. It is by other people who know that is a good place to hide.

The fact is, though, there is a huge problem with the movement of methamphetamine and other drugs into Indian country from out of this country.

The CHAIRMAN. Now, we all know that the suicide rate is up, right?

Mr. WALKER. Yes.

The CHAIRMAN. How much of that would you attribute to the methamphetamine problem?

Mr. WALKER. Difficult question. I would quickly tell you that we need to understand what is happening out in our Indian communities with methamphetamine. There is actually very little science. There are lots of facts and experience. But to answer your question, to make that relationship, I think it is a wonderful point that needs to be addressed. It reminds me that another recommendation we had is that perhaps in this bill some support from the National Institutes of Health might be useful to actually study these problems much, much more thoroughly.

The CHAIRMAN. Maybe we can seek for that to happen. I think that is a very good recommendation.

Ms. Kauffman.

Ms. KAUFFMAN. Thank you, Mr. Chairman.

I think the only thing that I would add here with regard to methamphetamine is what we have heard is the difficulty in treatment of individuals who are addicted to methamphetamine, and that it is much more difficult and intense than I think the treatment programs that have evolved around alcohol addiction or even drug addiction. And so that we are hearing from drug treatment providers.

The other thing that we have also heard is the difficulty in terms of law enforcement if there is ever jurisdictional ambiguities, I guess, that tend to work in favor of those who are hiding underneath the radar screen of law enforcement.

The CHAIRMAN. Thank you very much. We are in agreement on lack of funding. We are in agreement there needs to be more interagency coordination and effort. What else do we agree on, Dr. Walker?

Mr. WALKER. Well, first of all, I think that the consistency of three hearings in 1 year is raising the visibility and the ability for communities to talk about the issues. If I could give a very, very direct comment, it would have to do with how we maintain connections with our communities when we do technical assistance and do the kinds of work in providing best practices in those commu-

nities. That connection is so critical to maintain. Letting the communities alone or letting them drift is not an effective way, and we know that.

I think that the integration and support that we have seen from SAMHSA has been marvelous; the fact that we try to put, as you well know, if you talk about addictions and mental health, and prevention and treatment, those can also become isolated from each other. The fact that Mr. Curie states there is one SAMHSA is a wonderful message. The people are now starting to work together to move those things in partnership with the community.

The partnership, by the way, starts with the leadership of the tribe. We need much, much more influence and ability to provide information so the tribal councils can actually make decisions about their own health care.

The CHAIRMAN. Ms. Kauffinan.

Ms. KAUFFMAN. Thank you, Mr. Chairman.

One of the points that Dale just made with regard to tribal leadership we use with our communities, it is called a community readiness model to assess where a community is before coming in with interventions or assistance. Across the board so far, it has been too little awareness on the issue, too vague awareness on the issue. I think that so much energy and resources are taken responding to tragedies and events, as they should be, but so much more needs to be done with regard to prevention and awareness and training at the local level.

The CHAIRMAN. Mr. Martin.

Mr. MARTIN. We agree that we need to get the programs into the villages, but more with the cooperation of the people in the villages. Sometimes there is a stigma involved where they feel that we are coming in and telling them how to do things, when in effect we should be able to be working with them, with the leaders of the villages, along with the elders. We already have the commitment from the elders, who are always standing by ready to assist in the youth programs, but we need to be able to work from the, like in our case, central council. Tlingit and Haida needs to work with the individual communities to be able to set up programs.

The State Suicide Council is also willing to adapt its plan to any of the villages that would require assistance in setting up how to customize it for each individual village.

The CHAIRMAN. Ms. Vigil.

Ms. VIGIL. I think we all agree that we need more paraprofessionals and professional Native Americans who can provide services. We need Medicaid of our State to continue to pay us for providing those services because that is one of the major sources of funding for us.

Another thing we agree on is that treatment for Native Americans should be tailored specifically for them, to address all their issues.Thank you.

The CHAIRMAN. I want to thank the witnesses. Senator Thune had some records that need to be included as part of the hearing record. The letters are from South Dakota Native Americans who have lost relatives to suicide, to be made part of the record.

I want to thank the witnesses. I appreciate your commitment to trying to address this terrible and tragic issue. I am very grateful

for the leadership and conunitment of Senator Dorgan and other members of this committee. We will not quit, nor will you, and hopefully we can make some progress over time and bring more attention to this ongoing national tragedy.

Thank you. This hearing is adjourned.

[Whereupon, at 11:25 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. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

This is the third hearing in the 109th Congress that this committee has held on youth suicide among Native Americans. At a field hearing Senator Dorgan chaired in North Dakota last year, and at a subsequent hearing here, we learned that the suicide rate for Native Americans continues to escalate and is many times the national average for other population groups. The tragedy of young people taking their own lives has particularly impacted various native communities around the country that have experienced "clusters" of suicides among their school-aged children.

Legislation has been introduced to try to address the problem. Senator Dorgan introduced, and I co-sponsored, S. 2245, the *Indian Youth Telemental Health Demonstration Project Act of 2006,* which passed the Senate just last week. The bill authorizes a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth. S. 1057, the *Indian Health Care Improvement Act of 2006,* which has been reported out of the committee but which has not yet passed the Senate, includes the development of a comprehensive behavioral health prevention and treatment program for Indian Behavioral Health Services; an assessment of the scope of the suicide problem; and a grant program to provide research on the multiple causes of Indian youth suicide.

Today, the committee meets to examine how suicide prevention programs and resources that exist outside of Indian country might be applied to American Indians and Alaska Natives. To this end, committee staff has put together draft legislation to add a native component to existing Federal suicide prevention and related programs, and I welcome witnesses' comments today on these proposals.

I am pleased that representatives from the White Mountain Apache Tribe could be here today. Last year, committee staff traveled to White Mountain to meet with Apache Behavioral Health Services, where they learned that, in the tribe of about 15,000 members, there had been over 500 attempted suicides in 1 year. Even accounting for the different ways in which suicide attempts are counted, this number is both shocking and heart rending. I am pleased that the thoughtful and informed, if overwhelmed, people who helped to educate my staff in December are here today to again share their experience.

Again, I commend the vice chairman for his leadership on this issue, and look forward to the testimony of the witnesses.

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 May 17, 2006

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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 specialists 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 illness including substance abuse disorders.

The AACAP and APA would like to thank Senator 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, alcohol and substance abuse, 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 problems of alcohol abuse and suicide better illustrated than the March 2005 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 suffered from depression from years of family struggles with mental and alcohol problems. Weise infrequently attended Red Lake High School in his last year there.

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 were pleased that the Senate passed, with unanimous consent, the Indian Youth Telemental Health Demonstration Project Act on May 11,

2006. The bill, which authorizes $1.5 million for each year from fiscal year 2007 to 2010 to use electronic technologies to support long-distance mental health care aimed at preventing Indian youth suicides, addresses this disparity. We encourage the Committee to continue 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, 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 one 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.

Suicidal behavior is a serious concern in all children and adolescents. 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]

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% 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.

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 Native Americans 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 impede 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.

Lack of access to specialty mental health services, including child and adolescent psychiatrists, is a major problem when seeking access to mental health care in Native American communities. As the President's New Freedom Commission on Mental Health has stated, 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 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 illness, and nowhere is this model more urgently needed than in Native American communities. Programs that include consultation with mental health specialists through telemedicine or bi-monthly office visits are needed to ensure appropriate mental health care for children We look forward to working with the IHS to expand the implementation of community-based systems of care in Native American communities.

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 illness, 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 "wrap around" service delivery model should be available within the community.

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% of the patients responded positively to the combination treatment of medication and therapy, which is a rate double the 35% 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 antidepressant 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 parents and physicians with information on depression and its treatment options at 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.
- Enactment of the Indian Youth Telemental Health Demonstration Project Act.

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 Kristin Maupin at the American Psychiatric Association, 703.907.8644.

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.
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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.

TESTIMONY OF THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates this opportunity to submit testimony to the Senate Indian Affairs Committee on the issue of suicide among American Indian/Alaska Native (AI/AN) youth.

The AAP is proud to have enjoyed a long and fruitful relationship with the Indian Health Service (IHS). In 1965, the IHS Director noted serious health issues among AI/AN children and requested consultative services from the AAP. This relationship has been sustained for over 40 years and continues today. Experienced members of the AAP's Committee on Native American Child Health make regular site visits to IHS and Tribal health facilities and programs to provide consultation and advice on child health issues and concerns. An important recurrent issue of much concern to AI/AN health workers is the disproportionately high suicide rate among AI/AN teens.

The AAP commends the Committee for holding hearings to solicit Tribal and IHS input on the serious issue of suicide among AI/AN teens and to consider ways Congress may provide the best support possible to federal, state, and tribal programs. These programs require resources to study, develop, and implement effective suicide prevention and services to Indian families and communities. Families and communities affected by suicide specifically need competent and culturally effective support, and all AI/AN communities need knowledge and resources to prevent suicide.

Based on the most recent (1996-1998) data on the IHS service population, rates of suicide among AI/AN teens, 15 to 24 years of age are three to four times the rates among U.S. white teens (Table).[1]

Age (years)		Suicides per 100,000 population per year		
		AI/AN	White	Ratio: AI-AN/White
15 - 24	males	59.1	19.5	3
	females	14.7	3.7	4

Data from the Centers for Disease Control and Prevention (CDC) shows similarly high rates of suicide among Native Americans ages 0 to 19 from 1989 to 1998.[2] CDC data showed a general rate among AI/AN youth that was 3.1 times the rate among U.S youth. Wide regional differences were noted, with AI/AN youth in northern regions experiencing the highest rates of suicide. The AI/AN suicide rate over the 10 study years among teens in Alaska was 8.4 times the U.S. rate; among teens in the Northern Plains, it was 6.5 times the U.S. rate. These astronomical suicide rates among AI/AN youth may actually be higher if circumstances associated with "unintentional" injuries were carefully analyzed. What appears to be unintentional may, in fact, have been intentional and related to mental health and/or substance abuse issues.[3]

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[1] "TRENDS in Indian Health." Program Statistics Team, Indian Health Service, DHHS, 1998-1999
[2] "Atlas of Injury Mortality among American Indian and Alaska Native Children and Youth, 1989-1998." CDC Injury Center, http://www.cdc.gov/ncipc/pub-res/american_indian_Injury_Atlas/05Summary.htm.
[3] American Academy of Pediatrics Committee on Adolescence. Suicide and Suicide Attempts in Adolescents. *Pediatrics* 2000; 4:871-874.

These general statistics, however disturbing, fail to reflect the true scope of suicide's impact. The emotional and spiritual pain experienced among family members of a suicide victim and among the community is devastating and difficult to heal. Suicide in a small community with close interpersonal and family relationships is contagious. Unless experienced professionals and mental health workers are immediately available and active following a suicide, other vulnerable teens may copy what happened to their friend or friends.[4-5] It is not unusual for an Indian community or Alaska Native village to suffer the devastation of several successive suicides.

The AAP commends the IHS for establishment of a Suicide Prevention Committee in an effort to coordinate and develop consistent, culturally effective, and competent interventions[6]. In doing this, the IHS, in partnership with tribal programs, can provide medical and mental health guidance in addressing teen suicide in AI/AN communities. The IHS and tribes cannot fight teen suicide alone or without the necessary resources. In a welcome development, the IHS and BIA-funded schools are seeking stronger collaborations to better meet the mental health needs of AI/AN students, recognizing that the school environment is particularly an important environment in which to initiate prevention efforts, detect at-risk youth early, and initiate secondary prevention interventions when suicide occurs.[7]

Designing and implementing an effective suicide prevention effort in AI/AN communities poses a number of challenges which Congress could help address:

- AI/AN communities need support and resources to evaluate the needs of their youth, provide local recreational outlets, and create opportunities for employment.
- Adequate numbers of well trained, experienced mental health workers should be readily available for communities to identify and treat youth at risk of suicide and to respond if suicide occurs.
- Resources must be available to support the training needs of local IHS and tribal mental health and primary care providers.
- In areas where it is difficult to recruit and retain mental health staff, telemedicine linkages with mental health professionals can provide effective consultations and guidance. Funds and expertise to set up and service telemedicine equipment and connections must to be available for remote sites.
- Sufficient funding is needed to conduct thoughtful research on suicide risk factors among AI/AN youth and to evaluate interventions.
- The IHS needs adequate funding to support appropriate numbers of trained staff for school health programs that primarily serve AI/AN youth.

Ensuring the health and well-being of children is, without doubt, the best possible investment for the future. Our AI/AN communities recognize this fact, which was expressed succinctly in the

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[4] Ibid.
[5] http://www.nimh.nih.gov/suicide prevention/suicidefaq.cfm.
[6] P Stuart. The Indian Health Service Suicide Prevention Work Plan. *The Indian Health Care Provider.* 2005;30:223-226
[7] Statement of Charles W. Grim, DDS, MHSA, Director, Indian Health Service, before the Senate Committee on Indian Affairs hearing on Teen Suicide among American Indian Youth, May 2, 2005.

Crow Creek Sioux Tribe Community Environmental Profile: "The future of our people is in the hands of our children. The children of the Crow Creek Sioux Tribe will bring us into the 21st century with pride and dignity."[8] Suicide prevention programs can help preserve the future for AI/AN youth and the pride and dignity of their communities.

Our country's Indian and Alaska Native communities display a tremendous spirit, resilience, and creativity when confronting challenges. Given the support and resources necessary, AI/AN communities will successfully reduce the excess burden of teen suicide, again enjoy wholeness and well-being, and be models for other communities across the nation. The American Academy of Pediatrics commends the Committee for its attention to this issue, and urges that further resources be dedicated to stem the rise of suicide among AI/AN youth.

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[8] "Crow Creek Sioux Tribe Community Environmental Profile, 4/10/2001, http://www.mnisose.org/profiles/crwereek.htm.

PREPARED STATEMENT OF LORETTA BULLARD, PRESIDENT, KAWERAK INC.

Kawerak, Inc. is encouraging the Senate Indian Affairs Committee to introduce and support passage of language that would dedicate funds for tribal suicide prevention programs.

Kawerak is a tribal consortium and non-profit in northwest Alaska. We provide services throughout the Bering Straits Region. Our region encompasses 26,000 square miles, has 16 distinct communities and 20 federally recognized tribes. We have very few roads in the region, so most in-region travel is by small airplane, snow machine in winter, or small boats in the summer. We are authorized by resolution to provide BIA services to 18 of our tribes and 2 of our tribes compact independently. Our Board consists of the presidents of each of the 20 tribal councils in the region, two elder representatives and the chair of Norton Sound Health Corporation, a tribally authorized health consortium.

The incidence of suicide in the Bering Strait Region is staggering. The regional population is about 9,000 individuals of which 7,500 are Alaska Native. All suicides in the Bering Straits Region have been Alaska Native. The Bering Straits Region suicide rate is double the rate in Alaska and is six times the national rate. Suicide accounts for 17 percent of all deaths in the Bering Straits Region. Our population is small, but our problem is large. In regions such as ours, we know the individuals that commit suicide. They are our relatives, our friends, our tribal members, our children and young adults. Because our population is small and we know each other, I believe the suicides have a cumulative impact on our young people. In the last 3 years [2003–05], 20 people committed suicide in 11 of our 16 communities. The majority of individuals who committed suicide were between the ages of 15–29 years old. At least 122 individuals took their own lives from 1979–2004 [1991 statistics were not available]. 75 other individuals attempted suicide between 2003–05, and it is reported that 175 individuals talked about taking their own lives. [These are individuals who went through Norton Sound Health Corporation's Behavioral Health On Call system and do not include the number of attempts that went unreported or individuals who did not call for help.]

Nome Public Schools conducted a Youth Risk Behavior Survey in 2005 for ages 12–18 year old junior high and high school students and compared them to the same survey in 1999. To put this in perspective, there were only 203 students in the survey group. Fifty-three students [26 percent] who responded to the survey said they had seriously thought of killing themselves and 29 [14 percent] actually tried to kill themselves at one time.

Behavioral health providers in many rural areas of Alaska are either in short supply or are less than optimally trained for their duties [or both]. There is also a high turnover. It is difficult to provide comprehensive services in so many communities. Training local service providers would be an effective solution but funds are needed to do so.

Kawerak is recommending funds be set aside for tribal suicide prevention programs because of the epidemic proportions of suicide among our youth. Tribes and tribal consortiums currently compete with the States for SAMHSA's suicide prevention grant funds. When Kawerak talked to State Behavioral Health Services Division Suicide Prevention staff, we were encouraged not to apply for the SAMHSA grant because the State was going after the same grant funds. Statewide suicide prevention efforts tend to focus on broad planning and prevention activities that have had limited success in village Alaska. The State of Alaska has made funds available for some communities to hire village suicide prevention coordinators. This has been more successful.

Suicide is a serious problem in our rural villages. It is going to take time and money to address. We would like to design and implement a grass roots, hands problem—in keeping with the unique cultures and conditions in northwest Alaska.

We encourage this committee to make funds available such that we can begin to reduce the high rate of suicide among our youth.

For further information, contact:

Loretta Bullard, president, Kewerak Inc., PO Box 948 Nome, AK 99762, Phone: 907–443–5231 Fax: 907–443–4452

PREPARED STATEMENT OF CHARLES G. CURIE, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Mr. Chairman and members of the committee, good morning. I am Charles G. Curie, M.A., A.C.S.W., Administrator of the Substance Abuse And Mental Health Services Administration [SAMHSA] within the Department of Health and Human

Services. I am very pleased to be here today to describe how SAMHSA is working to address suicide among American Indians and Alaskan Natives.

I was scheduled to speak at a suicide prevention conference in Casper, WY today, but I am so personally concerned about suicide rates especially among American Indians and Alaskan Natives that I wanted to provide this testimony myself.

It is a privilege to testify along with Dr. Charles Grim, director of the Indian Health Service [IHS] this morning. SAMHSA and IHS have developed a strong partnership reflected in our current Intra-Agency Agreement to work efficiently and effectively together to help meet the public health needs of American Indians and Alaska Natives. It is also a privilege to be with Jerry Gidner, Deputy Bureau Director for Tribal Services at the BIA.

It was just over a year ago that Kathryn Power, Director of SAMHSA's Center for Mental Health Services, testified before this committee on my behalf, and Ulonda Shamwell, Director of Policy Coordination at SAMHSA, testified at a field hearing in North Dakota on suicide and violence among American Indians and Alaskan Natives. We have accomplished a great deal since then that I want to share this with you today.

Suicide

Suicide is a serious public health challenge that is only now receiving the attention and degree of national priority it deserves. Many Americans are unaware of suicide's toll and its global impact. Suicides make up 49.1 percent of all violent deaths worldwide, making suicide the leading cause of violent deaths, outnumbering homicide. In the United States, suicide claims approximately 30,000 lives each year. When faced with the fact that the annual number of suicides in our country now outnumbers homicides by three to two—approximately 30,000 and 18,000, respectively—the relevance of our work becomes clear. When we know, based on SAMHSA's National Survey on Drug Use and Health [NSDUH] for 2003, that approximately 900,000 youth had made a plan to commit suicide during their worst or most recent episode of major depression and an estimated 712,000 attempted suicide during such an episode of depression, it is time to intensify activity to prevent further suicides. The NSDUH data and the countless personal stories of loss and tragedy are why I have made suicide prevention a priority at SAMHSA.

Suicide Among American Indian and Alaska Native Youth

Last year, a suicide cluster occurred on the Standing Rock Reservation in North Dakota and South Dakota. Ten young people took their own lives, and dozens more attempted to do so. The Red Lake Indian Tribe in Minnesota is experiencing high suicide rates following the deaths of nine individuals at the hand of a 16-year-old high school junior. Tragically, many other reservations have similar stories to tell. Suicide is now the second leading cause of death (behind unintentional injury and accidents) for American Indian and Alaska Native youth aged 15–24. In 2003, the suicide rate for this population was almost twice the national average. American Indian youth have the highest rate of suicide among all ethnic groups in the United States, with a rate of 18.01 per 100,000 as reported in 2003. What is sad to report is that more than one-half of all persons who commit suicide in the United States, and an even higher fraction in tribal communities, have never received treatment from mental health providers.

SAMHSA's Role in Better Serving American Indian and Alaska Native Populations

SAMHSA focuses attention, programs, and funding on improving the lives of people with or at risk for mental or substance use disorders. Consistent with President Bush's New Freedom Initiative, SAMHSA's vision is "a life in the community for everyone." The agency is achieving that vision through its mission "building resilience and facilitating recovery." SAMHSA's direction in policy, program, and budget is guided by a matrix of priority programs and crosscutting principles that include the related issues of cultural competency and eliminating disparities.

To achieve the agency's vision and mission for all Americans, SAMHSA supported services are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. SAMHSA has put this understanding into action for the American Indian and Alaska Native communities it serves. SAMHSA's policy is to level the playing field in order to ensure that Tribal entities are eligible for all competitive grants for which States are eligible unless there is a compelling 4 reason to the contrary.

Since CMHS Director Power testified before the committee last year, and as a result of the Garrett Lee Smith Memorial Act [Public Law 108–355], SAMHSA is now working with State and local governments and community providers to stem the number of youth suicides in our country. In 2005, we awarded the first cohort of

grants, 14 in all, including a grant to Arizona, under the Garrett Lee Smith Memorial Act State/Tribal Suicide Prevention program. These funds are available to help States/Tribes implement a Statewide/Tribe-wide suicide prevention network. One of those first set of grants went to the Native American Rehabilitation Association in Oregon.

Today I am announcing almost $9.6 million in funding for 8 additional new grants [each for approximately $400,000 per year for 3 years] under this program to support national suicide prevention efforts. Grants have been awarded to programs in Oregon, Connecticut, Utah, Wisconsin, and Idaho, and grants specifically geared to American Indians and Alaskan Natives have been awarded to:

- *Manniilaq Association of Alaska* to provide a variety of suicide 5 prevention approaches to a region that has one of the highest youth suicide rates in the world;
- *United Indian Involvement, Inc.* to implement a Youth Suicide Prevention and Early Intervention Project targeting American Indian and Alaskan Native children and youth ages 10 to 24 in Los Angeles County; and
- *Montana Wyoming Tribal Leaders Council* to provide suicide prevention efforts to six Montana and Wyoming American Indian reservations, serving Blackfeet, Crow, Northern Cheyenne, Fort Peck, Fort Belknap, and Wind River populations.

An announcement for a third cohort of grants of $400,000 per year for 3 years under this program closed yesterday. SAMHSA again invited all American Indian and Native Alaskan tribes to apply for these grants. In an effort to increase the number of applicants from American Indian and Alaskan Native tribes, we provided technical assistance specifically for them.

The Garrett Lee Smith Memorial Act also authorized a National Suicide Prevention Resource Center, and for fiscal year 2006 we received an additional $1 million in supplemental funds for the center. We recently requested an application from the existing center for use of these supplemental funds, requiring them to address how they would expand the current youth suicide prevention technical assistance to tribes and tribal organizations.

Though not a part of the Garrett Lee Smith Memorial Act, SAMHSA has long supported a national suicide hotline—1-800 273-TALK. Funding to the current hotline grantee was increased by $369,000 in fiscal year 2006, and the grantee has been requested to submit an application that indicates how they will expand access to American Indians and Alaskan Natives.

The Administration's request for fiscal year 2007 for SAMHSA asks for nearly $3 million for a new American Indian/Alaska Native initiative, which provides evidence based programming on reservations and Alaskan Native villages to prevent suicide and reduce the risk factors that contribute to youth suicide and violence. We plan to continue our collaboration with IHS as we have done in the past in this initiative.

SAMHSA has also transferred $200,000 to IHS to support programming and service contracts, technical assistance, and related services for suicide cluster response and suicide prevention among American Indians and Alaska Natives. One example is the development of a community suicide prevention toolkit. This tool-kit includes information on suicide prevention, education, screening, intervention, and community mobilization, which can be readily available to American Indian and Alaska Native communities via the Web and other digitally based media for "off the shelf" use.

SAMHSA is proud of what we have done while knowing that this is not nearly enough. The problems confronting American Indian and Alaskan Native youth are taking their toll on the future of American Indian and Native Alaskan tribes.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

PREPARED STATEMENT OF JERRY GIDNER, DEPUTY BUREAU DIRECTOR FOR TRIBAL SERVICES, BIA, DEPARTMENT OF THE INTERIOR

Mr. Chairman, Mr. Vice Chairman and members of the committee, my name is Jerry Gidner and I am the deputy bureau director for tribal services in the Bureau of Indian Affairs [BIA] at the Department of the Interior. I am pleased to be here today to provide the Department's testimony on suicide prevention programs and their application in Indian country. Several of my BIA colleagues accompanied me today. They are Chet Eagleman, acting chief, Division of Human Services; Kevin Skenandore, acting director, Office of Indian Education Programs [OIEP]; and Peter Maybee, assistant to the deputy bureau director, Law Enforcement Services [OLES].

Each is a member of a federally recognized tribe, is a senior BIA program manager, and has invaluable field experience.

I would like to take the opportunity to share the BIA's concern about Indian teen suicide and the emotionally wrenching impact it has on Indian country.

Teen suicide is a serious long-standing problem in Indian country. Research has shown that social factors such as poverty, alcoholism, gangs, and violence contribute in the manifestation of suicidal ideation, suicidal behavior and suicide attempts by Indian children and teenagers.

The Indian Health Service [IHS] data document that suicide is the third leading cause of death in Indian children age 5–14, and the second leading cause of death in Indian teenagers and young adults age 15–24. In addition, the IHS data indicate that Indian teenagers/young adults' suicide rate is 2.5 times greater than the nationwide U.S. rate. Young Indian men are more at risk to completed suicides, whereas young Indian women are more at risk to suicide ideation or thoughts.

In addition, data from the biennial BIA High School and Middle School Youth Risk Behavior Surveys [YRBS] provide insight into the progression Indian children and teens go through from feeling sad or hopeless, to seriously considering suicide, to making a suicide plan, to actually attempting suicide, to incurring serious injury requiring treatment by a medical professional. The data demonstrate that approximately one-third of Indian children and teens feel sad or hopeless, in a given year, which is an early stage in a suicidal event. The most recent BIA YRBS data for Indian students enrolled in 2003 show that for Indian high school students:

- 21 percent seriously considered attempting suicide in the last year, and
- 18 percent actually attempted suicide one or more times in the last year.

For Indian middle school students, the data show that:

- 26 percent seriously considered attempting suicide, at some time in their life, and
- 15 percent had attempted suicide.

Furthermore, statistics from the 2002 Annual Report of the Alaska Bureau of Vital Statistics show that between 1990 and 1999, Alaska Native teens committed suicide at a rate of 110 per 100,000 or over 5 times greater than the rate of 20 per 100,000 non-Native teenagers in Alaska.

Although national hard data are not available on Indian country residents, the professional literature strongly suggests a close association between parental alcohol and drug abuse, child abuse [whether emotional, physical, or sexual], domestic violence and suicide in children and teens. Often suicide may be the only way a child or teen sees of extricating him/herself from a hostile or threatening environment. However, the following can help prevent suicide in Indian country:

- Improved housing conditions.
- Increased prevention and treatment services.
- Increased identification of at-risk individuals and families and referral to services.
- Enhanced community development and capacity building through technical assistance and training for tribal leaders and staff.

BIA programs assist tribal communities to develop their natural and social-economic infrastructures [that is, tribal governments, tribal courts, cultural vitalization, community capabilities, et cetera] or provide services to fill infrastructure gaps [that is, education, law enforcement, social services, housing improvement, transportation, and so on]. For the BIA, suicidal events significantly impact law enforcement personnel since they are the most likely first responders and have a significant impact on BIA/tribal school teachers and students when the suicidal individual is a child or teenager.

BIA's Law Enforcement, Education, and Tribal Services programs continually seek ways to collaborate and to support activities directed at suicide prevention and services coordination. An example of this type of coordination is the BIA Rocky Mountain Region [Montana and Wyoming] Native American Youth Suicide Prevention Health Initiative developed and presented by BIA, IHS, and Indian Development and Education Alliance [IDEA]. The region also hosted a workshop on Native American Youth Suicide Prevention Training of Trainers in 2005, which included "natural healers" to provide referral and support.

Within the BIA's OIEP school system all Bureau-funded schools receive supplemental program funds, through the U.S. Department of Education, to operate a Safe and Drug-free School program. Schools use these funds to address a myriad of issues to make their schools safe places for students and staff. BIA schools receive about $92 per student enrolled and use these funds to address a myriad of issues to make their schools safe places for students and staff. Past initiatives included the

Comprehensive School Health Program where OIEP partnered with IHS and the National Centers for Disease Control to assist schools in developing plans that brought together the involvement of their community partners such as local law enforcement, social services, and mental and physical health providers.

OlEP is committed to ensuring a safe and secure environment for our students. Our focus is the implementation of suicide prevention strategies. The OIEP's Center of School Improvement launched a Suicide Prevention Initiative using the IHS endorsed scientifically researched based Question Persuade Respond [QPR] model. QPR is an aggressive intervention program focused on suicide prevention. An initial training in QPR was held in Denver, CO. in August 2004 and provided training on the QPR model to all 184 BIA funded schools and dormitories. Administrators at the school and dorm level were instructed to complete 100 percent training in the QPR suicide prevention model for staff at their respective schools. Additional sets of training material have been distributed to the schools and dorms through the Education Line Offices on an annual basis. In 2004, OIEP provided training opportunities for schools to establish crisis intervention teams to address potential suicide incidents, using the QPR model.

OIEP has provided training almost yearly on prevention of risky behaviors as well as preparation required to address almost any emergency situation. Most recently OIEP sponsored a nationwide event whereby students were dismissed for the afternoon while staff met to review their policies and procedures addressing emergency situations. Just last week, the majority of Bureau funded schools attended a 2-day "Safe Schools" training in Denver, CO. The focus of the training was on emergency preparedness for any type of emergency situation that would include what to do in an attempted suicide or suicide incident.

In summary, the BIA, IHS, Substance Abuse and Mental Health Services Administration, other Federal agencies, and Indian tribes must continue to work together to address all aspects of suicidal events—both before and after the event happens. Because most Indian programs fall within the respective missions of the BIA or the IHS, it is essential that the programs, in each respective agency, that directly or indirectly relate to suicidal events are coordinated and function collaboratively. BIA invites other Federal, state and tribal organizations and agencies to contact BIA regarding programmatic information, to coordinate efforts and resources, and to collaborate in addressing suicidal Indian children, teens and young adults.

This concludes my statement. I want to thank you for your concern for the wellbeing of Indian children, teens and young adults. My BIA colleagues and I will be happy to answer any questions you may have.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

CHARLES W. GRIM, D.D.S., M.H.S.A.,

DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

SUICIDE PREVENTION PROGRAMS

AND

THEIR APPLICATION IN INDIAN COUNTRY

May 17, 2006

STATEMENT OF THE INDIAN HEALTH SERVICE
OVERSIGHT HEARING ON
SUICIDE PREVENTION PROGRAMS AND THEIR APPLICATION IN
INDIAN COUNTRY

May 17, 2006

Mr. Chairman and Members of the Committees:

Good morning, I am Dr. Charles Grim, Director of the Indian Health Service (IHS). I am accompanied by Dr. Jon Perez, National Behavioral Health Consultant. Today I am pleased to have this opportunity to testify on behalf of Secretary Leavitt on suicide prevention programs in Indian Country.

The IHS has the responsibility for the delivery of health services to an estimated 1.9 million Federally-recognized American Indians and Alaska Natives through a system of IHS, Tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial decisions, and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the provision of programs, services and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also included authorities for the recruitment and retention of health professionals serving Indian communities, health services for people and the construction, replacement, and repair of health care facilities.

Secretary Leavitt has also been proactive in raising the awareness of Tribal issues within the Department by contributing to our capacity to speak with one voice, as One Department, on behalf of the Tribes, and through the process of Tribal consultation. As such, he recognizes the authority provided in the Native American Programs Act of 1974, and utilizes the Intradepartmental Council for Native American Affairs to address cross cutting issues and seek opportunities for collaboration and coordination among HHS programs serving Native Americans.

We are here today to discuss suicide prevention programs and their application in Indian Country.

Background -

Suicide in Indian Country, is characterized by higher rates, for younger people, and affecting entire communities because suicide, like an infectious disease, quite often spreads rapidly among our families and peer groups in what are called suicide clusters.

- Using the latest information available, suicide rates for American Indians range from 1.5 to over 3 times the national average for other groups. *(Trends in Indian Health, 2000-2001) [Note: IHS acknowledges that other data sets are available, including household survey data used by the SAMHSA.]*
- It is the second leading cause of death (behind unintentional injuries and accidents) for Indian youth aged 15-24 and is 2.5 times higher than the national average. *(Trends in Indian Health, 2000-2001)[Note: CDC 2003 data states the rate among all self identified American Indian/Alaska Natives as almost twice the national rate compared to the IHS rate which is calculated only for the IHS service population.]*
- It is the 5th 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 percent of all suicides. *(Trends in Indian Health, 2000-2001)*

External demands upon individuals, families, and communities are many and powerful. Long histories of subjugation and continued resulting challenges of maintaining cultures, managing poor economies, and subsisting with lack of opportunities mean most of these demands are negative and destructive. The most common IHS mental health program model provides acute crisis-oriented

outpatient services. Inpatient services are purchased from non-IHS hospitals or provided by State or County mental hospitals. Triaged care is the rule, not the exception, in virtually all of our behavioral health programs. The Indian Health Service is requesting a total of $62 million for mental health in FY 2007, an increase of 5% percent over FY 2006.

Addressing Suicide Among American Indians

The most important thing to remember is 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. Quoting from the Institute of Medicine's landmark 2002 publication, *Reducing Suicide*, "Suicide may have a basis in depression or substance abuse, but it simultaneously may relate to social factors like community breakdown, loss of key social relations, economic depression, or political violence."

This is particularly true in Indian Country. To address it appropriately requires public health and community interventions as much as direct, clinical ones. In late September of 2003, I announced the IHS National Suicide Prevention Initiative, designed to directly support I/T/U's in three major areas associated with suicide in our communities:

- First, to mobilize Tribes and Tribal programs to address suicide in a systematic, evidence based manner.
- Second, to expand and enrich research and program bases.
- And, third, to support and promote programmatic collaborations on suicide prevention.

Since then, substantial progress has been made in developing plans and delivering programs, but it is still only the beginning of a long term, concerted and coordinated effort among Federal, Tribal, State, and local community agencies to address the crisis. The initiative addresses all eleven goals of the Department of Health and Human Services (HHS) National Strategy for Suicide Prevention (NSSP), which represents the combined work of advocates, clinicians, researchers and survivors around the nation. It lays out a framework for action to prevent suicide and guides development of an array of services and programs that must be developed. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. The NSSP Goals and Objectives for Action was published by the U.S. Department of Health and Human Services in May of 2001, with leadership from the Surgeon General.

- Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable
- Goal 2: Develop Broad-based Support for Suicide Prevention
- Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services
- Goal 4: Develop and Implement Suicide Prevention Programs
- Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm
- Goal 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment
- Goal 7: Develop and Promote Effective Clinical and Professional Practices
- Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services
- Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media
- Goal 10: Promote and Support Research on Suicide and Suicide Prevention
- Goal 11: Improve and Expand Surveillance Systems

It also extends and enhances work between Tribal communities, local, State, and Federal agencies, and now even includes the greater Tribal and Indigenous populations of North America through our ongoing partnerships with Health Canada, First Nations, and Inuit.

Let me briefly summarize some of the efforts we have undertaken in each of the three major initiative areas:

As over sixty percent of the IHS mental health budget goes directly to Tribal programs, it is clear that Tribes, are primarily providing services to their communities. IHS now seeks to support those direct services with programs and program collaborations to bring resources and methodologies to the communities themselves. The IHS National Suicide Prevention Committee was impaneled in February, 2004, to help guide the

overall IHS/Tribal effort. Composed of primarily Tribal behavioral health professionals from across the country, it serves not only to assist in providing direction for efforts, but also crisis services, training, and community mobilization tools for communities in need. It also serves to provide representative membership in some of the specific programs that have been developed. In September 2005, the Suicide Prevention Committee created the Indian Health Service Suicide Prevention Work Plan to reduce the impact of suicide and suicide-related behaviors utilizing a comprehensive, culturally sensitive and linguistically appropriate community-based approach.

IHS Headquarters is currently working with IHS Areas, Tribal communities, and States to:

- Establish area-wide suicide surveillance and prevention systems in collaboration with the Bureau of Indian Affairs (BIA) and States to collect information from law enforcement and medical examiner databases. This supplements the IHS Behavioral Health Management Information System which gathers information from Tribal and IHS health care facilities.
- Establish a partnership between the IHS and the BIA, to increase access to health and mental health care for children attending BIA funded schools. In February, 2006, Mr. James E. Cason, Associate Deputy Secretary of the Department of the Interior, and I signed the *Memorandum of Agreement for Indian Children with Disabilities* (including children with mental and substance abuse problems) to encourage collaboration in the delivery of appropriate coordinated services, by sharing resources and personnel between our respective national and local offices, as well as with State and local education agencies and other entities.
- Strengthen partnerships between State and Federal agencies in the area of suicide prevention. IHS representatives are members of many State suicide prevention teams/coalitions throughout the country, ensuring that AI/ANs are provided access to State services. For example, in the Albuquerque Area IHS has partnered with the State of New Mexico to deliver ASIST training, which is listed on Substance Abuse and Mental Health Service Administration's (SAMHSA) national registry of evidence based practices, to Tribal communities.
- Participate in workgroups to improve suicide prevention and intervention activities. As a result of the Transformation of Mental Health Care and the National Suicide Prevention strategy, IHS has formed an alliance with SAMHSA, other HHS agencies, and non-governmental organizations, States and

Tribes to address and reduce suicide activity across the U.S. and in Indian Country.

- Provide active outreach to attempters, families and affected communities. For example, the IHS Aberdeen Area and the Standing Rock Tribe's Oniyape program have created an MOU to expedite outreach services to community members who are affected by suicide.
- Continue to train community members as QPR (Question, Persuade and Refer) Gatekeepers. The IHS Aberdeen Area and the Aberdeen Area Tribal Chairmen's Health Board have a Question, Persuade and Refer (QPR) initiative, to assure competency for non-mental health providers to identify and respond appropriately to suicidal behaviors.
- Involve American Indian and Alaska Native youth in suicide prevention efforts, primarily through school programs/curriculums and boys and girls clubs. For example, Tucson Area is encouraging the Tohono O'odham and Pasqua Yaqui youth to plan and implement suicide prevention trainings and conferences for youth. National Strategy for Suicide Prevention (NSPN) provided $35,000 for suicide Prevention trainings/activities to the Tucson Area. The Tucson Area Division of Behavioral Health collaborated with the Tohono O'odham and Pasqua Yaqui youth to address suicide awareness, prevention, and the ramifications of suicide in Native Communities. In addition, the IHS Health Promotion and Disease Prevention (HPDP) program is holding the Northwest Regional Youth Summit, which is promoting suicide prevention awareness, in Eugene, Oregon, on June 20-22, 2006.
- Utilize Tribal colleges to provide suicide prevention trainings and programs. For example: IHS staff have provided technical assistance to the Ft. Peck community to create a suicide prevention program where Tribal college students will be recruited as positive adult mentors for youth in response to increased suicide rates in that community. The Aberdeen Area has also collaborated with the United Tribes Technical College to provide clinicians, community paraprofessionals and laypersons with an online community suicide prevention workshop which is centered on public health mobilization models.
- Provide workshops and forums on suicide prevention. For example, the IHS National Suicide Prevention Network (NSPN) provided $25,000 to each of the 4 areas with the highest rate of suicides (Aberdeen, Bemidji, Alaska and Tucson) to provide Area wide suicide prevention trainings to I/T/Us.
- Also, suicide prevention programming is being offered at the 4th annual IHS/SAMHSA National Behavioral Health Conference to be held in San Diego, June 6-8. It is the largest annual

gathering of behavioral health personnel in Indian Country and serves to disseminate the latest information on suicide prevention programs nationally. This year, youth attending Tribal colleges and universities (TCUs) are being specially sponsored to attend this conference.

- Promote innovative training and service programs to offer communities direct intervention capabilities they would otherwise not have. The Alaska Behavioral Health Aide Program, which is designed to offer services in very remote and isolated locales, has incorporated specific suicide prevention programming into their core training curriculum.
- Provide American Indian and Alaska Native communities with culturally appropriate information about best and promising practices and training for suicide prevention and intervention. The IHS National Suicide Prevention Network (NSPN) has developed a community suicide prevention website or "tool kit", which will be available on line next month.
- Health Promotion/Disease Prevention (HPDP)has developed a web-based clearinghouse to disseminate best practices, resources, training opportunities, and effective health promotion and disease prevention for I/T/Us and Tribal community organizations. Community health assessment tools and IHS Area health profiles are being developed to identify risk factors, including those for suicide, in order to create effective programming and interventions.

IHS is collaborating with the National Institute of Mental Health, Health Canada, and the Canadian Institute for Health Research, on a multiyear effort to better understand suicide in Indian Country, and to develop evidence based interventions for prevention. While we have increasingly more accurate prevalence data, as in the IHS RPMS reporting system, and SAMHSA's National Survey on Drug Use and Health (NSDUH), and Drug and Alcohol Services Information System (DASIS), substantive programmatic and evaluative research is still very limited. Additionally, what research is available suggests suicide in our communities differs in substantial ways from other populations.

After three years of international planning and collaboration, the Indigenous Suicide Prevention Research and Programs in Canada and the U.S. Conference was held in Albuquerque, NM, February 7-9, 2006. It was the first time a conference was held to specifically address the research needs among First Nations, Inuit and American Indians and Alaska Natives regarding suicide and suicide prevention. The IHS collaborated with the National Institute of Mental Health (NIMH) and Health Canada to facilitate this international conference with representatives from the National Congress of American Indians (NCAI), the Assembly of

First Nations (AFN), the Inuit Tapariit Kanatami (ITK), U.S. Territories, Indigenous researchers, clinicians, program personnel, wisdom-keepers, and community members. Over 200 international participants met to share current programs and methodologies and develop a concrete research agenda and specific programs for Indigenous populations.

These research agendas, clinical programs, and community mobilization efforts are all driven and evaluated using data. IHS has spent $4,000,000 over the last four years on system wide improvements to its Behavioral Health Management Information System (BH-MIS), including a comprehensive upgrade of its patient information and documentation systems, as well as programs and personnel to support clinics and Tribes using them. In fiscal year '05, the most recent upgrade to the Resource and Patient Management System (RPMS) behavioral health patient care system and the completely digital Suicide Reporting Form were deployed as an integrated part of the Behavioral Health Management Information System (BH-MIS) Resource and Patient Management System (RPMS) Package. Now patients can be screened for potential suicide risk, suicide clustering can be discerned quickly in communities and Areas, and clinicians have comprehensive treatment planning and documentation tools to support their clinical interventions and create more effective programs. The system is now deployed and in operation in over 250 clinical sites across the country.

For the first time, far more accurate data are being gathered and shared from individual clinicians to communities, and with national policy makers and programs. The data on prevalence in this testimony, for example, came directly from the information gathered via the IHS Behavioral Health Management Information System (BH-MIS). No longer are we estimating or extrapolating, because we now have representative information for the country and communities affected.

Future activities involve continued upgrading of the Behavioral Health Management Information System (BH-MIS). The new Electronic Health Record will, for the first time, fully integrate behavioral health and medical patient documentation in a single electronic chart. Telehealth technology is also being developed using the Behavioral Health Management Information System (BH-MIS) to provide direct clinical services, as well as sharing patient care documents and electronic charts across wide geographic areas in realtime. This will be primarily to support distant psychiatric services to remote communities where such services are not available now. Aberdeen, Alaska, Albuquerque, and Phoenix areas are already using these technologies as a cost

effective method to delivering high quality, specialized psychiatric services over vast, remote areas.

Finally, the IHS has established a National Suicide Prevention Network, composed of at least one person from each IHS Area. During 2005, the NSPN project provided suicide prevention skills training to approximately 20 NSPN team members and 370 community members, who were mostly youth (ages 15-21), in Albuquerque, NM, Billings, MT, Ft. Yates, ND, and Red Lake, MN. In 2006, IHS allocated $300,000 to carry the NSPN project forward. The NSPN project is providing (1) suicide prevention services/trainings to a minimum of 7 communities in crisis or in need of suicide prevention services; (2) at least one Area wide suicide prevention training for each of the 4 IHS Areas with the highest rates of suicide (Aberdeen, Alaska, Bemidji, and Tucson Areas); and (3) one or more suicide prevention trainings for NSPN team members to continue to build capacity. Some of the communities that are receiving assistance to date include:

1. Red Lake Tribe
2. Standing Rock Tribe
3. Crow Creek Sioux Tribe
4. Gros Ventre (pronounced Gro Von) and Assiniboine Tribes at Ft. Belknap,
5. Ft. Peck Assiniboine and Sioux Tribes,
6. Omaha, Winnebago, and Santee Tribes of NE,
7. To'hono Odham, Pasqua Yaqui, and the Supai Tribes of AZ,
8. Alaska Native Tribal Health Corporation.

So, taken all together, where are we?

I think we are still 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 becomes a natural consequence. The initiative and programs I have described are some methods and means to restore that hope and engage youth and their communities to sustain and nurture it. These efforts are not sufficient, in and of themselves, to significantly change many peoples' living conditions. However, if we can act together, among agencies, branches of government, Tribes, States, and communities, I believe that the tide can be turned and hope restored to these young people who have lost hope. To that end, I commit to work with you and anyone else in and out of government to bring services and resources to that effort.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss suicide prevention programs in Indian country. I will be happy to answer any questions that you may have.

KAUFFMAN & ASSOCIATES, INC.

Written Testimony of Jo Ann Kauffman, President
Kauffman & Associates, Inc.

Oversight Hearing on Indian Youth Suicide
United States Senate Select Committee on Indian Affairs
Wednesday, May 17, 2006

Introduction

Chairman McCain, Vice-Chairman Dorgan, and members of the Committee, thank you for inviting me to testify before the committee today. I deeply appreciate your continuing interest in the troubling topic of youth suicide among American Indian and Alaskan Native youth.

My name is Jo Ann Kauffman. I am the President of Kauffman & Associates, Inc. which provides policy analysis, planning, research and organizational development support to Indian tribes, intertribal consortia, nonprofit clinics and numerous agencies of the federal government.

Our offices are located in Spokane, WA, Sacramento, CA, and Washington, DC. I am an enrolled member of the Nez Perce Tribe and earned a Masters of Public Health Administration from the University of California at Berkeley. I have worked in the field of Indian health for over 30 years, from tribal communities, to urban Indian health centers to national health advocacy and representation.

Currently, my company manages contracts with the U.S. Indian Health Service, the U.S. Office of Indian Education, the Substance Abuse & Mental Health Services Administration (SAMHSA), the U.S. Administration on Aging, and others.

The Impact of Suicide in Indian Country

In 2002, the suicide rate of Native American males between the ages of 15 and 19 were the highest of any ethnic group in the U.S. and three times higher than the national average for the comparative age group. The violent crime rate for Native Americans in every age group below age 35, including between 15 and 19 years was significantly higher than the general population of the U.S. Similarly higher rates of illicit drug, marijuana, alcohol, smokeless tobacco, and tobacco use of Native Americans was higher than Whites in any age group throughout the U.S. In addition, 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.

As you are aware, on March 21st, 2005, a school shooting by a student occurred on the reservation of the Red Lake Band of Chippewa Indians in northern Minnesota. Ten deaths and seven injuries were caused and widespread psychological consequences resulted for the survivors and community members of the Red Lake reservation.

These escalating increases of suicide, violent crimes, substance abuse, and school violence among Native youth are accompanied by excessive rates of poverty, domestic violence, child abuse and neglect, and historical trauma throughout Indian Country. To respond to this rising crisis on American Indian reservations and in Alaska Native villages, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services has responded with an emergency contract. The purpose is to build the pro-social and helping behaviors of Native youth and children and their families. By improving the protective factors linked to the safe and healthy development of Native youth and children, risk factors contributing to school violence, suicide, and social aggression will also be reduced.

Unfortunately, too many tragedies like these occur in American Indian and Alaska Native communities across the country. Our challenge is how to prevent them. In September 2005, Kauffman & Associates, Inc. (KAI) was retained through an emergency contract from SAMHSA to develop a strategy that would prevent similar occurrences in other communities at risk for youth violence. The resulting 18-month project, currently underway, has been named Native Aspirations and is funded through March 2007. KAI worked in consultation with One Sky Center in the development and planning of this emergency prevention initiative.

My testimony today will provide information about the Native Aspirations project.

Native Aspirations

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, the Native Aspirations Project, has 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 of Native Aspirations Project includes a four-step community-based protocol including: (1) Community Selection; (2) Community Assessment and Planning; (3) Indigenous Workforce Training; and (4) Community Implementation.

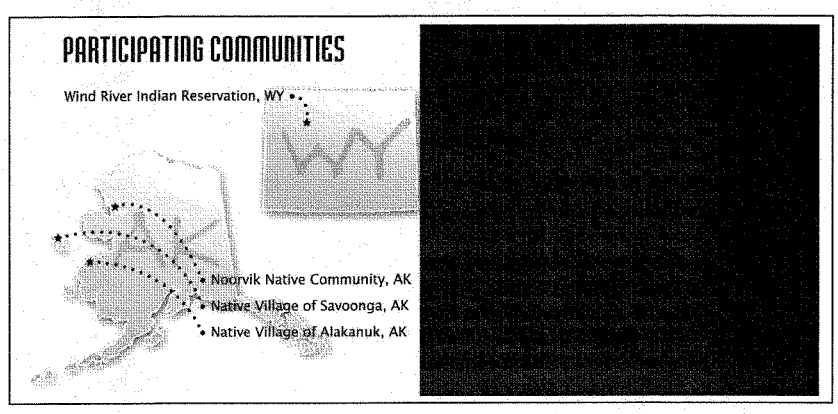
The Native Aspirations philosophy is based on recognizing the unique strengths and barriers to suicide and violence prevention planning of each of the participating tribal communities. KAI staff is providing individualized technical assistance to increase community collaboration and build capacity for suicide and violence prevention planning and implementation of evidence/practice based interventions. Native Aspirations creates a platform for networking and coordination of services in a community, and helps reduce barriers, that inhibit a community's ability to tackle its problems, building upon the positive assets from each community.

The following nine communities have agreed to participate in the Native Aspirations project.

Aberdeen IHS Area
Cheyenne River Reservation, SD
Crow Creek Reservation, SD
Pine Ridge Indian Reservation, SD

Alaska IHS Area
Native Village of Alakanuk, AK
Noorvik Native Community, AK
Native Village of Savoonga, AK

Billlings Area
Ft. Belknap Indian Reservation, MT
Ft Peck Indian Reservation, MT
Wind River Indian Reservation, WY



Community Selection

The Community Selection process enabled our team to identify approximately 9 high risk Native communities through the use of both quantitative and qualitative data gathered through multiple sources.

The first task was to identify nine American Indian tribal communities and Alaska Native villages that were most in need of assistance for youth violence, bullying, and suicide prevention. This was a difficult task. Reliable data was available only at the IHS Area levels, and not community specific. By examining and analyzing national data

sets regarding poverty (U.S. Census), suicide, homicide, and motor vehicle accident rates (U.S. Indian Health Service; IHS), and behavioral health funding from IHS, we determined that the three highest-risk IHS Areas for these factors were: Aberdeen, Alaska, and Billings.

Following the identification of these IHS Areas, we contacted key regional administrative stakeholders to identify communities "most at risk" for youth violence, of project services in their respective Areas. Key regional stakeholders were comprised of IHS Area directors, IHS directors of behavioral health, representatives of Native health boards, Bureau of Indian Affairs directors, state Indian education coordinators, and other regional social service and educational stakeholders. The Aberdeen Area included nominations from 14 stakeholders; the Billings Area, 13 stakeholders; and the Alaska Area, 11 stakeholders. Based on these nominations, the responses were computed and a ranking of communities was determined for each Area.

Evidence-Based Interventions (EBI's)

The contract required that Native Aspirations conduct an inventory of existing interventions that are evidenced based, practice based or commonly used in Native communities. In conducting this part of our work, we discovered that there are very few officially sanctioned 'Evidenced Based Interventions' that have been designed specifically for Native American communities.

SAMHSA maintains the National Registry of Evidence-based Programs and Practices (or NREPP). Programs included in this registry have been tested in communities, schools, social service organizations, and workplaces, and show evidence that they have prevented or reduced substance abuse and other related high-risk behaviors, including violence.

Native Aspirations examined those programs identified as "evidence based" interventions, as well as those selected by First Nations Behavioral Health Association (FNBHA) as "effective practice". Additional native specific interventions were identified, the North Dakota Suicide Prevention Program, One Sky's Community Assessment and Native HOPE. The intent of Native Aspirations was to provide a menu of "evidence based", "practice based" and "culture based" interventions to the nine communities participating in Native Aspirations.

Evidence Based Interventions (SAMHSA)—American Indian-Specific	Effective, Promising, or Unrated Practices (SAMHSA)	Effective Practices Identified by First Nations Behavioral Health Association (2006)
American Indian Life Skills Curriculum:	Yellow Ribbon	American Indian Life Skills Curriculum:
Project Venture	Applied Suicide Intervention Skills Training (ASIST)	Project Venture
	Counselors-Care (C-Care) / Coping and Support Training (CAST)	Positive Indian Parenting
	Lifelines	Community Readiness
	Reconnecting Youth Class	Gathering of Nations (GONA)
	Suicide Awareness Voices of Education (SAVE)	Na;nizhoozhi Center, Inc
	Signs Of Suicide (SOS)	Rural Human Services Program
	Teen Screen	Sacred Child Program
	Al's Pals	Sault Ste. Marie Tribe of Chippewa Indians Behavioral Health Program
	Families and Schools Together	Wakanyeja Pawicayapi, Inc. (The Children First)
	Bullying Prevention (Olweus)	**Other Native Programs Identified**
	Responding In Peaceful and Positive Ways	Native H.O.P.E.
	Second Step: A Violence Prevention Curriculum	North Dakota Adolescent Suicide Prevention Project
	Too Good for Violence	QPR collaborative between Eastern WA University and Kalispel Tribe
	Gathering of Native Americans (GONA)	One Sky Community Assessment

In addition to formal programs that are developed and tested, SAMHSA anticipated that traditional tribal practices or interventions may emerge from within the community in response to youth violence, bullying and suicide risks. The Native Aspirations project is not limited to only supporting EBI's or PBI's within the 9 communities, but may also support indigenous models for preventing youth suicide. This opportunity for communities to tap into a menu of existing, tested interventions, or to develop their own community based response is one of the key elements for the Native Aspirations model of community mobilization to address youth violence.

Culture based interventions include methods that have been historically utilized in Indian Country and are grounded in cultural values, spiritual healing practices, and ceremonies. These are practices that may have been utilized by the tribal community members for centuries, or may be reinstituted by a community in a more modern environment. Additionally, tribal communities may also incorporate the culture & values of the community into a more formal practice based or evidence based intervention.

The question of bringing more intervention types that are effective, practiced or culturally appropriate for Native communities into NREPP standing is important, as more and more federal funding to support youth services is tied to the NREPP status.

The decision to seek NREPP status of a culture based intervention is ultimately a local effort. First of all, it must be noted that there are inherent ethical questions which surface when tribal communities consider developing evaluations of these interventions – notably the protection and preservation of tribal spiritual/cultural ceremonies. Secondly, many tribal communities do not have the resources or expertise to design and conduct evaluations that would establish the efficacy of the intervention.

The current NREPP criteria, with the focus on outcome based quantitative data and the publication of that data, may close the door to many promising culture based and practice based interventions seeking this status. Clearly, more technical support will be needed to secure NREPP status for practice based and culture based interventions in Indian country.

Community Workforce Development

One of the most important aspects of the Native Aspirations project is capacity building in the form of transfer of skills and knowledge to a motivated, local workforce. In April, Native Aspirations held a 5-day Training-of-Trainers (TOT) workshop in Seattle, Washington with 26 representatives from the participating communities in attendance. The goal of the TOT was to introduce the Native Aspirations project to the members of participant communities who were selected to play a major role in carrying out the subsequent planning work.

Each of the participants from the 9 communities was provided an intensive training on a small selection of evidence based and practice based interventions. Second, the participant began to understand the Native Aspirations process for developing comprehensive youth violence, bullying, and suicide community prevention plans, and to begin planning to engage their local communities at home.

An important outcome of the Seattle meeting was the synergy and networking created among the otherwise disparate participant communities. These community members are tied together because of their unfortunate common bond: the high rates of youth violence, bullying, and suicide in their community. But they also share a dedication and desire to protect their children from further harm. The participants of the TOT are members of the communities and tribes, and many have lost children or family members themselves to violence or suicide.

We believe the meeting in and of itself is an effective intervention. It not only increased the capacity of those people who are designated or who take it upon themselves to deal with the difficult issues of violence, bullying, and suicide in their communities, but it helped to promote and further individual healing. An important aspect of community prevention is healing the healers. Through a healthy cadre of community workers, trained in proven and effective interventions, working through a network of supportive

and interdependent systems, communities can begin to change the environment for Native youth.

Community Mobilization

The next critical step in the project is to gain community ownership of this effort. This is no a project that provides 'top down' solutions. Instead, Native Aspirations facilitates a grassroots, community-based planning and mobilization process to engage the community and to support them in their identification of strategies and solutions.

Community Mobilization events are currently planned in each of the 9 communities. 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.

In most of our tribal communities, community violence and suicide prevention plans are either non-existent or out-of-date. State plans and resources often do not specifically target tribes or tribal people. Native Aspirations will assist each community to carry out a community mobilization planning event that brings together community members and social, health, and educational service providers to collaboratively develop a comprehensive violence, bullying, and suicide prevention plan. Additionally, communities will learn about effective intervention models, some of which have been utilized in or developed with the help of Native communities. Following the development of this Community Mobilization Plan, Native Aspirations will support each community's implementation of planned strategies by providing technical assistance through March 2007.

Native Aspirations utilizes the Community Readiness Assessment Model as a tool to begin initial community inquiry. Community Readiness involves interviewing key community stakeholders to assess their community's knowledge, understanding, and engagement in a particular issue, in our case, Native youth bullying, violence, and suicide issues and prevention. It seeks information about existing programs and any planning processes that may be in place to deal with the issue. Once interviews are conducted, the community receives a Community Readiness score that places them within a particular stage on a Community Readiness scale for various dimensions within the community. For example, it might be determined that community members are quite aware and ready to participate in prevention efforts, but that community leadership has other priorities or may not be as aware of the problem. When the score is presented to the community itself, planning participants discuss their particular score and planning takes place accordingly.

A process is undertaken to contact and conduct these interviews with the community key stakeholders prior to the community event. These interviews include tribal, school,

and health administrators, elected officials, social service, health, youth and other program directors, juvenile and police officers, and child protective services.

Through the work of the community facilitators, the CMP event is scheduled and preparation begins both at the community level and at KAI. Native Aspirations developed a sample CMP agenda with enough flexibility for important cultural aspects from the tribe and community to be included. We utilized the Gathering of Native Americans (GONA) model and GONA trainers to assist us in these community planning events. GONA is an effective model developed in the mid-90s by Native people with funding from the Center for Substance Abuse Prevention. Since its inception GONA has been utilized by hundreds of tribal communities and organizations to promote community healing and planning.

Last week, two such planning events took place, one on the Cheyenne River Reservation and the other on the Pine Ridge Indian Reservation in South Dakota. One important aspect of these planning events was the infusion of Lakota cultural elements, key community healers, and cultural experts into the planning process. Their intervention planning focused on identified readiness scores, memorandum of understanding between all stakeholders, annual renewal of the MOA to promote sustainability & collaboration. A shared vision for a healthy future for community youth emerged from these events, and a commitment to work toward this next year's plan.

Four more CMPs are scheduled in May and June, and the CMP events in Alaska are scheduled for July, August, and September, to accommodate the subsistence season beginning in tribal villages with many tribal members participating in fish camps, hunting, and gathering for the coming winter.

Implementation and Support of Plans

After the planning has occurred and the communities are vested and engaged in the project, an implementation plan spells out the events, activities and commitments for the remainder of the summer and into the 2006-2007 school year. Native Aspirations is designed to provide support to local community plans by providing a trained local workforce, by supporting that workforce with updates and regular communication, by funding additional expert consultants for the EBI's selected, and to fund the continued collaboration of the local service providers. Preventing violence, bullying and suicide in a tribal community, especially where these problems are an everyday occurrence, is an awesome challenge and responsibility. Each community prevention plan incorporates the unique vision of its community members and looks toward the restoration of a healthy community with all of its members supported by its leadership, programs, services, families, cultures, and other protective entities.

Each tribal or village plan includes tasks, timelines, and persons responsible for implementation of the plan. Building on the existing strengths and resources, and identifying possible barriers, the community plans will roll out over the life of the current SAMHSA contract but they will go well beyond that. Communities will set short-term and long-term goals, and identify how they sustain the efforts over the long haul. Existing plans and opportunities for collaboration are either incorporated or considered

during the implementation phase. Native Aspirations offers technical assistance support in the strategic planning process and encourages the continued engagement of community prevention efforts through matched funding and resources at the local level.

It is anticipated that the new school year will see the implementation of these specific plans for the Native youth in each community. One community might select the "American Indian Life Skills Curriculum" for their local school district. This will involve considerable interagency coordination and continued training. Native Aspirations will provide added support to provide the trainers skilled in this curriculum. Another community might select a combination of practice based or culture based interventions, and amend these efforts by incorporating local ceremony. Again, Native Aspirations will provide assistance and work to match local resources to ensure successful implementation of plans.

Evaluation Design

This is an 18 month contract, with less than 12 months provided for actually community based implementation. Our design is not therefore an outcome evaluation approach, however we are evaluating the benefits of this project with each Indian tribal community and Alaska Native village. Native Aspirations is using a community-specific, culturally-relevant, and scientifically sound approach as we partner with the communities for the evaluation process. In addition to conducting a formal evaluation, a goal of the project is to build program evaluation capacity with the participating community members. Through the evaluation measures, we are examining what the project benefits are to each community, what activities are put in place for the project, what difference the activities make in the community, and what type of other changes are found. To do this, Native Aspirations is holding youth focus groups using community-generated questions, providing Community Readiness Assessments, recording and tracking Community Mobilization Plans and corresponding community activities, using community satisfaction surveys and debriefings, and examining any available local data regarding violence, bullying, and suicide. Although we are primarily focused on process evaluation and short-term outcomes due to the 18-month duration of the project, a longer time period would allow the communities to assess the longer-term outcomes and impact of the project on the community and region.

Native Aspirations will continue to work with our partner, One Sky Center, to assist with the evaluation process as well as the final monograph, which will include the various project reports and tracking of activities, and provide a comprehensive and holistic picture of the project and its relationship to behavioral health in Indian Country.

Recommendations

1. **Sustained, Long Term Effort:** Too often, federal efforts to address difficult problems in tribal communities, such as youth violence, bullying and suicide, are short-term, and do not make the long term investment to realize or measure sustained change. While the 9 communities identified through Native Aspirations will benefit from the initial influx of training, planning and support, it will be important for their long term success to know more assistance beyond the first 18 months is coming. American Indian and Alaska Native communities have a better likelihood of success through a longer period of support, and their opportunity to evaluate the impact of their efforts is improved.
2. **Expanded Scope:** The initial analysis of those American Indian and Alaska Native communities most at risk for youth violence, bullying and suicide revealed a far greater need than the 9 communities identified. More communities are in need of support and resources to address youth violence, bullying and suicide.
3. **NREPP Status for Tribal Approaches**: The potential significance of NREPP status for determining future funding of interventions should not inadvertently eliminate tribal or cultural approaches found effective in local AI/AN communities. Practice based or culture based interventions should be accessible to tribal communities without jeopardizing access to federal support or reimbursement for services. Expanded technical assistance to secure NREPP certification for these unique interventions should be provided.
4. **Workforce Development**: More people trained in behavioral health fields are needed at the local level. Expanded support for youth counselors, prevention specialists, mental health technicians, and related professionals and paraprofessionals is needed. This can be accomplished through focused support for tribal colleges and universities to develop paraprofessional training in the areas of youth suicide, violence and injury prevention within the structure of existing human service coursework.
5. **Access to Resources:** The limited dollars available through the Bureau of Indian Affairs and the Indian Health Service will never meet the needs of Indian youth today. The vast majority of youth specific resources are found outside the limited Interior Appropriations Subcommittee. Tribes and urban Indian communities should be able to access other federal programs, state resources and reimbursement revenue streams.

This concludes my testimony this morning. Thank you.

Senate Committee on Indian Affairs
Hearing on Indian Youth Suicide
May 17, 2006

Testimony of William E. Martin
Chairman, Alaska State Suicide Prevention Council

INTRODUCTION

Chairman McCain, Vice Chairman Dorgan, and members of the Committee, thank you for inviting me to testify at this hearing - a hearing that I hope will help find ways to end a suicide crisis we face throughout all of Indian Country.

My name is William Martin and I am the Chairman of the Alaska State Suicide Prevention Council, appointed by Governor Frank Murkowski in 2004. I am also 1st Vice President for the Central Council of Tlingit and Haida Indian Tribes of Alaska. Our Tribe is constantly looking for ways to reduce the factors leading to suicide among our people.

ALASKA STATE SUICIDE PREVENTION COUNCIL

The Alaska State Suicide Prevention Council consists of governor-appointed representatives drawn from state behavioral health agencies and boards, the Alaska Federation of Natives, our state legislature, secondary schools, clergy and youth. Our Council meets quarterly to put a spotlight on what measures are working to combat suicide in Alaska.

The Council serves in an advisory capacity to the legislature and governor with respect to what actions can and should be taken to:

- Improve health and wellness throughout the state by reducing suicide and its effect on individuals, families and communities;
- Broaden the public's awareness of suicide and the risk factors related to suicide;
- Enhance suicide prevention services and programs throughout the state;

- Develop healthy communities through comprehensive, collaborative, community-based approaches;
- Develop and implement a statewide suicide prevention plan; and
- Strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

I want to outline briefly the magnitude of our problem, and then report on what seems to work in preventing suicide and what it would take to be more successful.

STATISTICS

For the past decade, Alaska has had the second highest rate of suicide in the United States; twice the national average. In the North Slope and West Coast regions of our state, the suicide rate is five times our average state rate. And what's worse, our highest rate of suicide is among those ranging in age from 15 to 24 years old.

Alaska Natives commit suicide at two to three times the rate of non-Natives in Alaska. Suicide is the fourth leading cause of death among Alaska Natives, accounting for almost one of every 12 deaths. Alaska Natives suffer suicide rates of 42.7 per 100,000 population, four times the national rate of 10.6. Native males and youth are hit the hardest. Our male Native suicide rate is 68.5 per 100,000 population, more than 6 times the national average. Our teen Native suicide rate is 110 per 100,000 - nearly six times the rate among non-Native teens.

RESPONSE

The aftermath of completed suicides leaves people and communities feeling helpless and overwhelmed. Our Suicide Prevention Council has offered a work plan to prevent suicide that we distribute within the many diverse communities throughout our State. While no one answer fits every one of our many cultures, we believe there are tools that make suicide preventable. Our job is to find, shape, and promote those tools.

Our work plan combines an analysis of the problem with words of wisdom from our Alaskan elders. It sets thirteen prevention goals that a community can use to meet its specific suicide prevention needs. The ultimate goal is, of course, to reduce the number of deaths by suicide. But to get there, communities need to watch out for the early signs of suicide, eradicate stigma of treatment, and remove the factors that often lead to suicide. I submit with my written testimony a copy of our work plan and our annual report to the Alaska State Legislature, and request that all of these documents be accepted into the record of this hearing.

GATEKEEPER PROGRAM

Our Suicide Prevention Council has increased its suicide prevention and awareness efforts through a media campaign and through effective use of the Gatekeeper program. Gatekeeper programs reduce suicide rates by training first responders, such as emergency personnel, public safety officers, clergy, and others who may be approached in a suicidal crisis but who typically lack specific suicide prevention experience. The Gatekeeper programs result in more effective crisis intervention. We shape our Gatekeeper programs to fit the diverse learning styles and modes of communication across the professional, cultural, and geographic challenges represented throughout Alaska. The program is cost-effective in that it uses personnel already in the community for other crisis response purposes and provides them with specifically targeted intervention tools to fend off crisis suicides. We could do far more Gatekeeper training if we could gain greater access to federal funding for these programs. This cost-effective approach works. It deserves more financial support.

SUICIDE IS AT ODDS WITH NATIVE COMMUNITY VALUES

As an Alaska Native leader, I have become convinced that my people must go back and study the lessons given us by our ancestors. They lived in a time before alcohol was introduced into our communities. Suicide then was unheard of except in a rare case where one had grievously shamed one's family or despicably hurt another. Our families and clans were central to our lives. Our ancestors realized that the unconditional love of a parent may interfere with the child learning the basic facts of life so the responsibility rested on the mother's brother or sister. Uncles and aunties thus had a big part in training children.

I myself was exposed to a suicide at an early age. I was about six or seven years old when a man in our community killed himself with a shotgun. My parents tried to protect me by not talking about it but my uncle explained to me in detail how the man killed himself. My father was a little bit upset that I was told this but that event is something that has lived in my mind for all my years. We don't stop further suicides by denying that a suicide has happened. We stop it by confronting it, in all its ugliness and horror.

And while my stance may not make me very popular, I am convinced tribal leaders must set an example for our people by abstaining from alcohol. Whether or not alcohol is a problem for us as individuals, we leaders need to demonstrate to our people that alcohol is the cause of most of our social problems. Alaska Natives as well as all Native Americans are very sensitive people. At times, I have looked at this as a fault, but now that I'm older, I appreciate this as a gift of the Creator. We are easily pleased, we laugh a lot, but we are also easily hurt. Alcohol magnifies our hurts many times over to the

point that many of can see no reason to go on living. Once depression sets in, we try to escape the hurt by drinking more which has a snowball effect from which too many of us cannot recover.

Suicides in a community tend to go in streaks, and I think I know why. I believe there is a copycat effect that is encouraged by how we talk about people after they kill themselves. For example, at a funeral for someone who has committed suicide, we celebrate the life of that individual by saying only good things about him or her. We never say anything bad about any person who has died. We don't talk critically about the awfully self-defeating choices they made that ended in the ultimate self-defeat - suicide. Some youngster attending the funeral may hear all this and ask himself "is this all I need to do to have them say nice things about me and be appreciated?" We need to talk to our young people before this happens. We need to praise their good qualities while they are living. Natives don't usually openly demonstrate day-to-day affection and love for our children because of some of our cultural ways - we just don't do that. We need to change this; our Native cultures are living entities to be shaped by us the Natives alive today.

NATIVE SUICIDE PREVENTION PROGRAMS THAT WORK - IF FUNDED

To change our culture, to change our ways, we will need funds from outside our impoverished communities to support suicide prevention programs that assist our elders and leaders in changing the attitudes of our people. Given how remotely located and diverse are our cultures and languages, such programs require relatively large sums of money when compared with the cost efficiencies of setting up and operating a suicide prevention program in suburban America. Native communities simply cannot compete on the same playing field for funds from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control (CDCs).

One of our regions hit hard by suicide, the Yukon - Kuskokwim Delta, through the Association of Village Council Presidents (AVCP), has organized a plan called "Kinguliamta Ciunerkaat" which means "Securing a Future for our Children". Its mission is to create a "well community" in which all entities work together under the direction of the Elders to restore a healthy community strong in its culture and language".

Likewise, my own Juneau Tlingit and Haida Community has developed a modest program that involves Native teachers in button-blanket making, weaving, and carving to pass on the knowledge to our youth. This has shown to be a great success in bringing back Native pride and Native values, the key defense mechanisms against hopelessness and depression that can lead to suicide. These youth are blossoming

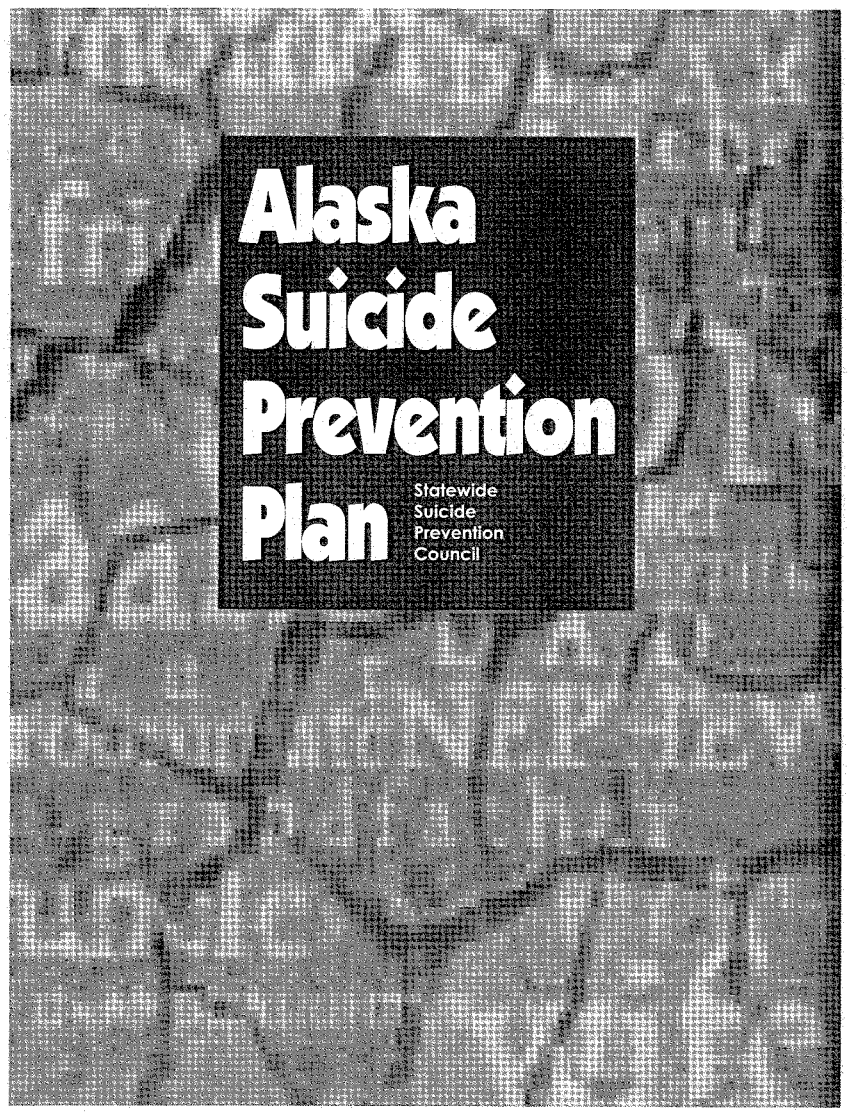
because they have a regular opportunity to simply talk with and learn from their Elders. Every Saturday afternoon you can see a bustle of activity and eagerness among the youth in being able to learn of and replicate their ancestor's way of life. My local community found this program to be so vital that, after outside funding dried up, we re-budgeted our paltry funds so that the program could be continued, albeit at a much smaller scale than the need demands.

SOLUTIONS MUST ADDRESS DIVERSE FACTORS, AND THAT IS COSTLY

We are making some progress in Alaska in our fight against suicide. But every new suicide tells us our battle is far from over. Our remote communities stretch over a land mass that is one-third the size of the continental U.S. Our communities have dozens of cultures and languages and histories. There is no single program that will work everywhere. But one single approach does work everywhere, and that is an approach that restores Native pride and culture and utilizes the existing Native community leadership of elders to teach our young the basic tools of suicide prevention.

This Committee, and the U.S. Congress as a whole, has long been sensitive to the unique challenges that confront the people in Alaska, Native and non-Native alike. I ask that you consider working with the other Committees of Congress and our state congressional delegation to carve out special pools of funding within existing SAMHSA and CDCs and Indian Health Service (IHS) competitive grant programs for suicide prevention efforts and thereby allow our Alaska communities, particularly the smaller and more remote communities, to more fairly compete for critically needed funds. A little bit can go a long way in our smaller communities, but we lack the infrastructure necessary to compete with the grant writers in America's inner cities and suburbs. Funding carve-outs for Alaska in each of these federal agency programs would allow us to compete among ourselves, and represents, I think, the fastest way to expand our most successful programs and reduce our disturbingly high rates of suicide.

Mr. Chairman, I again thank you for this opportunity to present testimony today. I am available to answer any of your questions.


Alaska
Suicide
Prevention
Plan
Statewide
Suicide
Prevention
Council

Statewide
Suicide
Prevention
Council

Dear Alaskans,

In October of 2001 the Alaska State Legislature helped to create the Statewide Suicide Prevention Council. Recently, the Legislature extended the Council through 2009. The Council consists of governor appointed members from the State Division of Behavioral Health, Alaska State Representatives and Senators, board members from the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, the Alaska Federation of Natives, clergy, general public, student and youth representatives. This group meets quarterly to better understand and comprehend the complexities of suicide in Alaska and to share this information with other Alaskans.

Alaska has one of the highest rates of suicide in our nation. Furthermore, some regions of our state have rates that are five times higher than our already statistically high state rate. Something must be done to address the needs of our people. The highest rate of suicide in our state is among our youngest and brightest individuals – those ranging in age from 20 to 24 years old.

The aftermath of completed suicides leaves people and communities feeling helpless and overwhelmed. We know that with our many Alaskan cultures and communities, there is not one set answer in which to approach prevention. But we do know that suicide IS preventable. With this in mind, the Suicide Prevention Council has written and published a working Suicide Prevention Plan, which is intended to be custom fit to each community or group.

The Plan addresses the scope of the problem by examining factors relating to suicide, statistics, graphs, regions, and words of wisdom from our Alaskan Elders. The plan then breaks down strategies of prevention into thirteen goals, with specific items that can be done to help obtain the goals; baseline data for the goals; and markers for success. The plan is intended for use as a guide for communities in creating a plan that suits their individual needs.

This plan is intended to be a document empowering communities in their response to suicide attempts and completion. Ultimately, our goal is to reduce the numbers of deaths by suicide in Alaska. The Suicide Prevention Council is available to assist communities in educating about suicide, eradicate stigma, and to formulate a working plan to help prevent needless deaths. Please contact us if we may be of service.

Most Sincerely,

Tracy Barbee

Tracy Barbee, Chair
Alaska Suicide Prevention Council

Dedicated to:

All Alaskans – Who Have Been Touched by Suicide

Special Notes

This plan would not have been possible without the assistance from the many Alaskans who donated their time and to share their wisdom, information and ideas about suicide awareness, education and prevention. The members of the Statewide Suicide Prevention Council would like to express their gratitude by acknowledging the support and assistance the following individuals provided during the completion of this plan. Many thanks go to:

Merry Carlson
Julie Feero
Agnes Sweetsir
Mike Irwin
Julie Kitka
Carol Seppilu
Russ Webb
Kami Frenette
Jewelee Bell
Chris Aquino
Jay Livey
Daniel Bill
Senator Rick Halford
Bishop Mark MacDonald
Representative Brian Porter
Ryan Hill
Kimberlee Vanderhoof
Dr. Margaret West

Elder Interviewers:
Sophie Batt
Dorothy Brown
Patrick Frank
Helen Gregorio
Enid Lincoln
Etta Fornier
Judy Simeonoff

Elders:
Walter Austin
Ole Lake
Pete Abraham
Andrew Franklin
Ivan Field, Sr.
Dorcas Maupin
Hazel Snyder
Eddie Smith
David Eluska
Mary Peterson
Rita Blumenstein
Alice Petrivelli
Mary Bavilla
May Nanalook
Ramona Field
Kenneth Toovak
Esther Murray
David Pierren
George Inga
Herman Squartsoff
Others interviewed who wished to remain anonymous.

All current and former Community-Based Suicide Prevention Program Coordinators for their on-going efforts to reduce self-destructive behavior and promote wellness in communities throughout Alaska.

And finally a special thanks to Jeanine Sparks and Susan Soule; their vision and diligent work completed this plan.

The Alaska Suicide Prevention Plan

Reducing suicide in Alaska through education, advocacy, and collaboration with Alaska communities

The Vision

The Alaska Suicide Prevention Plan is based on the strong belief that everyone has a role to play in suicide prevention and that individuals and groups that address the physical, psychological, emotional and spiritual needs of individuals and communities in Alaska must work together if we are to be effective. It is our hope that Alaska Suicide Prevention Plan will provide a springboard for collaborative action; improved understanding; and increased wellness in communities across Alaska.

Toward that end, the plan is not a prescription, but rather a resource to be used by anyone or any entity concerned about preventing suicide and suicidal behavior.

The Goal

The goal of this plan is clear: reduce the incidence of suicide and non-lethal suicidal behavior in Alaska.

Suicide is a not a disease or disorder. Rather it is a tragic ending in which a person dies as a result of an intentional self-inflicted act. Underlying suicide and suicidal behavior are complex painful feelings that have been termed "psychache", a mixture of hopelessness, depression, loneliness, burdensomeness, disconnection. There are many things that contribute to these feelings including biological, psychological, and social factors. There are also many possible strategies to prevent suicide. We can eliminate some of the causes of pain. We can help people develop the skills to avoid or cope with pain. We can encourage people in pain to seek help. We can learn to recognize people in pain and assist them in getting help. We can provide effective treatment to those in pain.

Scope of Problem

What Is Suicide?

Suicide is the act of voluntarily and intentionally taking one's own life. Most often people who chose suicide are suffering from intense psychological pain from which they see no other way to escape. There is no one cause of suicide, no one cause of psychological pain, and thus no easy answer to the "why did he do it" question.

The diagram on page15 illustrates the complexity of interrelated factors that can play a part in creating the pain. Inside the figure of the person are what we can call **Predisposing Factors.** These are things a person is born with, like temperament or genetic make-up, or born into, like family history or cultural group. These "givens" can make a person more or less vulnerable. For instance, some people are born with an easy going temperament. They can meet life's problems with a smile and keep on going. They are less vulnerable to psychological pain. Some people have an inherited tendency to develop depression. This makes them more vulnerable to extreme psychological pain. Some ethnic groups have a history that is full of trauma and cultural dislocation. Unresolved historical trauma appears to create vulnerability that is passed from generation to generation. Appendix VII includes a table that details Predisposing Factors in terms of what creates vulnerability or risk and what provides protection.

Inside the circle around the person are what we can call **Contributing Factors.** These factors exist in the various social environments in the community in which a person lives. They are also related to choices a person makes.

A supportive community that provides both supports and limits (mentors and curfews for instance) is protective. It makes extreme psychological pain less likely. On the other hand, choosing to use drugs or drink alcohol to excess creates pain and contributes to risk.

A mental disorder, especially a mood disorder or a substance use disorder like alcohol abuse or alcoholism is a major contributing factor. It has been estimated that as many as 90% of those who die by suicide are suffering from a diagnosable mental disorder. The disorder causes extreme psychological pain.

Appendix VII includes a table that details risk and protective Contributing Factors.

Last are what we can term **Precipitating Factors.** These are events that in a vulnerable person serve as the last straw. Most often they are associated with a loss of some kind, a death, the end of a relationship, loss of status or self-esteem. Sometimes people see these as the cause of a suicide, but there is never one cause, just the last in a string of factors that have created pain and vulnerability from which there seems no other escape.

People who have a lot of **PROTECTIVE FACTORS** (sometimes called **ASSETS**) tend to be able to survive and bounce back from losses and other bumps in the road of life. We refer these people as resilient. Preventing suicide is related to building resiliency and competency and to treating mental disorders.

While the complexity of the factors that contribute to suicide can make suicide prevention seem very difficult, in fact the opposite is true. The contributing factors are also all entry points or paths to prevention. Further, they are all interrelated so that you don't have to address every factor. It has been shown that if you address one, for instance poor problem solving skills, you also impact others. Teach a person good problem solving skills and you are also likely to raise his self esteem, increase ability to make good choices and you will probably reduce misuse of substances. If we think of suicide prevention in this way, we can see the many elements that interact to increase or decrease risk and the ways in which each of us can get involved.

The Approach

The plan has thirteen specific goals. For each goal we explain why the goal is important, how it might be achieved, and what markers might be used to measure success. Then we ask "what does it look like in my community?" This is the heart of the plan. It is meant to stimulate community level discussion, planning and action. We have also included several appendices that offer guidelines and suggestions for ways to mobilize and energize communities. Note that community does not just refer to a place, but rather to any group that works together for a common purpose.

The "how" sections are not inclusive. We have listed some strategies but certainly not all. The "how" list is intended as a starting point. Each community, be it a village, a school, a church group, a survivor organization or a behavioral health agency, needs to determine the "how" that is right for its population, culture and capability. Staff at the Statewide Suicide Prevention Council and the State Division of Behavioral Health are available to assist.

The Alaska Suicide Prevention Plan focuses specifically on suicide prevention and intervention strategies. There are many critical issues relating to health and well being outside the scope of this plan, among them: advocacy for mental health parity; retention of providers with rural and Native experience; community wellness; economic development; and others. We encourage partnerships in these and other areas simultaneous with the more targeted strategies presented here.

ALASKA PREVENTION GOALS

Universal Prevention Goals (aimed at general public)

Goal 1: Alaskans understand that suicide is a preventable problem.

Goal 2: Suicide prevention has broad-based support.

Goal 3: Alaskans recognize that mental illness, substance use disorder and suicidality respond to specific treatments and are part of health care. Any stigma associated with these disorders will be eradicated.

Goal 4: Alaskans store firearms and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

Goal 5: Alaskan communities support the development of protective factors and resiliency across the entire life span.

Selective Prevention Goals (aimed at specific vulnerable groups)

Goal 6: Alaskans recognize the warning signs for suicide risk and respond appropriately.

Goal 7: People who work in institutions and groups that serve or work with high risk populations are able to identify warning signs and respond appropriately.

Indicated Prevention Goals (aimed at high-risk individuals)

Goal 8: Behavioral health programs to promote mental health and reduce substance abuse, and relevant social services are available and accessible to all Alaskans.

Goal 9: Alaskan Behavioral Health Programs treat suicidality effectively using appropriate current practice guidelines.

Goal 10: Alaskan Behavioral Health Programs include an appropriate on-going continuum of supportive services for suicidal individuals from identification through treatment.

Goal 11: Alaskan communities respond appropriately to suicide attempts and suicide completions.

Program Evaluation and Surveillance Goals

Goal 12: Alaska suicide prevention and intervention research is supported and on-going.

Goal 13: Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions and evaluating progress.

Peter Ashman, *Chair-Elect*
Advisory Board on Alcoholism and Drug Abuse

Tracy Barbee, *Alaska Mental Health Board*
Chair

Representative Nancy Dahlstrom

Senator Kim Elton

Renee Gayhart, *Division of Behavioral Health*

Noelle Hardt, *Statewide Youth Organization*
Boys and Girls Clubs of Southcentral Alaska

Bill Hogan, *Member-at-Large*
Division of Behavioral Health Director

Kelsi Ivanoff, *Student*

Charles Jones, *Public*

William Martin, *Recorder/Treasurer Chair-Elect*
Alaska Federation of Natives

Karen Perdue, *Public*

Representative Woody Salmon

Senator Ben Stevens

Stan Tucker, *Pastor_*

Vacant
Secondary School Counselof

Kathy Craft, *Suicide Prevention Council Coordinator*

Frank H. Murkowski, *Governor*
State of Alaska

Joel Gilbertson, *Commissioner*
Department of Health and Social Services

Reducing suicide in Alaska through education, advocacy, and collaboration with Alaska communities

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The Alaska Suicide Prevention Plan is based on the strong belief that everyone has a role to play in suicide prevention and that individuals and groups that address the physical, psychological, emotional and spiritual needs of individuals and communities in Alaska must work together if we are to be effective. It is our hope that the Alaska Suicide Prevention Plan will provide a springboard for collaborative action; improved understanding; and increased wellness in communities across Alaska.

Toward that end, the plan is not a prescription, but rather a resource to be used by anyone or any entity concerned about preventing suicide and suicidal behavior.

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The goal of this plan is clear: reduce the incidence of suicide and non-lethal suicidal behavior in Alaska.

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The goal of reducing suicide and suicidal behavior is supported in The Department of Health and Social Services Comprehensive Integrated Mental Health Plan, *In Step* Healthy Alaskans 2010 publication published by the Department of Health and Social Services, Division of Public Health sets the following specific targeted reductions (see chart on page 10).

The Approach

The plan has thirteen specific goals. For each goal we explain why the goal is important, how it might be achieved, and what markers might be used to measure success. Then we ask "what does it look like in my community?" This is the heart of the plan. It is meant to stimulate community level discussion, planning and action. We have also included several appendices that offer guidelines and suggestions for ways to mobilize and energize communities. Note that community does not just refer to a place, but rather to any group that works together for a common purpose.

The "how" sections are not inclusive. We have listed some strategies but certainly not all. The "how" list is intended as a starting point. Each community, be it a village, a school, a church group, a survivor organization or a behavioral health agency, needs to determine the "how" that is right for its population, culture and capability. Staff at the Statewide Suicide

Prevention Council and the State Division of Behavioral Health are available to assist.

The Importance of Efforts Beyond Suicide-Specific Strategies

The Alaska Suicide Prevention Plan focuses specifically on suicide prevention and intervention strategies. There are many critical issues relating to health and well being outside the scope of this plan, among them: advocacy for mental health parity; retention of providers with rural and Native experience; community wellness; economic development; and others. We encourage partnerships in these and other areas simultaneous with the more targeted strategies presented here.

Next Steps

The next steps are up to you. Read through the plan. Think about the communities that you belong to. What is your community already doing to prevent suicide? Did you read something in the plan and think "my community could do that!" The Appendices on how to use this plan and the templates are designed to assist you in developing your community or agency plan. Call the Statewide Suicide Prevention Council for sources of technical assistance if you want some help getting started.

This plan really only takes on value when it comes to life, when people and communities pick-up, get to work and make it their own.

For More Information

Visit the Statewide Suicide Prevention Council website at http://www.hss.state.ak.us/suicideprevention/ for additional information regarding the Alaska Statewide Suicide Prevention Council. Learn more about suicide in Alaska, Alaska resources, potential partnerships, and ongoing activities.

Indicator	Alaska Data Source	U.S. Baseline	Alaska Baseline	Alaska Target Year 2010
Reduce the suicide rate (suicide deaths per 100,000 population	ABVS	10.6 (1999)	17.2 (1999)	11
Alaska Native	ABVS		32.6	11
Reduce the rate of suicide attempts among adolescents (percent of high school students grades 9 –12 who attempted suicide requiring medical attention in the past 12 months)	YRBS	2.6% (1999)	2.7%	1%
Alaska Native	YRBS		4.1% (1999)	1%

The Plan's Public Health Approach

The Alaska State Suicide Prevention plan uses a public health prevention model adopted by the National Institutes of Health (NIH), the Institute of Medicine (IOM), Washington State (the first state to develop a statewide suicide prevention plan), and certain other states. It includes a continuum of universal, selective, and indicated prevention approaches.

Universal prevention strategies target and benefit Alaskan communities by providing information and education to all its members. The goal is healthy communities. **Selective prevention** strategies target and benefit specific high-risk groups. Alaska's high-risk groups include youth and Alaska Natives, particularly young adult Alaska Native males. The goal is to prevent suicidal behaviors in targeted groups. **Indicated prevention** strategies target and benefit high-risk individuals who show signs of suicide risk factors. The goal is to prevent further suicidal behaviors in high-risk individuals.

Program Evaluation and Surveillance measures the effectiveness of programs and strategies. Program evaluation increases our understanding of the effectiveness of our efforts. Surveillance systems track trends in rates; identify new problems; provide evidence to support programs; identify risk and protective factors; identify high risk populations for intervention; and assess the impact of prevention efforts.

Table 1. Features of universal, selective, and indicated strategies.

Strategy	Benefits	Features	Examples
Universal	Village Community Region State	• Aimed at the general public • Raises public awareness • Brief • Low per person cost	• Regional and statewide suicide awareness education campaigns • School-based educational programs for youth and their parents
Selective	High-Risk Groups	• Aimed at specific vulnerable groups • Targets relevant risk and protective factors • Length sufficient to have desired outcome • Greater costs than universal interventions	• Depression and suicide screening programs for youth • Gatekeeper training / peer programs • Counseling friends and peers after a local or media-covered youth suicide
Indicated	High-Risk Individuals	• Individual risk factors and deficits in protective factors are identified • Interventions specific to the individual's needs • Length sufficient to have desired outcome • Greater costs than universal and selective interventions	• Depression, anger-management, and decision-making classes for small groups of vulnerable youth who have thought about or attempted suicide • Family support training • Crisis intervention

Themes

1 **Suicide prevention is everyone's responsibility.** Suicide is not "just a mental health issue." As the fifth leading cause of death among Alaskans, suicide affects families and communities across the state. To be effective, programs must involve people, agencies, and organizations of the community. In order to engage communities in suicide prevention and community wellness, this plan presents a wide range of ideas, specific actions, and concrete resources so that specific activities can be developed to fit each region and its community members, as well as the various professional groups and individuals who provide related services.

2 **Successful suicide prevention requires local plans and actions, supported by, and integrated with, regional, state, and national resources.** Local autonomy and the cultural appropriateness of activities are key. Local planning should be informed by the current knowledge of suicide risk and protective factors, best practices, statistics, and other information. Local plans are likely to be most effective when activities complement existing efforts and resources and are part of a comprehensive, integrated strategy. Prevention activities are more effective when programs are long-term, with repeated opportunities to reinforce targeted attitudes, behaviors, and skills in settings where people normally spend their time: schools, community events, faith communities, and the workplace.

3 **Suicide is related to many other problems facing Alaska's communities and cannot be addressed alone.** Suicide prevention programs should coordinate with other prevention efforts such as those designed to help reduce substance abuse. New and ongoing health, mental health, substance abuse, education, and human services activities in naturally occurring settings such as schools, workplaces, clinics, medical offices, correctional and detention centers, elder facilities, faith communities, and community centers should be part of an integrated approach to suicide prevention. Reducing Alaska's suicide rate will require substantial, long-term, system wide changes that expand and enhance prevention services. Suicide will not be reduced through implementation of short term, one-time efforts. Prevention efforts must occur in the context of a comprehensive mental health services system.

4 **Suicide prevention efforts should target at-risk populations.** Young adult Native males are at most risk but interventions should address all disparities due to race, age, geographic location or other factors. These may vary by region and should be assessed locally and at a statewide level.

5 **To prevent suicide, we need to develop healthy communities across Alaska.** We can do this through coordinated prevention planning with a local focus. Each community needs to develop its own suicide prevention plan that is tailored to meet local needs and build on local strengths. Any activity that promotes community wellness and individual and community strengths may potentially contribute to lower suicide rates.

6 **Successful suicide prevention will require sufficient resources.** Statewide capacity building for activities will ensure the resources, skills, training, collaboration, and evaluation necessary for success. Suicide is complex and has many contributing factors. Emphasize early interventions to promote protective factors and reduce risk factors for suicide. The higher the level of risk, the stronger the suicide prevention effort must be and the earlier it should begin.

Principles

Principles that apply to all suicide prevention programs

Note: In this section and throughout, the Plan uses "community" not just to mean city or village, but community of common interest – faith community, education community, corrections community, youth groups, civic associations, etc.

1 **Use evidence-based practices,** promising and where they exist and are appropriate. Evidence-based practices have been tried, evaluated and determined to be effective. Any given practice may have to be adapted for use with a population different from the one for which it was designed.

2 **Use data**. Data gives a clear picture of the size and nature of the problem, the who, what, when, where and how many. It enables us to design appropriate programs and evaluate their effectiveness.

3 **Establish a timeframe** for your program. Create a schedule for when specific activities are to take place. Set targets by time and who is responsible. This helps keep a program on track.

4 **Evaluate** your program. Plan how you will evaluate your program from the very beginning. This will help insure your goals and objectives can be measured and help determine if your program is effective. Remember to evaluate both the process of implementing the program (are we doing what we said we would when we planned to) and the outcome (is the program having the desired effect).

5 **Collaborate** with other groups in the community. Reach out to others. Build partnerships. Share the work.

6 **Pay attention to all age groups across the life span.** Suicide affects people of all ages. A comprehensive suicide prevention plan targets the entire community, is sensitive to the differences in suicide across the lifespan, and recognizes the varied roles different age groups can play in suicide prevention.

7 **Be culturally appropriate**. One size does not fit all. Know the values, beliefs, learning and communication styles of the group with whom you are working. Also keep in mind that culture varies not only by ethnic or national group, but also by age.

8 **Be appropriate to the community.** Communities vary in their readiness to recognize a problem and take action. It's important to determine what stage of readiness a community is at and design your program accordingly. If you "meet the community where it is at" you are more likely to get community support, ownership and action.

9 **Recognize and build on strengths.** Each individual and every community has qualities and abilities of which they are proud. Help identify these and use them to address problems. People and communities are energized when they work from their strengths.

See the appendices for additional information.

What Is Suicide?

Suicide is the act of voluntarily and intentionally taking one's own life. Most often people who chose suicide are suffering from intense psychological pain from which they see no other way to escape. There is no one cause of suicide, no one cause of psychological pain, and thus no easy answer to the "why did he do it" question.

The diagram on page 15 illustrates the complexity of interrelated factors that can play a part in creating the pain. Inside the figure of the person are what we can call **Predisposing Factors.** These are things a person is born with, like temperament or genetic make-up, or born into, like family history or cultural group. These "givens" can make a person more or less vulnerable. For instance, some people are born with an easy going temperament. They can meet life's problems with a smile and keep on going. They are less vulnerable to psychological pain. Some people have an inherited tendency to develop depression. This makes them more vulnerable to extreme psychological pain. Some ethnic groups have a history that is full of trauma and cultural dislocation. Unresolved historical trauma appears to create vulnerability that is passed from generation to generation.

Inside the circle around the person are what we can call **Contributing Factors.** These factors exist in the various social environments in the community in which a person lives. They are also related to choices a person makes. A supportive community that provides both supports and limits (mentors and curfews for instance) is protective. It makes extreme psychological pain less likely. On the other hand, choosing to use drugs or drink alcohol to excess creates pain and contributes to risk.

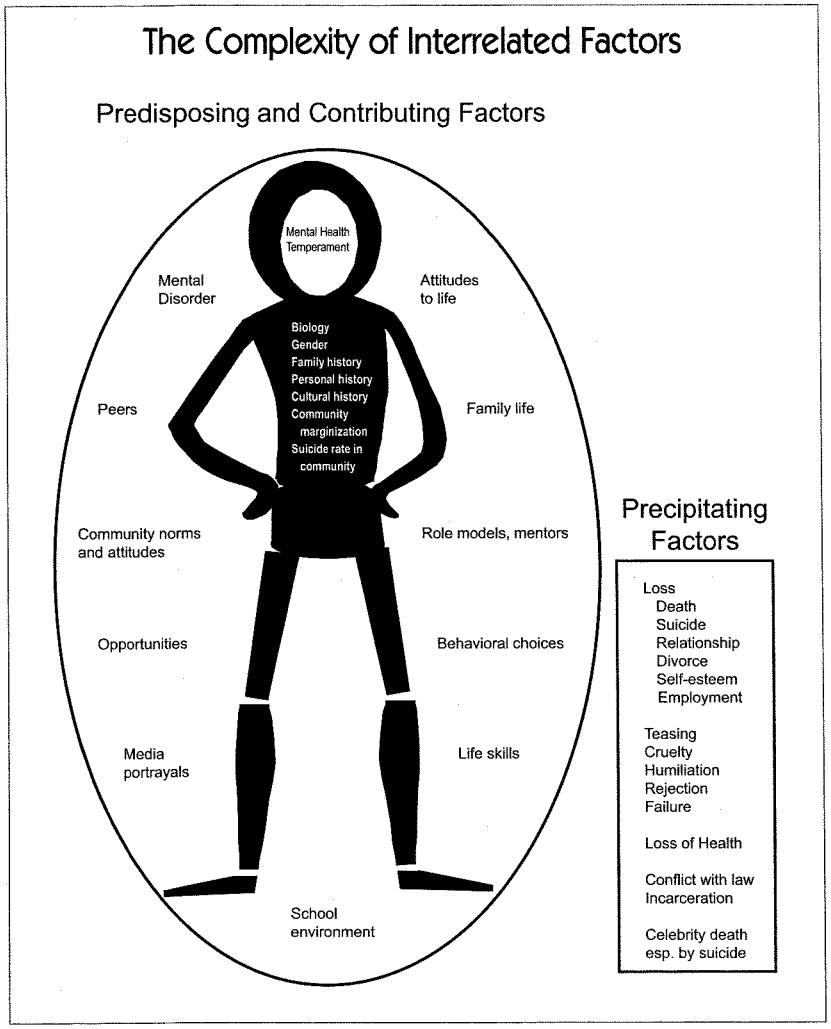
A mental disorder, especially a mood disorder or a substance use disorder like alcohol abuse or alcoholism is a major contributing factor. It has been estimated that as many as 90 percent of those who die by suicide are suffering from a diagnosable mental disorder. The disorder causes extreme psychological pain.

Last are what we can term **Precipitating Factors.** These are events that in a vulnerable person serve as the last straw. Most often they are associated with a loss of some kind, a death, the end of a relationship, loss of status or self-esteem. Sometimes people see these as the cause of a suicide, but there is never one cause, just the last in a string of factors that have created pain and vulnerability from which there seems no other escape.

People who have a lot of protective factors (sometimes called **ASSETS**) tend to be able to survive and bounce back from losses and other bumps in the road of life. We refer these people as resilient. Preventing suicide is related to building resiliency and competency and to treating mental disorders.

While the complexity of the factors that contribute to suicide can make suicide prevention seem very difficult, in fact the opposite is true. The contributing factors are also all entry points or paths to prevention. Further, they are all interrelated so that you don't have to address every factor. It has been shown that if you address one, for instance poor problem solving skills, you also impact others. Teach a person good problem solving skills and you are also likely to raise his self esteem, increase ability to make good choices and you will probably reduce misuse of substances. If we think of suicide prevention in this way, we can see the many elements that interact to increase or decrease risk and the ways in which each of us can get involved.

Appendix VII includes a table that lists the variety of factors that can make suicidal behavior more or less likely to occur.


The Complexity of Interrelated Factors
Predisposing and Contributing Factors
Mental Health Temperament
Mental Disorder
Attitudes to life
Biology
Gender
Family history
Personal history
Cultural history
Community marginization
Suicide rate in community
Peers
Family life
Community norms and attitudes
Role models, mentors
Opportunities
Behavioral choices
Media portrayals
Life skills
School environment
Precipitating Factors
Loss
Death
Suicide
Relationship
Divorce
Self-esteem
Employment
Teasing
Cruelty
Humiliation
Rejection
Failure
Loss of Health
Conflict with law
Incarceration
Celebrity death
esp. by suicide

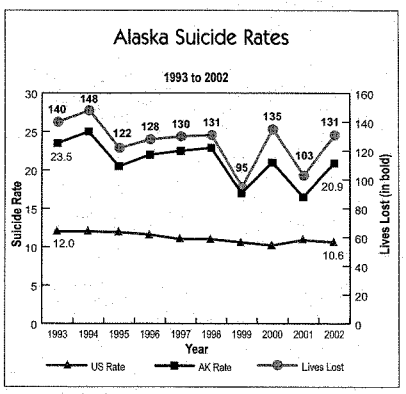
Suicide in Alaska—the Patterns and Numbers

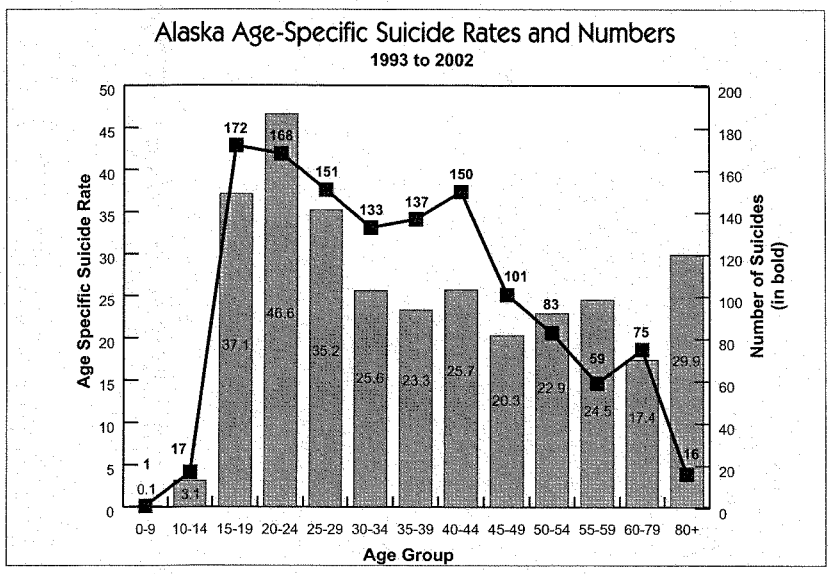
The Overall Picture of Suicide in Alaska

Few Alaskans have not been touched directly by the grief, anger, pain, confusion, and loss of suicide.

Every suicide intimately affects an estimated 6 other people. Suicide is twice as common as homicide and more frequent than motor vehicle deaths. An average of 126 Alaskan lives are lost each year by suicide. With a suicide rate of 20.9 suicide deaths per 100,000 population in 2002, which is twice the national average (10.6). Alaska is ranked 6th in the nation (2001 AAS data) for suicides.

Suicide is consistently the fifth leading cause of all deaths in Alaska and is the leading cause of injury-related death. The rate of suicide in Alaska varies dramatically by age, region, race, and gender. The majority of suicides (70%) are by firearm.





Scope of Problem

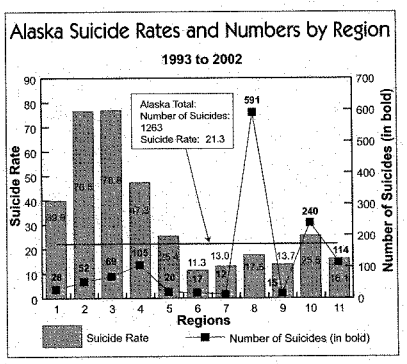
Risk of Suicidal Acts by Age and Gender

Completed Suicide. Suicide rates are highest in young Alaskan adults between 15 and 29, with the highest rates between the ages of 20–24. Over the past decade, 40.3% of suicides occurred before age 30; 33.3% in ages 30 to 44; and 26.4% in ages 45 and older. In Alaska, males were over four times likely than females to die of intentional self-harm (33.9 per 100,000 vs. 7.6) during 2000. Suicide was the eighth leading cause of death for females and the fourth leading cause for males (BVS 2002 Annual Report).

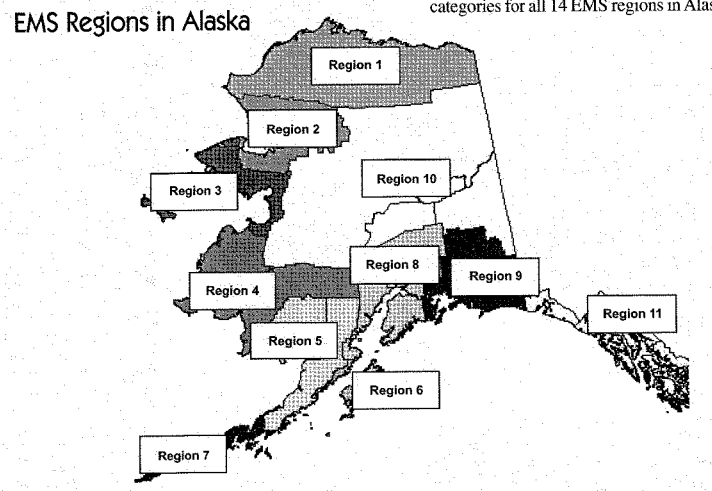
Attempted Suicide. There were 3,266 non-fatal hospitalized suicide attempts for 1994–99, almost 550 per year. 42% were among Alaska Natives, 63% among women, and 53% among those ages 20–39. Although males complete suicide more frequently, females attempt suicide almost twice as often. Natives attempt rates are four times that of non-Natives.

Regional Differences

Rural and bush areas experience suicide rates double those of urban Alaska. Suicide rates are highest in the western and northern regions. Five regions, all southern, have suicide rates below Alaska's suicide rate.



Suicidal injuries in children were in the top five injury categories for all 14 EMS regions in Alaska, 1994-1998.



Risk of Suicide for Alaska Natives

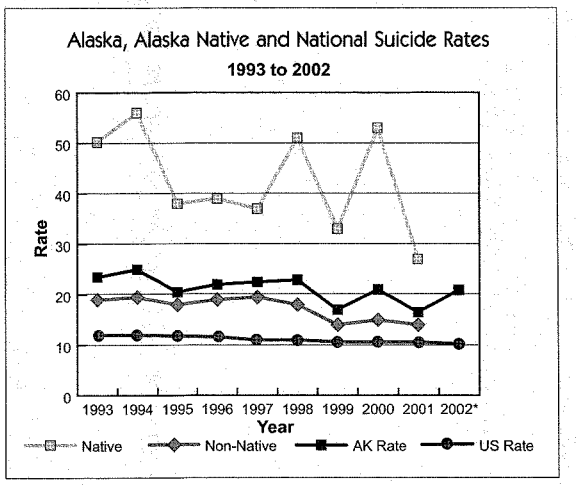
Among Natives, intentional self-harm was the fourth leading cause of death accounting for almost one of every 12 (8.1%) Native deaths (BVS 2002 Annual Report).

Alaska Natives experience suicide rates of 42.7 per 100,000 population, four times the national rate of 10.6.

Between 1994 and 2000, 286 of 834 suicides were by Alaska Natives. Alaska Natives account for less than 20% of the state's population (16%), yet account for one-third (34%) of the suicides in Alaska.

Alaska Native males commit suicide at rates of 68.5 per 100,000 population, more than 6 times the national average.

Alaska Native teens are much more likely than their non-Native peers to commit suicide. Between 1990 and 1999, Alaska Native teens killed themselves at a rate of 110 per 100,000-nearly six times greater than the rate of 20 per 100,000 among non-Native teenagers.



*Rates by Race not available for 2002.

What Alaska Native Elders Tell Us About Suicide

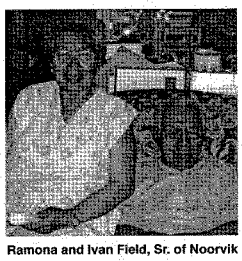
"We need to know how we got to such a place that our people, especially the young people, have decided that suicide is the only alternative. Then we need to talk among ourselves, the villages, individuals and whole regions, have to discuss what it is we need to do to become whole." – *Harold Napoleon*

It was Paul Jumbo of Toksook Bay who suggested that we turn to Alaska Native Elders to explore the questions raised by Harold Napoleon. With the help of people in many parts of Alaska, we were able to interview over 20 Elders. This section summarizes the interviews, using direct quotes where transcripts were available.

There is a perhaps not surprising consistency to what the Elders told us. Very few remembered any suicides when they were growing up. For most, suicide just did not exist and although many of those interviewed had lives that weren't always easy, almost all reported they had never considered suicide.

All spoke of having to work hard when they were growing up and saw that as a good thing.

Ramona Field, Noorvik, "Those days we were busy whole day even if we were children. Our parents or grandparents let us work whole day long. When they fish, they let us fish. When they need water we pack water or we get ready for the winter, summer, all day long we use to work for our parents."



Ramona and Ivan Field, Sr. of Noorvik

Alice Petrivelli, Atka and Anchorage, "My father believed God gave you daylight and you had to be productive during the daylight, o.k. It was a privilege. So he made us work, you know. Summer time you were at the camp gathering food. You learn how to fillet fish, how to dry fish. Winter time you did your homework. You carry in wood. Ladies taught you how bead and sew, more or less how to be productive.....It was just a nice, safe world for me."

Along with hard, meaningful work came instruction and discipline. Older people taught, and younger people listened.

Pete Abraham, Togiak, "At an early age young children were taught in the Qasgi (traditional men's house) about the facts of life, how to live clean healthy lives and respect for each other."

Rita Blumenstein, Tununak and Anchorage, "They didn't spank us. They didn't yell at us. Just like normal, you know, normal going but it teaches you to think that you are going to try to do it better. That's the way I grew up, by listening and following their instructions."

Rita Blumenstein, Tununak and Anchorage

Andrew Franklin, Togiak, "Our grandfather always instructed us especially about how to treat other people. How I treat others will come back to me. ..The Elders instructed on safety, good life, being helpful and having a good mind or thoughts toward people."

Most Elders agreed that things are different today. One difference is that children and young people don't seem to listen very well and don't handle criticism well.

Ramona Field, "You love your kids you gotta scold them and talk to them. They gotta know what's right. When you scold your little kids now-a-days, they get mad and think the other way. We never use

to do when our grand parent scold us and tell us the right thing. Today the kids quit real easy when they get scolded."

Alice Petrivelli, "My aunt and the elders taught us. They're the ones that weeded out the punishment and the discipline, ok. If you sassed an elder back, you knew about it. You just did not do that. That was not allowed. If someone says you don't to that, you stopped. Today, to make a comparison, when I was home in Atka some little boys were doing things. You better stop that. And they asked me what are you going to do about it. I'll make you stop. And he looks at me.... This was a five, six year old kid. I'll tell my mother and she'll sue you, ok. You hear the difference in how I grew up and the kids today?"

Hazel Snyder, Noorvik, "Today kids when you ask for them to help you, they don't listen. They just stand up and wait for the money. It's not the way we were raised up. It's not good at all to me."

Hazel Snyder, Noorvik

In addition to not listening, Elders said that young people seem not to be as busy as the Elders were when they were young, and that the things young people do and are exposed to today are not as healthy. Alcohol and drugs were mentioned by many.

Pete Abraham, "Young people are exposed to too many wrong things at an early age..... There is too much exposure to TV violence and drugs and alcohol."

Walter Austin, Wrangell and Anchorage, "The children in my time they were pretty well off because there was not alcohol or drugs that we have today."

Esther Murray, Elim, "Drinking has a lot to do with suicide today."

Ramona Field, "Right now when we start eating white man food or easy life nothing to do maybe that's why our kids change. There is nothing to do just watch TV."

Ivan Field, Noorvik, "We have to stop all the liquor and drug use."

To use the language of prevention and health promotion, the Elders saw meaningful work done together as a family and the active teaching by the Elders as protective or resiliency building factors that were strongly present in their childhoods, but are much less present or absent today. Conversely, drugs, alcohol, boredom and too much TV (especially violent TV) are cited as risk factors present today, but absent in the past.

Perhaps these changes account for the difficulties the Elders noted between today's parents and children. Parents are being asked to help their children with problems they themselves never experienced. Young people are not sure their parents and Elders really can understand what life is like for them today.

Pete Abraham, "Young people now days are exposed to too many wrong things at an early age. Nobody listens to them. Children are not open with parents or anybody. They are scared. There is no understanding between parents and young people."

Andrew Franklin, "Sometimes when you tell a younger person something they think you don't like them. Now days children don't get instruction from their parents."

Walter Austin, Wrangell and Anchorage

Rita Blumenstein, "When I work with them (young people) they say 'my parents are never home'. And so we have to do something at home. See they're trying to get their attention. And then parents get mad at them."

Scope of Problem

Change complicates communication between the generations in most cultures and the degree of complication is related to the pace of change. The "generation gap" is a feature or Western cultures where change itself often seems to be a value and information comes not just from families and tribal members, but from strangers via books, radio, television, and most recently the internet. Traditional, subsistence based cultures left to themselves evolve and change too but the pace is slower and most knowledge comes from within. For Alaska Natives contact with Western cultures is relatively recent and change has come at an amazing pace and with a considerable amount of pain and loss, both physical and spiritual.

Ole Lake, Hooper Bay and Anchorage

Ole Lake, Hooper Bay and Anchorage, "I think when there is a change of autonomy in the village that something takes over the cultures and traditions; I think there is a sense of great loss with the people. First it starts with the Elders and grandparents and then the parents mourn the loss of the cultural traditional ways of doing things and the spiritual beliefs."

Alice Petrivelli, "World War II came and changed our whole lifestyle... And after that came the land claims. Land claims was a great thing in a lot of respects, but it kind of divided the people...And then people lost their identity, I think when we was rushed into the western society. It was not a slow progress. So we didn't have a suicide problem until the '80s."

That perhaps is at the heart of what these interviews tell us about suicide and the Native community. Alaska Native people did not always have a problem with suicide. Suicide is not a Native tradition. The high rates of suicide have come about relatively recently as rapid change and the introduction of conflicting values weakened the protective factors that were so strongly present in traditional cultures and lifestyles.

The Elder interviews suggest that Alaska Natives cannot go back to the old ways of life, but can go forward and regain the resiliency that was such a part of that life. An important element in going forward is to honor, respect and teach traditional cultural values, and to insist that others respect those values as well.

Andrew Franklin, "We can't go back to the Qasgi but we need to instruct our youth. Our leaders need to be leaders and model to our community."

Alice Petrivelli, Atka and Anchorage

Alice Petrivelli, "No matter if we're corporate president or not, we are who we are. Our place of origin comes from our village. Like me, I'm an Aleut and I'll always be an Aleut no matter what. And you have to let the kids be proud of who they are... I think the state and the feds have to listen to the Elders in the village. They have to work as one unit and not come in and try to tell you how to do it."

Rita Blumenstein, "See if you are going to fix our people, you have to understand their culture. Teach it from their culture. Accept them who they are."

The Elders also suggested ways to talk to someone who expressed suicidal feelings. Their suggestions appear throughout the plan. For now we return to Harold Napoleon's request to "discuss what it is we need to do to become whole" and end with the words of Pete Abraham of Togiak:

"Villagers need to work together, take pride in who they are. We need to show young people that we care about them, maybe talk in a circle. Then the generation gap would close; we would have more communication between Elders and the younger generation. Things would be better so we could prevent suicide. We need to appreciate what we have and take pride in it."

Universal Prevention Goals

Goal 1: Alaskans understand that suicide is a preventable problem.

Goal 2: Suicide prevention has broad-based support.

Goal 3: Alaskans recognize that mental illness, substance use disorder and suicidality respond to specific treatments and are part of health care. Any stigma associated with these disorders will be eradicated.

Goal 4: Alaskans store firearms and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

Goal 5: Alaskan communities support the development of protective factors and resiliency across the entire life span.

Selective Prevention Goals

Goal 6: Alaskans recognize the warning signs for suicide risk and respond appropriately.

Goal 7: People who work in institutions and groups that serve or work with high risk populations are able to identify warning signs and respond appropriately.

Indicated Prevention Goals

Goal 8: Behavioral health programs to promote mental health and prevent substance abuse, and relevant social services are available and accessible to all Alaskans.

Goal 9: Alaskan Behavioral Health Programs treat suicidality effectively using appropriate current practice guidelines.

Goal 10: Alaskan Behavioral Health Programs include an appropriate on-going continuum of services for suicidal individuals from identification through treatment.

Goal 11: Alaskan communities respond appropriately to suicide attempts and suicide completion.

Program Evaluation and Surveillance Goals

Goal 12: Alaska suicide prevention and intervention research is supported and on-going.

Goal 13: Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions and evaluating progress.

Universal Prevention Strategies

Goal 1: Alaskans will understand that suicide is a preventable problem.

Why – If people understand that suicide and suicidal behavior can be prevented, they are more likely to be willing to learn how to prevent suicide. When people are made aware of the roles they can play in suicide prevention, they become more willing to get involved and lives can be saved.

How – Increase understanding through varied educational efforts that replace myths with facts.

Increase people's willingness to get involved by replacing a sense of helplessness with the knowledge that there are specific actions we can take that will make a difference.

Inform about the warnings signs and signals of depression and suicidal thinking.

Teach how to respond when we see the signs, and educate about community resources that can help.

Some specific things we can do

- Implement public awareness campaigns using a variety of mass media.
- Get suicide prevention on the agenda at meetings of service and professional organizations.
- Make suicide prevention information available in a wide variety of settings including primary care, churches, courts, bars, beauty parlors etc.
- Ensure that mental health education with age appropriate suicide prevention is part of the basic school curriculum starting in elementary school.
- Work with the media so that press and broadcast reporting about suicide, mental health and related issues is accurate, responsible and follows the guidelines established by the American Foundation for Suicide Prevention.

Baseline data

No data is available at this time.

Markers for Success

- More Alaskans, including those in high-risk groups, will know basic information about suicide, depression, warning signs, how to offer help, and where to go for help.
- More Alaskans will report offering or seeking help.

- Track number of individuals who attend or participate in these activities.
- Track number of trainings or meetings given.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do people in my community see suicide as preventable?

What can we do to increase the number of people who see suicide as preventable?

What are our markers for success?

Some suggested resources to assist you in reaching this goal.

American Association of Suicidology

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

SPAN - Suicide Prevention Advocacy Network

National Institute of Mental Health

Alaska Statewide Suicide Prevention Council

Alaska Division of Behavioral Health

Community Based Suicide Prevention Program, Alaska Division of Behavioral Health

Community Mental Health Centers / Behavioral Health Centers

Alaska Injury Prevention Center

Alaska Native Tribal Health Consortium

See Appendix I on page 48 for website addresses.

Goal 2: Suicide Prevention will have broad-based support.

Why – Just as there are many factors that contribute to suicide, so there are many approaches to preventing suicide: mental, emotional, biological, social, cultural, spiritual. With broad-based support all groups - schools, health care providers, faith-based organizations, youth groups, senior citizens centers, and local and tribal governments to name but a few – will recognize the roles they can play and the ways in which they can collaborate.

Broad-based support can lead to additional public and private funding for prevention and treatment programs and for research and evaluation.

How – Broad based support is created when individuals understand that there are many approaches to suicide prevention and therefore many ways to get involved.

Some specific things we can do

- Prepare written reports and make presentations to a wide variety of public and private organizations to encourage them to explore ways they can incorporate suicide prevention into their work.
- Provide regular reports to the legislature and the Alaska Mental Health Trust Authority on suicide and related issues.
- Provide information to Alaskans about national suicide prevention advocacy groups, such as SPAN USA.
- Work with community leaders to insure widespread distribution of appropriate suicide prevention educational materials in all Alaskan communities.

Baseline data

Number of communities participating in Community-Based Suicide Prevention Program in FY04 – 57 (52 funded by state).

FY04 State funding:

Services
Community-Based Suicide Prevention grant awards - $763,697
Rural Human Services grant awards - $1,323,028
Total Division of Behavioral Health funding was $50,100,961

Training
Gatekeeper program development – $248,375 – federal funds

Research
Follow-Back Study – $195,925

Markers for Success

- More organizations and agencies will include suicide prevention in their programs.
- More communities will be actively involved in suicide prevention activities.
- Suicide prevention, intervention, treatment, and research programs in Alaska will help reduce the number of suicides and suicide attempts.
- Communities will see a decline in the suicide rate.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

How much interest in suicide prevention is there in my community? What does my community do to support suicide prevention?

How can we increase support for suicide prevention in my community?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

American Association of Suicidology

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

SPAN - Suicide Prevention Advocacy Network

National Institute of Mental Health

Alaska Statewide Suicide Prevention Council

Alaska Division of Behavioral Health

Community Mental Health Centers / Behavioral Health Centers

Alaska Injury Prevention Center

Alaska Native Tribal Health Consortium

See Appendix I on page 48 for website addresses.

Goal 3: Alaskans recognize that mental illness, substance use disorder and suicidality respond to specific treatments and are part of health care. Any stigma associated with these disorders will be eradicated.

Why – We know that there are links between suicide, mental illness and substance use, and we know that there are many effective treatments for mental illness and substance use. But if there is shame or guilt associated with these disorders, or if people fear they will be discriminated against if others know they suffer from them, they are less likely to seek help. Sometimes family members try to hide the disorders or suicidal behavior because they feel ashamed or guilty or just plain scared of what might happen if people know. Sometimes people believe that there is no help, that treatment doesn't work.

The fact is that with appropriate treatment, those disorders often get better. Untreated they usually get worse. And, research is giving us new medications and new therapies that promise even more successful treatment. We know that most people who feel suicidal do not want to die. They want their pain to stop and cannot figure out any other way. Treatment helps them find ways to reduce the pain and go on living.

How – Misinformation and stigma can be reduced through comprehensive public information and education campaigns.

Some specific things we can do

- Collaborate with mental health and substance abuse agencies to implement public information campaigns that present mental health and substance abuse treatment as part of basic health care.
- Develop public service announcements that feature those who have recovered from mental illness, substance abuse or suicidality after treatment.
- Where appropriate, honor and celebrate those who have successfully sought and completed treatment.
- Develop a speaker's bureau on mental health, substance abuse and suicide prevention and include consumers of treatment services, as well as treatment providers and researchers.
- Provide information to the media that educates about safe, responsible reporting and portrayal of suicide, mental illness and substance abuse.
- Hold ongoing Clergy/Clinician Forums for mutual education and to promote closer working relationships.

Baseline data

No data is available at this time.

Markers for Success

- More community members, treatment providers, and consumers view mental disorders as illnesses that respond to specific treatment and see mental health as equal in importance to physical health in overall well-being.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

How do people in my community see mental illness, substance abuse and suicidality? Do they see these as treatable disorders, as permanent weaknesses, as moral problems or ...?

How can we increase the number of people who see these conditions as disorders that can be successfully treated?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

American Association of Suicidology

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

SPAN - Suicide Prevention Advocacy Network

National Institute of Mental Health

Alaska Statewide Suicide Prevention Council

Alaska Division of Behavioral Health

Community Mental Health Centers / Behavioral Health Centers

Alaska Injury Prevention Center

Alaska Native Tribal Health Consortium

National Alliance for the Mentally Ill

National Institute of Mental Health

Alaska Mental Health Trust Authority

Alaska Mental Health Board

Governor's Advisory Board on Alcoholism and Drug Abuse

Commission on Aging

Governor's Council on Disabilities and Education

See Appendix I on page 48 for website addresses.

Goal 4: Alaskans store firearms and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

Why – There is a great deal of research evidence indicating that limiting access to the means of suicide - weapons, pills, harmful gases, and the like - is an effective way to prevent suicide and suicide attempts. Sometimes suicidal behavior appears to be impulsive. Especially when alcohol is involved, the move from thought to action can be very fast. When the means are easily available, it is too easy for the person to act on the impulse. When the available means are highly lethal, the consequences are often tragic and fatal.

How – Encourage safe storage of firearms and other potential items of self-harm through an education campaign that acknowledges the role that firearms play in Alaskan lifestyles and recognizes that potential items of self harm are commonly found in homes.

Some specific things we can do

- Implement broad-based public information campaigns about responsible gun ownership, gun safety and safe storage of medications and household poisons.
- Work with health provider organizations to encourage including basic information about safe storage of firearms and medications as a part of routine medical care.
- Educate health care providers about ways to talk to those at high-risk for suicide and their families about decreasing access to firearms and other means of self-harm.
- Provide information to emergency room staff and emergency medical technicians about the importance of advising those treated or admitted for a suicide attempt and their families about the importance of the removal or safe storage of firearms or other lethal means of self harm.
- Work with law enforcement to ensure that officers responding to domestic emergencies and suicide-related crises ask about the presence of firearms and other lethal means and advocate for their safe removal or storage.
- Work with Injury Prevention Practitioners to develop materials to educate parents about how to safely store firearms, medications and household poisons.

Baseline data

State of Alaska Department of Fish and Game – www.adfg.state.ak.us/ or call 907-267-2241

Markers for Success

- More communities are actively considering and implementing ways to reduce access to lethal means of self harm within their community.

- More primary care providers, community health aides, emergency room staff and public safety officers routinely ask about the presence of lethal means of self-harm including firearms, drugs and poisons in the home, and provide education about actions to reduce associated risks.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do people in my community store and handle firearms safely and teach their children to do so? Do people in my community store medications and other potential items of self-harm safely?

Do health care providers in my community ask about and encourage safe storage of firearms, medications and poisonous household items?

How can we encourage more people to store and handle firearms safely and take appropriate precautions with other items?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

Alaska Native Tribal Health Consortium

Local Health Corporations

National Rifle Association

Alaska Injury Prevention Center

Law Enforcement – Troopers, Police and VPSO

Office of Children Services

Girl and Boy Scouts

Local Hospitals

See Appendix I on page 48 for website addresses.

Goal 5: Alaskan communities will support the development of protective factors and resiliency across the entire life span.

Why - Resilience is the natural ability to "bounce-back" from hardships and become stronger. Resilient people understand that life is full of challenges, joys, losses, disappointments, and unexpected events. Resilient people learn from their mistakes, get support from others, and keep a broader perspective. They are less likely to succumb to the feelings of hopelessness and helplessness that are associated with suicidal behavior.

How - Build resilience by creating opportunities for young people to succeed through exercising judgment, discretion and imagination. Success helps young people grow and develop a sense of competence and mastery. Equally important, resilience is developed when young people are treated with respect and feel supported and valued even when they don't succeed, when they feel loved and encouraged when they make mistakes or experience hard times. Resilience is reinforced and sustained when people feel connected to each other and their community and feel that their life has meaning.

Some specific things we can do

Organizations, community members, faith communities, teachers, Elders, friends and family can help build resilience by:

- Being good role models.
- Being mentors.
- Upholding, honoring and respecting cultural traditions.
- Sharing the lessons of experience that help young people to cope with the challenges of inexperience.
- Teaching and modeling culturally appropriate life and communication skills.
- Creating environments, in schools, churches, and other structured settings, in which people feel welcome and accepted.
- Creating opportunities for people to experience new things, take on responsibilities and succeed.
- Reaching out to those in need (helping with groceries, caring for children, making sure there is heat, providing companionship and support during times of stress and loss.)

Baseline data

The 2003 Youth Risk Behavior Survey (YRBS) reports:
46.94% of boys and 47.26% of girls have three or more adults (other than parents) they feel comfortable seeking help from.

59.96% of boys and 55.04% of girls believe that their teachers really care about them and give encouragement.

YRBS data will be updated in 2005.

Markers for Success

- An increase in cultural, or intergenerational events and activities.
- Youth report they have adults they can turn to discuss personal problems.
- Students report that their teachers care about them.
- Adults report they have friends they can turn to discuss personal problems.
- Youth and adults can identify healthy ways they cope with stress and life problems.
- Youth and adults are hopeful about the community's future.
- Youth and adults are positive about their own future.
- Youth and adults believe their efforts can make the community a better place.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do young people have lots of safe opportunities to try out new skills and experience new things?

Do adults spend time helping youth learn new skills and explore new ideas?

Do young people feel welcome in schools, libraries, health clinics, other organizations?

Are there frequent events that bring people of all ages together and are they well attended by all ages?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

Division of Behavioral Health

Initiative for Community Engagement (ICE)
– Alaska Association of School Boards

Alaska Association of Sports

Boys and Girls Clubs

Big Brothers/Big Sisters

4-H Clubs

Camp Fire Kids

Boy and Girl Scouts

See Appendix I on page 48 for website addresses.

Selective Prevention Strategies

Goal 6: Alaskans will recognize the warning signs for suicide risk and respond appropriately

Why – Most people who consider suicide do not want to die, rather they want to end the pain they feel and cannot see any other way. Most people considering suicide display behaviors or say things that are clues to how they are feeling. If others recognize and respond to the clues in appropriate ways, we can get people into treatment and help them find other ways to reduce their pain and go on living.

How – Provide widespread appropriate educational materials and training to the general public and to community gatekeepers, first responders, education, healthcare, social service, recreation and law enforcement personnel and clergy so that people can recognize and respond appropriately to individuals at risk for suicide. Community gatekeepers are those in non-mental health or social service roles to whom people frequently talk openly about their problems and feelings – hairdressers, bartenders, coaches, lawyers, etc. We refer to them as gatekeepers because they can open a pathway to getting help.

Some specific things we can do

- Collaborate with national, state and local agencies to develop appropriate education materials.
- Make well designed appropriate gatekeeper training widely available.
- Inform people about the Yellow Ribbon campaign.
- Develop creative ways to post warning signs and crisis line numbers.
- Promote peer education programs such as natural helpers in schools and youth organization.

Baseline data

In FY04 the Injury Prevention Program of the Division of Public Health distributed 94 copies of their Gatekeeper Training video to EMS programs.

Four ASIST Gatekeeper trainings were conducted in 2003–2004. Each training was attended by 15 to 30 people

- Two in Akiachak
- Two in Mat-Su Valley

In FY04 95 people participated in the Community-Based Suicide Prevention Project Coordinators Conference.

Markers for Success

- More Alaskans will know the warning signs for suicide risk and will know how to respond when the recognize them.
- Appropriate gatekeeper training will be readily available throughout Alaska and the number of gatekeepers who believe they can and will effectively respond to potentially suicidal individuals will increase.

- Relevant professional groups including healthcare, social service and law enforcement will require gatekeeper training as part of their initial and continuing education programs.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do people in my community know the warning signs of suicide? (See Appendix VII for a list). Do people know how to respond?

How can we increase the number of people in my community who can identify the warning signs for suicide and know how to respond appropriately?

How can we insure that relevant professionals in my community receive gatekeeper training?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

ASIST – Applied Suicide Intervention Skills Training – contact 907-352-8237 or jeaninesparks@gci.net

Living Works, Calgary - http://cmhabrant.tripod.com/ASIST.htm

QPR Training, Spokane - http://www.qprinstitute.com/aboutus.htm

Alaska Division of Behavioral Health – Gatekeeper Training

American Association of Suicidology

Suicide Prevention Resource Center

CDC – Center for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

Suicide Prevention Council - SPC

Community Mental Health Centers / Behavioral Health Centers

SPAN – Suicide Prevention Advocacy Network

American Foundation for Suicide Prevention

National Alliance for the Mentally Ill

National Institute of Mental Health

See Appendix I on page 48 for website addresses.

Goal 7: People who work in communities and institutions with a concentration of known higher risk populations are able to identify warning signs and respond appropriately.

Why – Data tells us that suicide is not evenly distributed across Alaska by place, age, gender, or by cultural group. Some communities have higher rates of suicide than others. The rate of suicide is higher in some age groups than others and these age groups may be concentrated in certain settings. We need to be especially vigilant to insure that the people who work in these settings, those most likely to come into contact with high risk populations, are trained to recognize and respond to warning signs.

How – People need to know the groups in Alaska at highest risk for suicide. We need to provide training for people working with these groups so that they are able and willing to recognize and respond promptly to suicide warning signs.

High risk populations include people in correctional institutions and those awaiting trial, people with substance use disorders, and people experiencing depression. Data indicate that rates of suicide are high among people in their late teens and twenties and we know that people in this age group concentrate in universities, the National Guard and the military. We know that rates of suicide are higher among older Caucasian people and younger Alaska Native males. We know that the rate of suicide is higher among some occupational groups than others. We know that gay and lesbian youth are at higher risk for suicide attempts.

Some specific things we can do

- Encourage institutions and agencies with a high concentration of those in a group at higher risk to develop suicide prevention plans and to require all staff be trained in suicide prevention.
- Incorporate screening and referral of persons at risk into naturally occurring settings, including schools, colleges, correctional institutions, substance abuse treatment programs and programs serving youth and young adults.
- Incorporate suicide education and prevention programs into the professional development activities of associations of those in high risk occupations.

Baseline data

No data is available at this time.

Markers for success

- There is an increase in the number of institutions and agencies serving high risk populations that have regular, on-going suicide prevention training programs.
- More professional associations of higher risk occupations include suicide prevention in their professional development programs.

- More schools, institutions and treatment programs routinely screen and refer for suicide risk.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

- Can the people who work in my institution or agency identify the warning signs of suicide and respond appropriately? (see appendix VII for a list of warning signs)
- Does my professional association provide suicide prevention education?
- Do the schools, institutions or agencies screen for suicide risk?
- How can we work with the institutions, schools, agencies or associations to help implement appropriate training, education and screening programs?
- What are our markers for success?

Some suggested resources to assist you in reaching this goal

P-FLAG (Parents and Friends of Lesbians and Gays)

Tribal Health Organizations

ASIST – Applied Suicide Intervention Skills Training - – contact 907-352-8237 or jeaninesparks@gci.net

Living Works, Calgary - http://cmhabrant.tripod.com/ASIST.htm

QPR Training, Spokane - http://www.qprinstitute.com/aboutus.htm

Alaska Division of Behavioral Health – Gatekeeper Training

American Association of Suicidology

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

Alaska Statewide Suicide Prevention Council

Community Mental Health Centers / Behavioral Health Centers

SPAN – Suicide Prevention Advocacy Network

American Foundation for Suicide Prevention

National Alliance for the Mentally Ill

National Institute of Mental Health

See Appendix I on page 48 for website addresses.

Indicated Prevention Strategies

Goal 8: Behavioral health programs to promote mental health and prevent substance abuse and relevant social services are available and accessible to all Alaskans.

Why – The easier and more acceptable it is to seek and receive treatment and social services, the more likely it is that people will do so. With timely and appropriate treatment and social services most people can recover and rebuild healthy productive lives.

How – Services become more available when they exist close to the recipient's home. They become more accessible when barriers are removed and service providers are consistently welcoming.

Some of the recognized barriers to treatment include cost, the availability of health insurance, cultural and/or language differences between the provider and the recipient, perceived stigma attached to receiving treatment, and fears about confidentiality.

Different barriers are addressed in different ways. Village-based counselors or behavioral health aides help insure that treatment is available in Alaska's smaller communities. Employing traditional healers, and staff who culturally and ethnically reflect the client population helps to reduce cultural and language barriers. Education programs and an informed media help to eliminate stigma.

Crisis lines can also make services more available by providing an easy to access, anonymous source of help 24 hours a day, 7 days a week. The CareLine (1-877-266-4357) is Alaska's only certified statewide crisis line and should be adequately supported to insure the 24/7 availability of trained listeners.

Some specific things we can do

- Increase support for CareLine so it is more adequately supported.
- Inform Alaskans about CareLine using a variety of strategies such as bumper stickers, wallet cards, posters in public places, and public services announcements.
- Support parity for mental health in health insurance.
- Increase support for village based counselors and village health aides.
- Ensure that services are available in all languages spoken in Alaska, either by employing bilingual service providers or translators.

Baseline data

In FY04 149 village-based counselors who had completed or were currently attending the Rural Human Services Training program were working across Alaska. Ninety-five of them worked in 87

different villages and 54 worked in agencies in hub communities, in cities, or itinerated to several communities.

Markers for Success

- Services are available in an increased number of communities.
- More treatment and social service programs employ traditional healers and staff that culturally and ethnically reflect their client population.
- More Alaskans are aware of the CareLine and how to access it.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

How easily available are mental health and substance abuse programs, and relevant social services in my community?

How comfortable are people about using these services and how confident are they about their ability to help?

How can we insure that people experience these services as easy to access, welcoming, effective, and respectful?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

Denali KidCare

Alaska Statewide Suicide Prevention Council
Division of Behavioral Health

Community Mental Health Centers /
Behavioral Health Centers

NAMI - National Alliance for the Mentally Ill

National Institute of Mental Health

Alaska Mental Health Trust Authority

Alaska Mental Health Board –
Resource Directory on website

Governor's Advisory Board on
Alcoholism and Drug Abuse

Commission on Aging

Governor's Council on
Disabilities and Special
Education

Alaska Native Tribal Health
Consortium

See Appendix I on page 48 for website addresses.

Goal 9: Alaskan Behavioral Health Programs will treat suicidality effectively using appropriate current practice guidelines.

Why – Research and evaluation tells us more and more about how to assess suicidality and about the relative effectiveness of different treatments. Effective assessment and treatment of the underlying personal stressors and feelings associated with suicidal behavior and of any underlying mental illness reduce the risk of suicide.

How – Provide the treatment community with up to date information about current best practices in assessing and treating suicidality.

Some specific things we can do

- Provide information which can be presented at conferences, in professional newsletters, through in-house staff training, through continuing education courses at the University and other educational institutions.
- Insure that information about current best practices is widely disseminated.

Baseline data

No data is available at this time.

Markers for Success

- The number of presentations and workshops on best practice guidelines increase.
- There are regular articles on clinical guidelines for treating suicidality in the newsletters of relevant professional organizations and agencies.
- The University and other educational institutions offer seminars and courses on suicide including best clinical practice guidelines.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do providers in my behavioral health program treat suicidality using current practice guidelines and recognized best practice treatments?

How do we increase the number of behavior health providers and programs that follow best practice guidelines and use best practice treatments?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

See Appendix VI.

Goal 10: Alaskan Behavioral Health Programs will include an appropriate ongoing continuum of supportive services for suicidal individuals from identification through treatment.

Why – Suicide is not a disease. Rather it is a tragic ending, the result of a complex and varied mixture of biology, illness, feelings, thoughts, beliefs, behaviors, relationships, cultural history, community attitudes, and life events. Comprehensive treatment helps a suicidal individual address all of these areas. It provides support along the entire journey from hopelessness to health.

How – Provide education and adequate resources to behavioral health programs so they understand the need for and have the ability to offer appropriate care throughout the course of treatment.

Some specific things we can do

- Treatment programs must recognize the need for and institute mechanisms to provide ongoing support after an immediate crisis is resolved.
- Centrally located or residential treatment programs need to develop strong linkages with local service providers and develop and maintain referral systems so that clients can move between programs with minimal disruption of services.
- Treatment programs need to work with the families of suicidal individuals to help the individual re-integrate into the family and community.

Baseline data

No data is available at this time.

Markers For Success

- More behavioral health programs have and follow written policies regarding how clients are referred for ongoing support when treatment ends.
- More behavioral health programs include families in the treatment process.
- More clients report satisfaction with the support they received in re-integrating into their families and communities.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Does my behavioral health program provide seamless services from admission through discharge, including on-going community-based support as appropriate?

Do people from my community receive seamless services from admission through discharge, including on-going community-based support as appropriate?

How can my behavioral health program provide any services that are missing?

How can my community help insure that all needed services are available?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

Substance Abuse and Mental Health Services Administration

Alaska Department of Health and Social Services

Alaska Division of Behavioral Health

National Institute of Mental Health

Indian Health Services

See Appendix V and see Appendix I on page 48 for website addresses.

Goal 11: Alaskan communities respond appropriately to suicide attempts and deaths by suicide.

Why – It is said that every suicide directly impacts six other people. In small communities where everyone knows each other, everyone is impacted to some degree. Those closely impacted by a suicide are often referred to as survivors. In the immediate aftermath of a suicide and for some time thereafter, all survivors need support. Some may need treatment. Suicide is a difficult death to grieve because it raises so many unanswerable questions and contradictory feelings. A suicide may put some survivors at risk for suicide. Sometimes suicide appears to be contagious, in that one suicide seems to lead to other suicides or suicide attempts. Appropriate responses to suicide reduce the risk of other suicides.

Suicide attempts provoke similar confused and painful feelings in others. Friends, classmates, family members and colleagues often need guidance as to how to welcome back and resume normal relationships with someone who has attempted suicide. The attempter also needs advice, support and assistance in reintegrating into the community when treatment is complete.

How – Communities can learn how to respond to a suicide in ways that reduce the risk of other suicides and help promote healing. Communities can learn how to help someone who has attempted suicide feel comfortable back in the community. Treatment centers can help those who have attempted suicide understand how to talk with family and friends about the attempt and the treatment.

Some specific things we can do:

- Behavioral health programs can provide needed information and training in how to respond to a suicide and how to help a suicide attempter.

- Schools, universities and similar communities should have suicide (and other crisis) response plans, and provide regular training to all staff in how to implement them. Crisis response plans include information on appropriate memorials.
- Survivors and survivor groups can play a big part in assisting others who are impacted by suicide.
- Clergy can learn safe, responsible ways to help those who have lost someone to go through the greiving process, come to terms with the loss and heal.

Baseline data

No data is available at this time.

Markers for Success

- The number of programs available that train communities to respond appropriately to suicide and the number of communities that have accessed these programs.
- The number of schools and universities that have crisis response plans.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Does my community know the appropriate ways to respond to a suicide or to someone who attempts suicide?

Does my community have a crisis response plan?

How can I help my community gain the knowledge to develop appropriate plans?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

See Appendix VIII, "After A Suicide: Recommendations for Religious Services and Other Public Memorial Observances" by David Litts

Community Mental Health Centers / Behavioral Health Centers

Alaska Statewide Suicide Prevention Council

Alaska Injury Prevention Center

SAVE – Suicide Awareness Voice of Education

Department of Education and Early Development

Alaska Division of Behavioral Health

See Appendix I on page 48.

Program Evaluation and Surveillance Strategies

Goal 12: Alaska suicide prevention and intervention will be guided by research and program evaluation.

Why – Research and evaluation tell us what programs are most effective. Resources for implementing programs are always limited and it only makes sense to put the resources into the programs that are most likely to work.

How – Create a climate that values evaluation and provides for its incorporation into all suicide prevention programs.

Some specific things we can do:

- Funding for all programs should include adequate funds for evaluation and programs should be required to conduct evaluations. Training in how to do so should be provided.
- Establish a registry of programs that have demonstrated effectiveness in Alaska. Establish a linkage with the national Suicide Prevention Resource Center's database on effective programs elsewhere in the nation and the world.
- Advocate for increased funding for suicide prevention research nationwide and within Alaska.

Baseline data

In FY04 and FY 05 there are two research/evaluation projects in Alaska, the Follow Back Study funded through the Alaska Injury Prevention Center, and the development of the Targeted Gatekeeper Training.

Markers for Success

- More suicide prevention-research is available at the state and federal level.
- There is more Alaska specific research on suicide and suicide prevention including psychological autopsy and follow-back studies.
- There are more resources and more technical support to implement and evaluate Alaskan suicide prevention programs.

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Is there on-going Alaska specific research and program evaluation to guide suicide prevention and intervention?
How can we insure that adequate research and evaluation are on-going?
What are our markers for success?

Some suggested resources to assist you in reaching this goal.

See Appendix IV and see Appendix I on page 48 for website addresses.
National Institute of Mental Health
Centers for Disease Control
Substance Abuse and Mental Health Services Administration
American Foundation for Suicide Prevention

Goal 13: Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions and evaluating progress.

Why – Data provide information about the pattern of suicide and who, by age, race, sex, location, is most at risk. Data tell us which communities and groups have higher rates of suicide and suicide attempts. Such data allow us to target our programs and interventions more precisely and increase the likelihood of their effectiveness.

How – Work with a variety of agencies that currently collect data to create a comprehensive uniform surveillance system for suicide and suicide attempts.

Some specific things we can do:

- Find out who is collecting what data at the present time and develop data sharing procedures.
- Develop and implement standardized protocols for death scene investigations in rural and urban Alaska.
- Integrate questions on suicidal behavior into health-related surveys.
- Provide adequate support for the collection and analysis of vital statistics and the trauma registry.
- Integrate data collected from investigations into a statewide suicide database in a timely manner, so that emerging patterns and problems can be promptly identified and an appropriate response initiated.

Baseline data

Division of Behavioral Health – AKAIMS (Alaska Automated Information Management Services)

Division of Juvenile Justice – JOMIS (Juvenile Offender Management Information System)

Office of Children's Services – ORCA (Online Resources for the Children of Alaska)

Division of Health Care Services – MMIS (Medicaid Management Information System)

Division of Public Health – Bureau of Vital Statistics

Markers for Success

- More comprehensive and consistent data about suicide and suicidal behavior will be available in a timely manner.
- More questionnaires and surveys will include questions related to suicide and suicidal-related behaviors.

Alaska Prevention Goals

WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Does the suicide surveillance system(s) Alaska has provide adequate data to plan services, target interventions and evaluate progress at the community level?

Can this information be easily accessed?

What do we need to do to insure that it does and can?

What are our markers for success?

Some suggested resources to assist you in reaching this goal

Alaska Bureau of Vital Statistics

Alaska Trauma Registry

Division of Behavioral Health – AKAIMS (Alaska Automated Information Management Services)

Division of Juvenile Justice – JOMIS (Juvenile Offender Management Information System)

Office of Children's Services – ORCA (Online Resources for the Children of Alaska)

Division of Health Care Services – MMIS (Medicaid Management Information System)

Law Enforcement

National Violent Death Reporting System

Medical Examiner

Indian Health Services

Alaska Child Fatality Review Team

Alaska Injury Prevention Center

National Center for Health Statistics

Centers for Disease Control

Suicide Prevention Resource Center

See Appendix I on page 48 for website addresses.

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"One time I see a young guy and he missing _____ so bad. I talk to him of how I would feel, I would feel worst if he do that. I tell him "don't do that please." I sure talk to him. Ever since I see that guy I always say "Hi son take care I love you". That's what we have to do we have to talk to young people. Gotta love them. I always tell them my house is always be open."

— Anonymous from Noorvik

Appendix I

Resources
State Data Sources

State of Alaska Bureau of Vital Statistics
www.hss.state.ak.us/dph/bvs/death_statistics/default.htm
www.hss.state.ak.us/dph/bvs/publications/default.htm (for annual reports)
www.chems.alaska.gov/Injury_Prevention/TraumaRegistry.htm

Statewide Suicide Prevention Council
www.hss.state.ak.us/suicideprevention/

Department of Health and Social Services
www.hss.state.ak.us/

Division of Behavioral Health
www.hss.state.ak.us/dbh/

Governor's Advisory Board on Alcoholism and Drug Abuse
www.hss.state.ak.us/abada/

Governor's Council on Disabilities and Special Education
health.hss.state.ak.us/gcdse/

Alaska Mental Health Board
www.alaska.net/~Eamhb/

Alaska Commission of Aging
www.alaskaaging.org/

Community Based Suicide Prevention Program, Alaska Division of Behavioral Health
health.hss.state.us/suicidePrevention/Resources/AKSPP Programs.htm

Community Mental Health Centers / Behavioral health Centers
health.state.ak.us/suicideprevention/AboutUs/MHCenters.htm

Alaska Injury Prevention Center
www.alaska_ipc.org

Alaska Native Tribal Health Consortium
www.anthc.org

National Data Sources

Centers for Disease Control
www.cdc.gov/ncipc/wisquars/ (an interactive database)
www.cdc.gov/nchs/fastats/suicide.htm

American Association of Suicidology
www.suicidology.org

SAMHSA
www.samhsa.gov (Substance Abuse and Mental Health Services Administration)

Suicide Prevention Resource Center
www.sprc.org

Suicide Prevention and Advocacy Network
www.spanusa.org/ (not just data, lots of useful information about suicide prevention and links to other sites)

American Foundation for Suicide Prevention
www.afsp.org

National Institute of Mental Health
www.nami.org

National Institute of Mental Health Suicide Research Consortium
www.nimh.nih.gov/research/suicide.cfm

Indian Health Services
http://www.ihs.gov/

Suicide Awareness Voices of Education
www.save.org/

World Data Source

United Nations World Health Organization
www.who.int/mental_health/prevention/suicide/country_reports/en/

Appendix II

Suicide Prevention/Intervention Participation Points

Different kinds of communities and individuals in various occupations and roles can all participate in suicide prevention and intervention. The ways in which they participate vary with the nature of the community and the occupation. Here is a list of some of key communities and occupations that are important participation points in the prevention of suicide.

Education System
- Elementary School
- Middle School
- High School
- University/College
- Boarding Schools

Medical System
- Emergency Room Staff
- EMTs/ETTs
- Health Aides
- Public Health Nurses
- School Health Clinics
- Primary Care Physicians
- Gerontologists & others who treat the elderly

Justice/Corrections System
- Jails
- Prisons
- Youth facilities
- Probation Officers
- Attorneys
- Judges

Behavioral Health System
- Outpatient
- Residential
- Substance use disorder treatment programs
- Crisislines
- Village-based Counselors
- Behavioral Health Aides

Social Welfare System
- Social Workers
- Fee Agents
- Public assistance workers

Churches/Clergy

Community Organizations
- Youth Groups
- Senior Citizen Groups
- Neighborhood Associations
- Athletic Teams and Coaches
- Cultural Associations

Professions with "public intimacy"
- bartenders
- hairdressers
- tailors
- massage therapists

Employers

The Media
- print
- radio
- TV

Artists/Musicians

Local governments

Survivors

Appendix III

How to Use this Plan in Your Community

Whether you are in a village, a church group, a city neighborhood, a school, or in any other community, it is valuable to develop a clear roadmap to guide you towards your specific goals and objectives for suicide prevention. We hope that you will use the goals, activity suggestions and markers for success outlined in the Alaska Suicide Prevention Plan to help you in the development of your own suicide prevention project.

This section may assist in your community planning.

Why do we need to plan our suicide prevention activities?
Our experience with other suicide prevention projects teaches us that the most successful projects are ones in which there is good planning that involves the community and, also, are flexible enough to take advantage of changes and opportunities that come up in the villages from time to time. Before talking about specific activities, though, it is important to remember that the overall goal of the project is to reduce suicide and self-destructive behavior and to increase individual, family and community health. So, as you plan your activities, you should be sure that you can see a logical connection between your chosen activities and this overall goal.

How do I get input from community members in the planning for the project?
It is important to get the ideas of many individuals in the community. **A community meeting** where people can talk about their ideas is a wonderful idea and can lead to a lot of interesting activities. You probably should hold a community meeting at least once a year, but you may decide to hold more. You can even pass out survey forms at the community meeting and allow everyone to write their ideas down. Be prepared for some disagreement on activities since (fortunately) not everyone has the same ideas. The important thing, of course, is to allow everyone to express their ideas and to use the ideas as much as you can. There are times when you are able to take advantage of a group that is gathered for another purpose, such as a class or a community gathering, to get some quick ideas.

You may decide to distribute copies of the Alaska Suicide Prevention Plan in your meeting and discuss the goals and the suggestions for activities. Your community may already be working towards some of these goals. You should discuss these preexisting activities, as well as the possible need for other ones.

What if a community meeting is not possible (or not well attended)?
In this case, you must go out and talk to individuals or small groups to get their ideas. Sometimes you might visit with people to hear what they have to say but you can also try to take advantage of "chance meetings" where you run into community members at church, the store, or the community center. Finally, you can also try to post flyers around the community that invite people to either come see you and talk about their ideas or to just write you a quick note with ideas. If you feel more people would be willing to share, you may decide to keep suggestions confidential.

Who should be involved with planning for the project?
In thinking about your suicide prevention activities, it is valuable to get as many ideas about available resources and specific community challenges as possible. It is also important to involve community members from the beginning to facilitate better participation and communication throughout your project. Members of your planning team should come from different backgrounds and represent different interests. This might include: Elders, elected officials, clergy, media, business owners, community health workers and counselors, law enforcement, parents and youth.

How do I get community leaders to participate in the planning for the project?
The best place to start involving the community is with local leaders. There is no one "best way" to get the input of community leadership, but here are some ideas:

- Meeting with community leaders as a group and hearing what they have to say about activities they would like to see.
- Meeting with them individually and letting them tell you about their ideas for activities.
- Taking a survey of community leaders (you can design a form, if you like) and letting them put their ideas in writing.

You may discuss some of the goals outlined in the Alaska Suicide Prevention Plan and share your support for efforts towards suicide prevention and community health promotion. The most important thing about this process is for you to listen to their ideas and use the ideas as a foundation for your project.

What should we discuss in our planning?
The first thing to talk about when we consider planning is what kind of planning to do. One of the most important questions that you must answer is what kind of activities are going to be best for your community. This is an important question because different communities have different needs and what works best in one community may not work well in another. This can also be a difficult question because different people within a community may have different ideas. It is important to remember that you are representing the interests and desires of the community. It is also important that as many community members as possible participate in the design. The Alaska Suicide Prevention Plan provides several ideas for specific activities under each goal.

Once you have identified the activities that your community would like to see, you must then identify the resources that are needed and determine if you have those resources. For example, if the community would like to have educational suicide prevention classes, there must be someone who has enough skill to teach the classes and who is willing to teach them. You must also look at the timing of the activities and make sure that they do not conflict with other community activities that may be going on at the same time.

Other questions to consider are:

- What is the interest in suicide prevention in our community?
- How can we use the Alaska Suicide Prevention Plan to help guide our activities?
- What projects, resources and activities already exist that work for suicide prevention? Looking at the goals of the Alaska Suicide Prevention Plan, what are our goals and expectations?
- What kind of training will we need to achieve our goals?
- How can we increase support for suicide prevention in our community?
- How will we make decisions about our activities and how will we prioritize the activities?
- What roles and responsibilities should individuals have in the activities?
- How will we inform and educate the community about our activities?
- Looking at the markers for success in the Alaska Suicide Prevention Plan, how will we know that we are doing a good job with our activities?
- Who will be responsible for keeping track of all of the activities that are done?
- How will we recognize individuals for a job well done?

Why is it important to get the input of the community?
You should use all of the ways that work in your community to engage people and get their ideas. The value in getting input and ideas from different people in the community is that:

- The more ideas you have, the more likely you are to come up with activities that work for the community.
- The more that you get engagement and ideas from the community, the more likely the community is to support your project once it is up and running.
- When you are reporting your progress to the community and local leaders during the year, the more that they have been involved in the process, the more they will understand your report and your needs.

Appendix IV

About evaluation and determining markers for success and where to find more information

"If you don't know where you are going, how will you know when you arrive?"

Evaluation establishes goals that tell you where you want to go. It sets up a map (or plan) of how you are going to get there with landmarks (or objectives, or markers for success) that can tell you how far you have come toward reaching the goal.

It is important to plan your evaluation at the same time you plan your project.

There are many resources on evaluation. Here are a few.

Centers for Disease Control

www.cdc.gov/eval/framework.htm

www.cdc.gov/eval/evalcbph.pdf

The Community Toolbox

http://ctb.ku.edu/tools/en/part_J.htm This is specific to evaluation, but the website http://ctb.ku.edu/ contains helpful information on all areas of project planning, implementation, management etc. as well as information on organizing communities, social marketing and the like.

Empowerment Evaluation plus lots of links to other useful sites.

http://www.stanford.edu/~davidf/empowermentevaluation.html

Appendix V

About practice guidelines and evidence-based practices and programs and where to find more information

Practice guidelines and best or evidence-based practices represent the most current thinking about what works best to prevent and treat suicidal behavior.

The list below is current as of June, 2004.

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors The American Psychiatric Association 2003. It is available at: www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf

Reducing Suicide: A National Imperative The Institute of Medicine, 2002

Includes chapters on medical and psychotherapeutic inte4rventions and program for suicide prevention. It is available at: www.nap.edu/catalog/10398.html

The Harborview Injury Prevention and Resource Center in Washington reviews some best practices in adolescent suicide prevention. The article is located here: http://depts.washington.edu/hiprc/practices/topic/suicide/

The Suicide Prevention Resource Center has begun a project to identify evidence-based practices in suicide prevention. You can read about the project at: www.sprc.org/whatweoffer/ebp.asp

Aboriginal Youth: A manual of Promising Suicide Prevention Strategies is distributed by the Centre for Suicide Prevention in Alberta Canada. It is available to order at: www.suicideinfo.ca/csp/assets/promstrat_order.pdf or as a free (but almost 300 page) download at: www.suicideinfo.ca/csp/go.aspx?tabid=144

Appendix VI

Warning Signs

Warnings signs alert us that a person might be considering suicide. If we observe a warning sign and suspect a person is considering suicide, the appropriate response is to show our concern, ask the person if he or she is thinking about suicide, and assist the person to get help. This is often referred to as "gatekeeping". There are numerous training programs that train potential "gatekeepers" in how to recognize warning signs, intervene and refer. Two of the best known are:

QPR – Question Persuade Refer, http://www.qprinstitute.org/

ASIST – Applied Suicide Intervention Skills Training, www.livingworks.net/ for more information

Contact the Statewide Suicide Prevention Council for the names of trained Alaskan ASIST trainers.

The Alaska Division of Behavioral Health and the Statewide Suicide Prevention Council are currently developing gatekeeper training specifically for the different communities and groups in Alaska. It should be available beginning in July 2005.

Warning Signs

Verbal – some of the things a person might say:

I'm thinking of ending it all.
I might as well shoot myself.
I might just jump in the river.
I can't go on.
Life is not worth living.
Nothing matters anymore.
I wish I were dead.
I'm a loser.
I can't do anything right.
No one can help me.
What's the use?
I just can't keep my thoughts straight anymore.
If I killed myself, then people would be sorry.
If I wasn't around no one would miss me.
All of my problems will end soon.
I won't be needing these things any more.
I'm going to be with (names someone who has died).

Behaviors – some of the things a person might do:

Drop out of usual activities.
Withdraw from friends and family.
Act recklessly.
Put affairs in order.
Give away valued possessions.
Increase use of drugs or alcohol.
Crying.
Fighting.
Getting into trouble in school or with the law.
Impulsiveness.
Self-mutilation.
Writing about death and suicide.
Not taking care of physical needs and appearance.
Sleeping or eating too much or too little.

Be especially concerned if you observe several of these signs and/or if you are aware that the person has recently experienced a loss of some kind.

The most significant predictor of suicide is a prior suicide attempt. If you observe warning signs in someone you know has attempted suicide in the past, it is especially important to intervene and assist the person in getting help.

Appendix VII

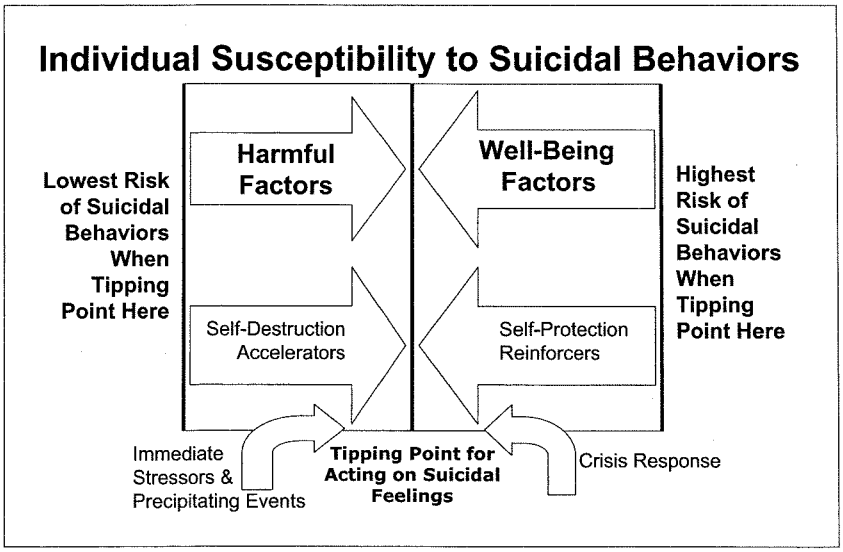
Factors making suicidal behaviors more or less likely to occur

These tables and the chart following were contributed by Lucy Davidson, MD, EdS, President-Elect of the American Association of Suicidology. They offer a slightly different model for looking at the factors that contribute to (harmful) or protect from (Well-Being) suicidality. Dr. Davidson's chart portrays the factors as operating like "force vectors" that move the individual's tipping point for acting upon suicidal feelings towards or away from self-destructive behavior. Special thanks to Dr. Davidson for sharing this very interesting and useful formulation.

Harmful Factors	Well-Being Factors
Poor Mental Health Presence of a mental disorder, especially mood disorders (depression, bipolar disorder) or substance use disorders (alcohol abuse, alcoholism, other drug abuse) Not enough treatment or barriers to treatment Genetic predisposition to suicide	**Good Mental Health** Absence of mental disorders Effective treatment of existing mental disorders or substance use disorders No family history of suicide
Negative Attitudes Towards Life and Self Pessimistic, hopeless Loner, isolated Feels useless, of no value Feels there is no meaning to life	**Positive Attitudes Towards Life and Self** Optimistic, hopeful, sense of autonomy Feels part of community & peers Feels useful, has role in community Faith, spirituality, church attendance
Harmful Behaviors Substance abuse Risk taking actions Defiant, hostile, sullen towards others	**Healthy Behaviors** Clean and sober Bases actions on foreseeable consequences Social connectedness
Deficient Life Skills Poor problem solving skills Poor communication skills Unable to share feelings or seek help	**Strong Life Skills** Creative problem solver Good communicator Able to ask for help when needed Cultural reinforcement
Unstable Family Life Substance abuse in home/family Ongoing conflict or violence Neglect	**Supportive Family Life** Parents model healthy behaviors Warm, respectful relationships Stability and consistency Parents have high and realistic expectations, set clear limits

Harmful Factors	Well-Being Factors
Destructive Relationships Peers abuse substances "Outlaw" peers, get into trouble, alienated "Tough guys/girls" Negative attitude to adults Poor adult role models Adults pay little or no attention esp. to teens Generations are disconnected Adults put youth down, non-supportive	**Positive Relationships** Peers that model healthy behaviors Community engagement Supportive "natural helpers" Have adult mentors and positive role models Good role models Create opportunities for youth to contribute Elders are involved with youth Adults keep faith in youth, never give up on them
Adverse School Environment Allows bullying, harassment Disconnected from community, parents do not feel welcome Teachers, staff uncertain how to help Students feel belittled, shamed Abusive boarding school	**Constructive School Environment** All students feel safe, welcomed Parents are involved in school, school is part of community Teachers, staff trained as natural helpers Students feel supported by school Community school
Economic Decline High unemployment Poverty	**Economic Resurgence** Opportunities for meaningful work Opportunity to live comfortably
Disengaged Communities Substance abuse is high and tolerated Violence is high and tolerated Suicide seen as ordinary and typical Firearms are openly available Bootlegging is common and open Feeling politically powerless Media sensationalizes suicide Fragmented medical, behavioral health, and social services	**Communities That Care** Drunkenness is not acceptable Ordinances and laws are enforced Suicide is seen as preventable by addressing its underlying causes Safe storage of firearms, lockboxes Enforced local option laws Feeling that one can have an impact on political processes Responsible reporting, follows guidelines for media Coordinated medical, behavioral health, and social services

Self-Destruction Accelerators	Self-Protection Reinforcers
Local clusters of suicide that have a contagious influence Loss: relationship, financial, job, social Stigma associated with seeking help Previous suicide attempt(s) Hopelessness Aggressive/impulsive tendencies Unwarranted self-criticism Previous trauma or abuse Unrelieved anxiety or agitation General medical conditions, such as stroke, that can produce depressive illness	Purposefulness and social support Optimistic nature, sense of future Ability to tolerate own emotions and use foresight Realistic self-acceptance Healing, peer support Restoration of sleep, appetite, and daily routine Appropriate medical care, pain relief, and palliative care; vigorous treatment of depression



Appendix VIII

AFTER A SUICIDE: RECOMMENDATIONS FOR RELIGIOUS SERVICES AND OTHER PUBLIC MEMORIAL OBSERVANCES

Suicide Prevention Resource Center. (2004). *After a suicide: Recommendations for religious services and other public memorial observances*. Newton, MA: Education Development Center, Inc.

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Website address: www/s[rc.org/library/aftersuicide.pdf

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After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances

When an act of suicide causes the end of a life, it affects the community of survivors in a very profound way—much different from a death caused by heart disease, cancer, or an accident (Barrett & Scott, 1990). The unique social, cultural, and religious contexts regarding suicide are complicated by nearly pervasive misinformation and misunderstanding. Consequently, stigma, shame, embarrassment, and unwarranted guilt add unnecessarily to the already heavy burden on those grieving (Worden, 1991). Planning a religious service or other memorial observance under these circumstances provides a number of challenges.

It is also important to note that people who are exposed to a loved one's suicide have a heightened risk of suicide themselves. Therefore, leaders who can effectively respond to survivors can lessen the likelihood of future suicides.

These recommendations were created to aid members of the clergy and other community and faith leaders as they care for those who have survived the loss of a loved one due to suicide and to assist them in helping to plan a memorial observance. This document provides background information, suggests ways to care for and support survivors, offers recommendations for planning memorial services, and lists additional resources. This information is provided as part of the implementation of the *National Strategy for Suicide Prevention* (U.S. Department of Health and Human Services [DHHS], 2001). The suggestions herein are based on a considerable body of scientific research, as well as extensive consultations with clergy and counselors who represent the broadest range of religions and cultural communities and who have provided care during the aftermath of suicide.

It is not possible for one document to answer all the questions that will come in the wake of a suicide. Hopefully, though, these recommendations will help faith and community leaders plan memorial observances that not only promote healing but also help prevent future suicides.

Background

Understanding Why

Although many questions are left unanswered when someone takes his or her own life, in retrospect, suicide is rarely entirely unexplainable (Shneidman, 2004). Those who end their lives do not act out of moral weakness or a character flaw, as some used to think. They are nearly always suffering from intense psychological pain from which they cannot find relief. In 90 percent of suicides, this pain may be associated with a brain illness, such as depression, schizophrenia, and bipolar disorder, and is often complicated by alcohol or other drug abuse (National Institute of Mental Health, 2003). The illness may have existed for some time or be of relatively recent onset. These people are commonly constrained in their thinking and are unable to make rational choices, the way most are able to do under normal circumstances (Cantor, 1999). There are effective treatments for these brain illnesses, but too often people suffering with this psychological pain are not able to (or choose not to) find access to those treatments (DHHS, 1999). And in some instances, even when treatment is given, it is not enough to prevent the suicide.

In a proportion of cases, suicidal acts are responses—sometimes impulsive—to difficult life situations, however temporary those situations may be (Simon et al., 2001). Even very close family members and friends may not have had sufficient awareness of the issues to understand the true severity of the crisis.

Although some suicidal individuals go to great lengths to hide evidence of their selfdestructive plans, most individuals communicate their intent in some way or display signs of suicide risk (Shneidman, 1996). However, these signs often pass by without eliciting a response, for a variety of reasons. Sometimes the communications are obtuse, making them difficult to recognize as warning signs. Or, when someone *does* recognize the signs, he or she may not know how to respond effectively. In other cases, even the most determined responses by loved ones do not prevent a tragic end.

Theological Issues

A suicide within their local faith community may provide the first opportunity for some clergy members to carefully examine their own theological views regarding suicide. They will almost certainly be required to

answer the theological questions raised by the surviving family members and the greater faith community. Fortunately, the perspectives held by many faith groups have developed over recent years to reflect today's more complete understanding of the complexities of suicide. Members of the clergy now have an opportunity to bring healing and comfort to survivors by framing their informed responses with sensitivity, compassion, grace, and love. (The "Additional Resources" section includes a Web site that offers theological statements on suicide from a variety of faith groups.)

Support For and Care of Survivors

Surviving family members and intimate friends can best be helped by people who accurately understand the special ramifications of a suicide. Only by paying special attention to these factors can community and faith leaders effectively support survivors as they progress on their journeys of grieving and healing.

There are a variety of ways in which the community can support survivors (Jordan, 2001):

- Recognizing the unique challenges in grieving the loss of a loved one from suicide.
- Reaching out to intentionally draw survivors into the fabric of the community's normal activities. Deliberate inclusiveness is an important antidote to the inappropriate stigma that so often accompanies a death due to suicide. The faith community should be an important source of love and grace for the grieving.
- Supporting them with the same gestures of kindness that are extended to others who have deaths in the family (taking in meals, etc.).
- Talking with the survivors about the deceased in the same sensitive way they would about any other person who had recently died. This openness will help the surviving family overcome any embarrassment or shame they may be feeling.
- Encouraging them to seek specialized support in their grieving process, either through support groups for survivors of suicide or by seeking professional grief counseling with a therapist experienced with suicide survivors.

Grieving

Faith and community leaders may also experience grief following a suicide, especially if they had provided care, counseling, or support in a direct way to the deceased prior to the suicide. Consequently, these leaders must pay attention to their own emotional, psychological, and spiritual needs as they provide essential support to the greater community.

Grieving after a suicide can be distinctly different from other grieving experiences, due to the complexities discussed above. The grief may be marked by extremely intense emotional pain, which, though it may wax and wane, can persist for an extended time. Some survivors may also experience nightmares or flashbacks to the event, both of which are associated with post-traumatic stress (Knieper, 1999).

It is not unusual for well-meaning friends, fellow workers, classmates, etc. to inappropriately criticize those closest to the deceased for the manner or duration of their grieving. It is important to remember that people grieve at their own pace and in their own way.

Sometimes, the difficult life of the deceased has caused such intense conflict and suffering for the loved ones that grief is complicated by a sense of relief. Whatever the mix, the emotions are usually intense and complex,

and require unusual sensitivity and understanding from those in roles of support.

Aging and Infirm Populations

Faith communities can work to prevent suicide among their aging members in a variety of ways:

- **Striving to recognize signs of depression and encouraging those suffering to seek effective treatments**
- **Improving the emotional, psychological, and spiritual support provided to those with physical infirmities**
- **Supporting community providers of end-of-life care, such as hospices, to ensure wider availability of this important service**
- **Honoring older community members, regardless of their current health, in a way that contributes to their feelings of worth and diminishes their sense of being a burden**

Suicide among people who are elderly, disabled, or terminally ill involves an additional set of unique and complex issues. In most cases, these suicides occur in the context of hopelessness, depression, or both, and are undoubtedly influenced by societal attitudes around these issues (Szanto, 2003). Between 8 and 20 percent of older Americans suffer from depression, and a substantial proportion receive either no or inadequate treatment (DHHS, 1999). Although the health care system needs to respond with significant improvements, the faith community can also improve its understanding and support of this population (see box).

Educating the Community

As a society, we have not informed ourselves well about suicide. Misinformation and inaccurate religious views of suicide create an environment that leaves survivors isolated and embarrassed, even though they may have been powerless to prevent the tragic event (DHHS, 2001). This should be a time for healing, not judging. The individual act cannot be undone. A community will be able to bring healing to its members if it has a better awareness and more accurate understanding of suicide. A better informed community is also better equipped to recognize and respond to signs that someone else they know and love is at risk of taking his or her own life (DHHS, 2001).

Recommendations for Memorial Services

Memorial services are important opportunities for increasing awareness and understanding of the issues surrounding suicide and thereby ridding the community of some of its unfounded stigma and prejudice (DHHS, 2001). The ultimate goal of a memorial service is to foster an atmosphere that will help survivors understand, heal, and move forward in as healthy a manner as possible. In preparing for memorial services, it is important to recognize that public communication after a suicide has the potential to either increase or decrease the suicide risk of those receiving the communication (Centers for Disease Control and Prevention [CDC] et al., 2001). The following recommendations can facilitate a community's healing in the aftermath of a suicide and, at the same time, reduce the risk of imitative suicides.

Comfort the Grieving

A death by suicide often leaves surviving family and friends with excruciating emotional pain, which may persist for an extended time. Help survivors find comfort within the context of their faith and their faith community.

Help Survivors Deal with Their Guilt

Survivors are almost invariably left with a sense of unwarranted guilt or an exaggerated sense of responsibility from not being aware of what was going on with their loved one, or not acting in time to prevent the suicidal death (Van Dongen, 1991). Others may feel unfairly victimized by the act of their family member or friend and by the stigma that society inappropriately places on them. Consequently, it is common for survivors to relive for weeks, months, and even years a continuous litany of "What if . . . ?," "Why did . . . ?," and "Why didn't . . . ?" Rehearsing or rehashing these questions, although a nearly universal experience, will not necessarily produce answers that satisfy the longing for understanding and closure. Once again, it is helpful to offer survivors solutions that can be found within their faith traditions. After sufficient time, a better understanding of why suicide occurs may provide the beginning of healing for some survivors.

Help Survivors Face Their Anger

Feelings of anger commonly occupy the minds and hearts of those mourning the loss of a loved one to suicide (Barrett & Scott, 1990). These feelings may take several forms: anger at others (doctors, therapists, other family members or friends, bosses, the deity, etc.), anger at themselves (because of something done or not done), and/or anger at the deceased (for abandoning the survivor, throwing away all plans for a future, and abrogating responsibilities and obligations). Surviving family and friends should be assured that feeling or expressing their anger is often part of the normal grieving process. Even when their anger is directed toward the deceased, it does not mean they cared for their loved one any less.

Attack Stigma

Stigma, embraced by ignorance, can be the greatest hindrance to healing if it is not dealt with directly (Jordan, 2001). Take this opportunity to make as much sense as possible of what could have led to the person's tragic end. One approach is to disclose selected information about the context of the specific suicide, such as a mental illness from which the deceased may have been suffering. (Do not describe the suicidal act itself.) An alternative approach is to discuss the factors commonly associated with suicidal acts (e.g., psychological pain, hopelessness, mental illness, impulsivity) without mentioning the specifics of the person's death. At a minimum, dispel the common myths about moral weakness, character flaws, or bad parenting as causes (except in cases where parental violence or abuse was known to be a contributing factor). Recognition of the role of a brain illness may help community members understand suicide in the same way that they appreciate, for example, heart disease, another common cause of death.

Use Appropriate Language

Although common English usage includes the phrases "committed suicide," "successful suicide," and "failed attempt," these should be avoided because of their connotations. For instance, the verb "committed" is usually associated with sins or crimes. Regardless of theological perspective, it is more helpful to understand the

phenomenon of suicide as the worst possible outcome of mental health or behavioral health problems as they are manifested in individuals, families, and communities (DHHS, 2001). Along the same lines, a suicide should never be viewed as a success, nor should a non-fatal suicide attempt be seen as a failure. Such phrases as "died by suicide," "took his life," "ended her life," or "attempted suicide" are more accurate and less offensive.

Prevent Imitation and Modeling

Public communication after a suicide can potentially affect the suicide risk of those receiving the communication (CDC et al., 2001). Some types of communication about the deceased and his or her actions may influence others to imitate or model the suicidal behavior. Consequently, it is important in this context not to glamorize the current state of "peace" the deceased may have found through death. Although some religious perspectives consider the afterlife to be much better than life in the physical realm, particularly when the quality of physical life is diminished by a severe or unremitting mental illness, this contrast should not be overemphasized in a public gathering. If there are others in the audience who are dealing with psychological pain or suicidal thoughts, the lure of finding peace or escape through death may add to the attractiveness of suicide. (Information about resources for treatment and support should be made available to those attending the observance.) In a similar way, one should avoid normalizing the suicide by interpreting it as a reasonable response to particularly distressful life circumstances.

Instead, make a clear distinction, and even separation, between the positive accomplishments and qualities of the deceased and his or her final act. Make the observation that although the deceased is no longer suffering or in turmoil, we would rather she or he had lived in a society that understood those who suffer from mental or behavioral health problems and supported those who seek help for those problems without a trace of stigma or prejudice. Envision how the community or society in general could function better or provide more resources (such as better access to effective treatments) to help other troubled individuals find effective life solutions. The goal of this approach is to motivate the community to improve the way it cares for, supports, and understands all its members, even those with the most pressing needs, rather than contribute to the community's collective guilt.

Consider the Special Needs of Youth

In a memorial observance for a young person who has died by suicide, service leaders should address the young people in attendance very directly, since they are most prone to imitate or model the suicide event (Mercy et al., 2001). The death of their peer may make them feel numb or intensely unsettled. Regardless of how disturbing this sudden loss may be, impart a sense of community to the audience, highlighting the need to pull together to get through this. Make specific suggestions that will unite the community around the purpose of caring for one another more effectively. Also, ask the young people to look around and notice adults on whom they can call for help in this or other times of crisis, such as teachers, counselors, youth leaders, and coaches. Consider pointing out specific adults who are known to be particularly caring and approachable. Note the desire of these adults to talk and listen to anyone who is feeling down or depressed or having thoughts of death or suicide. In the course of this discussion, endeavor to normalize the value of seeking professional help for emotional problems in the same way one would seek professional help for physical problems.

Focus attention on the hope of a brighter future and the goal of discovering constructive solutions to life's problems—even when these problems include feelings of depression or other signs of mental or emotional pain. Encourage the youth to reach outside themselves to find resources for living their lives to the fullest and to talk with others when they are having difficulties. Additionally, it is critically important that the young people who

are present watch one another for signs of distress and that they never keep thoughts of suicide a secret, whether those thoughts are their own or a friend's. Stress the importance of telling a caring adult if they even *think* one of their friends may be struggling with these issues.

Schools and faith communities may wish to organize individual classes or small discussion groups with prepared adult leaders in which youth can more comfortably discuss their thoughts and feelings regarding their loss and where questions may be more easily raised and addressed.

Consider Appropriate Public Memorials

There have been several cases where dedicating public memorials after a suicide has facilitated the suicidal acts of others, usually youth (CDC, 1988). Consequently, dedicating memorials in public settings, such as park benches, flag poles, or trophy cases, soon after the suicide is discouraged. In some situations, however, survivors feel a pressing need for the community to express its grief in a tangible way. Open discussion with proponents about the inherent risks of memorials for youth should help the community find a fitting, yet safe, outlet. These may include personal expressions that can be given to the family to keep privately, such as letters, poetry, recollections captured on videotape, or works of art. (It's best to keep such expressions private; while artistic expression is often therapeutic for those experiencing grief, public performances of poems, plays, or songs may contain messages or create a climate that inadvertently increases thoughts of suicide among vulnerable youth.) Alternatively, suggest that surviving friends honor the deceased by living their lives in concert with community values, such as compassion, generosity, service, honor, and improving quality of life for all community members. Activity-focused memorials might include organizing a day of community service, sponsoring mental health awareness programs, supporting peer counseling programs, or fund-raising for some of the many worthwhile suicide prevention nonprofit organizations. Purchasing library books that address related topics, such as how young people can cope with loss or how to deal with depression and other emotional problems, is another life-affirming way to remember the deceased.

Additional Resources

For more information about suicide and suicide prevention, please visit the Suicide Prevention Resource Center Web site at www.sprc.org.

Links to other interfaith resources, including statements on suicide issued by a variety of denominations, is available on the Web site of the Organization of Attempters and Survivors of Suicide in Interfaith Services at www.oassis.org.

Information on specialized grief support services and groups for survivors of a suicide is available from the following:

American Association for Suicidology
www.suicidology.org
4201 Connecticut Avenue, NW, Suite 408
Washington, DC 20008
(202) 237-2280

American Foundation for Suicide Prevention
www.afsp.org
120 Wall Street, 22nd Floor
New York, NY 10005
(212) 363-3500
Toll-free: (888) 333-AFSP

The Compassionate Friends, Inc.
www.compassionatefriends.org
P.O. Box 3696
Oakbrook, IL 60522-3696
(630) 990-0010
Toll-free: (877) 969-0010

The Link's National Resource Center for Suicide Prevention and Aftercare
www.thelink.org/
348 Mt. Vernon Highway
Atlanta, GA 30328
(404) 256-2919

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Appendix IX

GLOSSARY

Activities – the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Advocacy groups – organizations that work in a variety of ways to foster change with respect to a societal issue.

Best practices – activities or programs that are in keeping with the best available evidence regarding what is effective.

Community – a group of people residing in the same locality or sharing a common interest (ex. a town or village, and faith, education and correction communities, etc.).

Comprehensive suicide prevention plans – plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

Connectedness – closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Consumer – a person using or having used a health service.

Contagion – a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Contributing factors – see risk factor.

Culturally appropriate – a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture – the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Elderly – persons aged 65 or more years.

Evaluation – the systematic investigation of the value and impact of an intervention or program.

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective.

Follow-back study – the collection of detailed information about a deceased individual from a person familiar with the decedent's life history or by other existing records. The information collected supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Gatekeepers – those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal – a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health – the complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Healthy People 2010 – the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

Impulsive – a suicidal act that occurs with little planning or forethought.

Indicated prevention intervention – intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intentional – injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Means restriction – techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Mental disorder – a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

Mental health – the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

Mental health problem – diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Mental health services – health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness – see mental disorder.

Objective – a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often.

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention.

Predisposing factor – a precursor that provide the rational or motivation for a behavior.

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors – factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Public information campaigns – large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Rate – the number per unit of the population with a

particular characteristic, for a given unit of time.

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools – those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention – intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm – the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Social services – organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Stigma – an object, idea, or label associated with disgrace or reproach.

Substance use disorder – a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

Suicidal act (also referred to as suicide attempt) – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicidal behavior – a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior.

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide attempt survivors – individuals who have survived a prior suicide attempt.

Suicide survivors – family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Unintentional – term used for an injury that is unplanned; in many settings these are termed accidental injuries.

Universal preventive intervention – intervention targeted to a defined population, regardless of risk; (this could be an entire school, for example, and not the general population per se).

Appendix X

Sample Templates and Draft Plans

Community Suicide Prevention Plan
Template

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?
Goal Number:_____
Goal Statement:

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
B. Who will get the information?
C. Start and Completion Dates for getting information
5.2 Decision Making
Meet with work group or community, share information, brainstorm, and decide on a plan. Decide on how we will know if our plan is successful (evaluation).
5.3 Step by Step Planning
For each step in the plan be sure to state:
Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success
Costs (budget)

6. Implement the Plan.
Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

Step by Step Planning

State Plan Goal #

Goal Coordinator:

Community Goals	Steps	Resources Needed	Responsible Party	Start Date	End Date	Marker for Success	Costs

Community Suicide Prevention Plan

Sample – a local church

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?
Goal Number:___**3**__
Goal Statement: **Alaskans recognize that mental illness substance use and suicidality are disorders that respond to specific treatments and that are part of health care. There is no stigma associated with these disorders.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?
The church congregation will support members and families who experience mental health, substance abuse or suicidal behavior. We will be better informed about these problems.

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
A family who experienced a suicide said they felt isolated in their grief. Other parishioners reported feeling they didn't know what to do or say.

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
Minister Jack
Sunday school teacher Alice
Member Peter who is a psychologist
Dan and Betty, suicide survivors
Members of religious education committee, Paul, Elizabeth, Sarah
Etc.

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
Other churches that have addressed this problem and how they have done it. Basic facts about Mental Illness, Substance Abuse, Suicide
B. Who will get the information?
Minister Jack and Psychologist Peter
C. Start and Completion Dates for getting information
February 1 start March 1 complete

5.2 Decision Making
Meet with committee share information, brainstorm, and decide on a plan to meet the goals. Decide on how we will know if our plan is successful. (evaluation).

5.3 Step by Step Planning
For each step in the plan be sure to state:
Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success
Develop a budget and seek funds if needed.

6. Implement the Plan.
Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

(see the sample Step by Step Plan on the following page)

Step by Step Planning (sample Goal 3 – a local church)

State Plan Goal 3 Alaskans recognize that mental illness substance use and suicidality are disorders that respond to specific treatments and that are part of health care. There is no stigma associated with these disorders.

Goal Coordinator: Pastor Jim

Community Goals	Steps	Resources Needed	Responsible Party	Start Date	End Date	Marker for Success	Costs
1. The church congregation will support members and families who experience mental health, substance abuse or suicidal behavior. We will be better informed about these problems.	1. Select or develop materials on mental illness, substance abuse and suicide that are appropriate to adult and teen members of church.	1. Internet, phone, computer, possibly writer and artist. Printer.	1. Peter and Paul	3/2/04	3/31/04	1. Posters, pamphlets for adults and teens.	1. $200
	2. Plan and schedule sermons, discussion groups, speakers and religions school classes on mental illness, substance abuse and suicide.	2. Expert speakers, information, videos. Contact appropriate professional and membership organizations.	2. Minister Jack, teacher Alice, survivor family.	3/5/04	3/31/04	2. Coordinated schedule for education efforts.	2. video rental $100
	3. Deliver activities as planned.	3. Time, meeting space.	3. Minister Jack	4/1/04	5/15/04	3. Number of sermons, classes, discussion groups, lectures etc.	3. $50. coffee/ cookies etc.
	4. Form on-going committees for continuing education and support.	4. People who agree to serve.	4. Elizabeth for education, Survivor family for support.	5/1/04	On-going	4. Committees have at least 5 members, meet regularly, provide educational programs, 4x year and offer support and en-couragement.	4. none

Community Suicide Prevention Plan

Sample – a small Alaska Native village plan

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?

Goal Number:___**4**__

Goal Statement: **Alaskans manage guns and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.**

2. What will it look like in our community?

What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?

The community would like to manage their guns and other potential items of self-harm.

1. 90% - All the rifles/handguns in this village have trigger locks or guns are locked in safes; Ammo and guns are kept in separate locations

2. All children by the age of 10 have successfully passed a certified gun safety course.

3. 90% of all of the homes have locks on their medicine cabinets and household poisons.

4. Health care providers, educators, and health aides in my community routinely use a screening tool for asking the question.

5. 90% of the homes have the poison control number posted by their telephone

3. Where are we now?

What is the problem we are trying to solve or situation we are trying to change?

Guns and other items of potential self-harm are too readily accessible. People handle guns when they are intoxicated. People don't know about poison control. People aren't being asked or informed about safe storage issues.

4. Who is willing to work on this?

Form a work group, task force or committee.

Members and Contact Information

Health Aide Mary.....

VPSO Tom.....

Council member Jack .....

Community member(s) Ella .....

Bill .....

Etc.

5. What are we going to do: developing an action plan.

5.1 Information Gathering

A. What information do we need?

Other places or programs that have addressed this problem and how they have done it.

B. Who will get the information?

Tom and Mary

C. Start and Completion Dates for getting information

5.2 Decision Making
Meet with work group or community, share information, brainstorm, and decide on a plan to meet the goals. Decide on how we will know if our plan is successful (evaluation).

5.3 Step by Step Planning
For each step in the plan be sure to state:
Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success
Develop a budget and seek funds if needed.

6. Implement the Plan.
Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

(see the sample Step by Step Plan below)

Step by Step Planning (sample Goal 4 – a small Alaska Native village plan)

State Plan Goal 4 Alaskans manage guns and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

Goal Coordinator: Tom VPSO

Community Goals	Steps	Resources Needed	Responsible Party	Start Date	End Date	Marker for Success	Costs
1. 90% - All the rifles/handguns in this village have trigger locks or guns are locked in safes; Ammo and guns are kept in separate locations.	1. Posters and flyers to inform village of project	1. Artist, writer, paper, copy machine.	1. Mary Jane	8/1/04	8/10/04	1. 200 posters and flyers distributed.	1. $50 for paper and copying
	2. Survey village: count guns by type and whether person prefers lock or safe.	2. Two people, tracking form, pen, time.	2. Ella	8/10/04	8/1704	2. Completed tracking form with info from 90% of households.	2. None. Paper, pens donated by council.
	3. Order # of locks and safes from ANTHC.	3. One person, phone.	3. Tom	8/18/04	9/1/04	3. locks & safes arrive in village.	3. None. ANTHC donation

Community Goals	Steps	Resources Needed	Responsible Party	Start Date	End Date	Marker for Success	Costs
	4. Community Potluck to teach how to use and distribute	4. Room, food, dishes etc., publicity, printed information, instructors	4. Sarah Jane	9/6/04	9/6/04	4. 90% of households attend.	4. $25 paper plates etc. $25 turkeys $25 pop Contributio ns from families and stores
	5. One week follow-up home visits.	5. information sheets, tracking forms	5. Tom	9/13/04	9/15/04	5. 60% of households visited with 90% of those using locks or safes.	none
	6. 3 month follow-up sample home visits.	6. Information sheets, tracking form	6. Tom	2/15/05	2/17/05	60% of households visited, 90% continue to use locks or safes	none
	7. 1 year follow-up sample home visits.	7. Information sheets, tracking form	7. Tom	9/15/05	9/17/05	60% of households visited, 90% continue to use locks or safes	none
	8. Evaluation report and continuation plan.	8. Tracking forms	8. Tom and committee	9/18/05	10/18/05	Report and plan to continue to support safe storage project completed and presented to community.	none
Goal 2. All children have successfully passed a certified gun safety course by age 10.	STEP BY STEP	PLAN	DEVELOPED	AS IN	GOAL	ONE	
Goal 3.90% of all homes store medicines and household poisons in locked cabinets.	STEP BY STEP	PLAN	DEVELOPED	AS IN	GOAL	ONE	
Goal 4. 90% of homes have the poison control number posted by their telephone.	STEP BY STEP	PLAN	DEVELOPED	AS IN	GOAL	ONE	

Community Suicide Prevention Plan
Sample – Alaska Mental Health Board

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?

Goal Number **9**
Goal Statement: **Alaskan Behavioral Health Programs will treat suicidality effectively using appropriate current practice Guidelines.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? ~~What will be the end result?~~
This pertains to the statewide behavioral health provider community.
1. All Alaska Behavioral Health Programs will become and remain knowledgeable about current evidence based practices for treating suicidality.
2. All Alaska Behavioral Health Programs will use current evidence based practices appropriate to their client population and clinical capabilities.

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
Currently it is up to each program to keep current with evidence based practice guidelines and it can be difficult, especially for smaller programs to do so. Similarly, there is no uniform application of appropriate evidence based practices.

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
Two members of Ak. Mental Health Board
Mental Health Board research analyst
Two representatives of Behavioral Health Programs

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
We need information about evidence based practices. We need to contact the American Association of Suicidology; the American Foundation for Suicide Prevention, The Suicide Prevention Resource Center, the American Psychiatric Association, the American Psychological Association, the National Institute of Mental Health, the Alaska Division of Behavioral Health, the Alaska Statewide Suicide Prevention Council.

B. Who will get the information?
Research Analyst and one Board member
C. Start and Completion Dates for getting information
January 1 – January 30
5.2 Decision Making
Meet with entire committee, share information, agree on guidelines to disseminate and develop preliminary plan for dissemination and continued updating. Develop Step by Step Plan which will include: development and distribution of evidence based guidelines in written form, websites references, a face to face training plan, development of procedures to insure clinical licensing requires the CEUs include training in

evidence based guidelines for treatment of suicidality, plan to work with DBH to include documented use of evidence based treatment guidelines in quality assurance reviews.

5.3 Step by Step Planning
For each step in the plan be sure to state:
Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success
Develop a budget and seek funds if needed.

6. Implement the Plan.
Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

Community Suicide Prevention Plan
Sample – a residential school

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?

Goal Number **11**
Goal Statement: **Alaskan communities respond appropriately to suicide attempts and deaths by suicide.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?
1. We will have a written plan to provide guidance and direction to all staff in responding to a death by suicide or a suicide attempt.
2. All staff will be trained 2x/year at the start of each semester so that they understand the plan and their part in it.
3. There will be no additional suicides and suicide attempts will be reduced by 75% from the number in the academic year 2003-4.

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
Two students completed suicide during the 2003-4 school year and there were 10 suicide attempt with 6 of those requiring inpatient treatment.

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
School Principal
School Counselor
Director of Dormitory Life Program
House parents Judy and Jack
Teachers Ed and Jane
Student representative Evan

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
Policies and programs from other residential schools (Mt. Edgecumbe and ??)
Information from suicide prevention organizations including Suicide Prevention Resource Center, American Association of Suicidology, American Foundation for Suicide Prevention, Alaska Division of Behavioral Health, Alaska Statewide Suicide Prevention Council.
Information from Alaska Department of Education and Early Development.
B. Who will get the information?
Counselor, Ed and Judy
C. Start and Completion Dates for getting information
June 1 start June 30 complete.
5.2 Decision Making
Meet with entire committee, share information, brainstorm, and develop preliminary outline for crisis response plan. Develop Step by Step Plan which will include: who will write the plan; who will develop

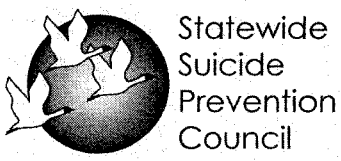
the training on the plan; a schedule for the committee to review drafts; target date for completion of the plan; target dates for training; evaluation plan for training, cost of any materials needed.

5.3 Step by Step Planning
For each step in the plan be sure to state:
Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success
Develop a budget and seek funds if needed.

6. Implement the Plan.
Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.



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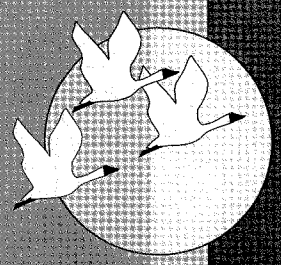
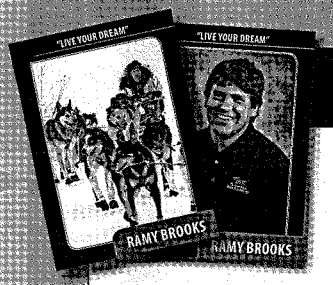
January 2006

Statewide Suicide Prevention Council



Annual Report to the Legislature: 2006



Ramy Brooks

During 2004/2005 Ramy Brooks, Iditarod Musher and Yukon Quest Winner, became a Champion and hero of a new sort for many Alaskans suffering from mental illness and the damaging effects of alcohol and other substance abuses. Ramy tells his life story in *One Boy Walks Along the Yukon - A Journey in Despair; A Journey of Hope**. He shares his teenage struggles with suicide ideation, his own suicide attempt and the second chance he found to live his dream. Ramy continues to speak across the state and nation about suicide prevention and awareness, realizing that his new-found strength is a gift he needs to share. Ramy's involvement in this Coodinated Communication Campaign to reduce stigma and increase awareness that treatment works was made possible by funding through the Alaska Menal Health Trust Authority.

One Boy Walks Along the Yukon – A Journey in Despair; A Journey of Hope* can be found in its entirety at **www.hss.state.ak.us/suicideprevention

Frank H. Murkowski
Governor
Karleen Jackson
Commissioner

FY'06 Performance Measures

In response to the 2005 legislative Suicide Prevention Council sunset extension hearings, Council members drafted the following performance measures to guide their work over the next several years. These measures were chosen to respond directly to the legislative audit findings and more importantly to reflect the Council's concern with Alaska's high suicide rate.

Performance Measure 1.

In an effort to get Alaska off the national list of the "top ten" states with the highest suicide rates for the first time since 1991. The Statewide Suicide Prevention Council will partner with the Division of Behavioral Health to reduce the 3-year average rate of Alaska suicides from 21 deaths per 100,000 population to 15 per 100,000, representing a 29% decrease over a 7 year period.

Progress

The current 3-year Alaska suicide rate for 2002-2004 is 21.59/100,000. This is an increase from the 3-year average listed above of 21.1/100,000 illustrating the high number of Alaskans who took their lives during 2004; a total of 154. This data indicates that the Council and the Division of Behavioral Health was unable to meet its goal and decrease the rate to 20.1/100,000. The Council and the Division, however, have increased their suicide prevention and awareness efforts through the enhanced media campaign, additional Gatekeeper trainings, and mandatory training for the Community Based Suicide Prevention grantees.

The 3-year average rate
for 2002 - 2004 = 21.1/100,000

2006 | 21.1 X 5% = 1.05 = 20.1/100,000
2007 | 20.1 X 5% = 1.01 = 19.1/100,000
2008 | 19.1 X 5% = 0.95 = 18.14/100,000
2009 | 18.14 X 5% = .91 = 17.23/100,000
2010 | 17.23 X 5% = .86 = 16.37/100,000
2011 | 16.37 X 5% = .82 = 15.55/100,000
2012 | 15.55 X 5% = .78 = 14.78/100,000

Performance Measure 2

On a yearly basis, review and update the Statewide Suicide Prevention Plan as indicated by community feedback and Council member's recommendations.

Progress

In May 2005, the SSPC Plan was revised.

Performance Measure 3

Through the Follow-Back Study and other data sources, consistently review data and information in an effort to identify trends, make analysis and forward recommendations to the department regarding prevention, education and services needed statewide.

Progress

Progress. The Alaska Injury Prevention Center and our research partners (American Association of Suicidology and the Critical Illness and Trauma Foundation) have collected data on suicides in Alaska since September 1, 2003. A preliminary analysis of data from September 1, 2003 through December 31 2004 has been completed and submitted to the Alaska Suicide Prevention Council.

Performance Measure 4

Support and assist Alaskans in starting a SPAN~Alaska (Suicide Prevention Awareness Network) affiliate. This grass root community effort enlists the support of individuals to:

a) Establish a group who will oversee the SPAN~ Alaska affiliate by becoming a 501 (c) 3 non-profit; draft Articles of Incorporation and bylaws;
b) Sign up a minimum of 150 new members
c) Survivor Support Groups

1) Develop a Survivor Support Group list
2) Gather baseline data on the number of Survivor Support Groups
3) Track the increase of Survivor Support Groups

Progress

The SSPC had a Council member volunteer to act as a liaison to the group of suicide survivors who informally work with the Council to provide information, recommendations and suggestions. The Alaska state team who attended the suicide prevention conference in Portland Oregon has also partnered and merged with this group. Together they have decided not to become a SPAN affiliate member but will continue to work on suicide prevention and awareness efforts including survivor support groups. This ad hoc group of Alaskan suicide survivors and other interested persons felt that decision-making and fundraising efforts should be kept at the community level resulting in the SPAN affiliate performance measure being removed as an indicator during FY06.

Performance Measure 5

Support the Division of Behavioral Health in its efforts to increase the number of communities who can recognize the warning signs of suicide by tracking the number of Community-based Suicide Prevention Grantees who align their community suicide prevention funding with the Statewide Suicide Prevention Plan

a) Conduct 8 community trainings on the use of the Statewide Suicide Prevention Plan
b) Track the number of trainings provided from July 1, 2005 – June 30, 2006

Progress

The Division of Behavioral Health Request for Proposals required that all Community-Based Suicide Grantees align their suicide prevention efforts with the suicide prevention plan. To date the Council has provided 4 trainings on the use of the Statewide Suicide Prevention Plan. These trainings took place at the DBH Community Based Suicide Prevention grantee meetings, Alaska Federation of Natives and the Public Health Summit. Future trainings are scheduled in Anchorage, Juneau and Bethel.

Performance Measure 6

Assist the Division of Behavioral Health in their SAMSHA Garrett Lee Smith Memorial Act youth suicide prevention application and if awarded in its implementation.

Progress

The Council actively participated in the planning and developing the state's Garrett Lee Smith Memorial Act youth suicide prevention application. Although Alaska's application was not successful, some of the activities that had been included in the response, such as, the Gatekeeper training and extending the Follow-Back Study have been funded through other avenues.

Performance Measure 7

Provide technical assistance to Boys & Girls Clubs of Alaska statewide youth suicide prevention initiative, Project LEAD (Leadership, Education, Acceptance and Determination). Project LEAD build protective factors in youth through academic and leadership programming, along with alcohol and substance abuse prevention programming.

Progress.

Project LEAD is targeted towards at-risk and in-crisis youth in Clubhouse communities throughout urban and rural Alaska. The project empowers instructors in 22 communities to network with mental health and medical providers, school counselors, cultural leaders, churches and parents to identify and serve at-risk and in-crisis youth. In the project's first year, 16 youth suicide interventions took place. As of June 30, 2005, 61 suicide interventions occurred; three interventions were suicide pacts involving a total of nine young people.

The Suicide Prevention Council provides technical support to the program via research and best practice updates and referral resources, and training and conference opportunities. This support is essential to the success of the 85 Club professionals trained in suicide intervention and prevention, and the 243 at-risk and in-crisis Club members currently being monitored.

Performance Measure 8

Gather data from the Division of Behavioral Health on the SAMHSA funded Gatekeeper Training.

a) Number of trainings held
b) Number of attendees

Progress

From October 1, 2004 to September 30, 2005, pilot implementation of the Targeted Gatekeeper Training was completed. This included the completion of the Targeted Gatekeeper Training Manual, a Gatekeeper Participants manual, and seven piloted Gatekeeper workshops across Alaska. Phase II of the Gatekeeper Training Project will focus on disseminating gatekeeper information through the train-the-trainer approach. Timeline: Phase II Targeted Gatekeeper Training is scheduled for completion by September 2006.

Targeted Gatekeeper Pilot Training Sessions

Date	Location	Audience	Participants
March 18, 2005	Anchorage	Law Enforcement - Urban	9
April 8, 2005	Sitka	Law Enforcement - Rural	8
April 22, 2005	Juneau	Health Care - Urban	9
May 13, 2005	Fairbanks	Health Care - Rural	10
May 27, 2005	Fairbanks	Clergy - Urban	7
June 17, 2005	Dillingham	Clergy - Rural	1
July 21, 2005	Anchorage	Campus Residence Life staff - Urban campus	12
August 17, 2005	Anchorage	UAA-Residence Advisors - Urban campus	63

Suicide Prevention Council Member

Annual Performance Measures

Over the last two years the Council has had a turn-over in both members and staff, and as a way to fully engage these new members the executive committee drafted a council member yearly performance measure checklist. This checklist serves many purposes but most importantly gives guidance and direction for active member participation; a way to keep suicide prevention efforts on the "front burner" between quarterly meetings.

1. Present statewide suicide prevention plan in two public venues.

   These venues might include conferences, training opportunities, forums or panel discussions, and guest speaking engagements. The Council member will provide a written or oral report on presentations to the full Council including date, audience, context, and feedback.

   Date completed ___/___/___
   Date completed ___/___/___

2. Submit two digital photographs and one written article of member or constituent activity relevant to suicide prevention awareness or activities for the legislative report.

   Date completed ___/___/___

3. Arrange and attend at least two meetings with legislators, other than Council members who are legislators, to discuss the Council's mission, activities, and performance measures.

   These meetings may take place in Juneau during the legislative session or in your hometown during the rest of the year.

   Date completed ___/___/___

4. Convene and/or participate in three committee meetings, and perform assigned committee tasks in a timely and accurate manner.

5. Submit one Letter to the Editor to a newspaper of member choice addressing suicide prevention awareness and Council activities.

   Date completed ___/___/___

6. Demonstrate meaningful participation in a statewide or worldwide suicide prevention effort (i.e. Worldwide Suicide Prevention Awareness Day, September 10th).

   Date completed ___/___/___

7. The above items may be substituted for leadership on a significant Council priority/project that impacts the visibility, longevity and/or financial sustainability of the Council.

'06 Highlights & Accomplishments

The Alaska Mental Health Trust Authority in partnership with the Council, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Governor's Council on Disabilities and Special Education, and the Alaska Traumatic Brain Injury Association worked together through the Coordinated Communications Campaign to increase awareness that treatment works in an effort to reduce stigma. The "YOU KNOW ME" print, radio and television announcements are a part of this campaign and have been running for the past six months and have resulted in an increased amount of calls to the CARELINE.

The Council has enhanced relationships with the above-mentioned entities by:

- ensuring that time is allotted on Council's agenda for each to provide updates and discuss concerns;
- participating in the bi-weekly Coordinated Communications work group;
- participating in weekly legislative committee meetings during the session;
- drafted a MOA with the Trust depicting roles and responsibilities for each;
- worked together on the Comprehensive Integrated Mental Health Plan;
- shared national data and teleconference training opportunities; and
- provided (at no cost) posters, pens, pencils and magnets to beneficiaries and providers as requested.

The latest suicide prevention campaign effort consists of various colored silicone bracelets with "Live Your Dream." printed on the outside, and "To talk, call 1-877-266-HELP" on the inside. When designing this idea the council worked toward targeting Alaskan youth, both rural and urban. The positive exterior message is clear and succinct with a link to a resource on the interior.

Risk Factors
Signs a person might be suicidal

- Talks about suicide – seriously or "just kidding".
- Has attempted suicide before.
- Has trouble eating or sleeping.
- Prepares for death – makes out a will and final arrangements.
- Gives away prized possessions.
- Has had recent severe losses, lost someone to suicide.
- Drastic changes in behavior.
- Withdraws from friends, social activities.
- Loses interest in hobbies, work, school.
- Takes unnecessary risks.
- Loses interest or dramatic change in personal appearance.
- Increases use of alcohol or drugs.

Ways to Help

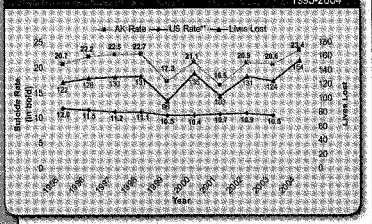
- Be willing to listen. Allow expression of feelings. Accept the feelings.
- Be non-judgemental. Don't lecture the value of life.
- Don't dare someone to do it.
- Don't be sworn to secrecy. Connect with services specializing in crisis intervention. Offer to accompany the person in need.
- Pay attention when a person "just kids" about ending it all.
- Offer hope that alternatives are available, but don't offer glib reassurances.
- Take action: Remove means, such as guns or stockpiled pills.

www.hss.state.ak.us/suicideprevention

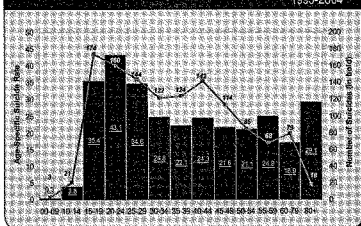
Alaska suicide information and data

from the Department's Bureau of Vital Statistics

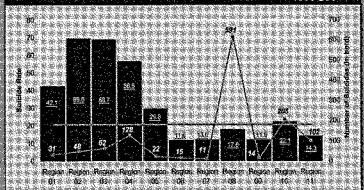
Alaska Suicide Rates
1995-2004



Alaska Age-Specific Suicide Rates and Numbers
1995-2004

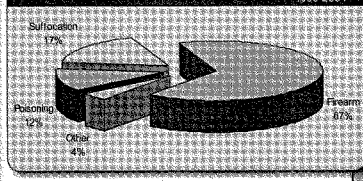


Alaska Suicide Rates & Numbers by Region
1995-2004

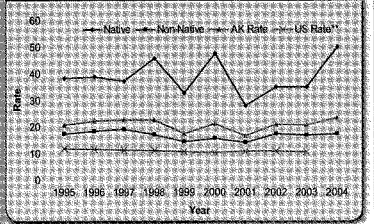


Region Key: 01-North Slope Borough, 02-Northwest Arctic Borough, 03-Nome census area, 04-Wade Hampton census area, Bethel census area, 05-Dillingham census area, Bristol Bay Borough, Lake Peninsula Borough, 06-Kodiak Island Borough, 07-Aleutians East Borough, Aleutian West census area, 08-Matanuska-Susitna Borough, Municipality of Anchorage, Kenai Peninsula Borough, 09-Valdez-Cordova census area, 10-Juneau Borough, census area, Fairbanks North Star Borough, Southeast Fairbanks census area, Denali Borough, 11-Haines Borough, Ketchikan Gateway Borough, Sitka Borough, Wrangell-Petersburg census area, Prince of Wales-Outer Ketchikan census area, Skagway-Hoonah-Angoon census area

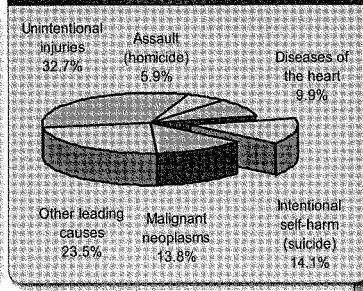
Suicide Methods in Alaska
1995-2004



Alaska Native, Alaska Non-Native, and U.S. Suicide Rates
1995-2004



Percentage of Years of Potential Life Lost by Leading Cause of Death
1995-2004



**U.S. suicide rate for 2003 is preliminary and 2004 data is unavailable at time of publication

Division of Behavioral Health *corner*

The mission of the Division of Behavioral Health is to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships. The vision of the Division of Behavioral Health is "Partners promoting healthy communities."

"Partners Promoting Healthy Communities" means that communities are given technical assistance and guidance in developing their programs to allow for the integration of local culture, resources and community readiness into their programming. When communities are able to identify key players, and assess readiness with reference to their issue, strategies to address the issue become more apparent. It is vital that community readiness be ascertained when developing strategies, to ensure program effectiveness, appropriate outcomes measurements and program evaluation. "Building Healthy Communities" seeks to assist and allow communities to increase their capacity for addressing problem issues in a localized way, which braids the larger preventative concepts with specific strategies which are meaningful and effective on the local level.

To this end, the Division of Behavioral Health released its Comprehensive Behavioral Health Prevention and Early Intervention Services Request for Proposals (RFP) on March 25, 2005 for FY06. This three-year funding opportunity combined the Community-Based Suicide Prevention Program with Substance Abuse Prevention funds, FASD funding, and Youth Resiliency funds to reflect an integrated approach to the combination of these services. A second round of applications were accepted in July, 2005, to allow for communities under 2000 to meet the requirements of the RFP with additional technical assistance from DBH staff. In all, 24 communities received funding under the umbrella of suicide prevention programming. In the RFP, applicants who chose to apply for Community-based Suicide Prevention funds were directed to incorporate the Statewide Suicide Prevention Plan in their programmatic goals. The overall goal for all grantees is "To Promote a Healthy Community Utilizing Effective Practices and Partnerships." Funded communities will continue to receive ongoing technical assistance from DBH in implementing effective practices and outcome measurements to achieve one of three long-term community impacts:

1. Reduction in the harmful effects of substance abuse in one or more communities;
2. Reduction in incidents of suicide and non-lethal suicidal behaviors in one or more communities; and/or
3. An increase in community members' connectedness, resiliency and life skills in one or more communities.

A general grantee meeting was held in September, 2005. Together, the Statewide Suicide Prevention Council and DBH presented training on the Statewide Suicide Prevention Plan, and provided grantees with an update of the Targeted Gatekeeper Training to be completed by September 2006.

Alaska Suicide Follow-Back Study

Partial 2005 Information

From January 1, 2005 through September 30, 2005, there were 96 suicide deaths in Alaska as reported by the state Medical Examiners Office. Of those, 21 were females and 75 were males. Nine were younger than 20, 25 were in their 20's, 19 were in their 30's, 25 were in their 40's, 9 in their 50's, and 9 were 60 or older.

Of the 96 cases so far in 2005, there have been 6 follow-back interviews completed and another 5 are pending. There is a delay of several months before an interview is conducted due to ethical considerations and as a courtesy to the grieving family members. Analysis of the data from 2005 will not be completed until Summer of 2006. It is at this point that the richer information that addresses the research questions listed above will become available.

The suicide data that we have compiled for deaths taking place between January 1 – September 30, 2005 in Alaska include (It is important to know that this is not final information). It is based on the best available sources collected to date, and are subject to change.

Racial Demographics

- 37 Caucasion
- 35 Native
- 3 Other
- 7 Unknown

Method of Suicide

- 60 Gun
- 26 Hanging
- 8 Drug Overdose
- 2 Unknown

Known or suspected use of Alcohol or Drugs

- 9 No
- 45 Yes
- 42 Unknown

Location of Death

- 26 Anchorage
- 9 Fairbanks
- 33 Rural
- 25 On the Road System and South East

AIPC also analyzed two years worth of hospitalized suicide attempts to add to our knowledge base of the problem. Also important to note is that the Alaska State Legislature and the Alaska Mental Health Trust Authority (AMHTA) have been major funders for the follow back study.

Summary of the Suicide Attempt Hospitalization Study:

Introduction

In 2002, nearly 32,000 people took their own lives in the United States, and estimates indicate that 20 times that number sought treatment for self-inflicted injuries. Alaska had the highest age adjusted suicide rate of all the states in 2002 at 21.12, which is nearly double the U.S. rate of 10.99 per 100,000 population. An average of 125 people die from suicide each year in Alaska, making it the number one cause of death for Alaskans under the age of 50 years (if unintentional injuries are examined individually instead of grouped). The epidemiology for suicide deaths is very different from the epidemiology for suicidal acts that result in hospitalization. This analysis looks at the epidemiology and costs associated with hospitalizations for self inflicted injuries.

Results

Using data supplied by the Alaska Trauma Registry (ATR) and funding from the Alaska Mental Health Trust, the Alaska Injury Prevention Center (AIPC) conducted a thorough analysis of the 1,223 hospitalized suicide attempts in Alaska for 2001 and 2002. The epidemiology and hospital costs associated with this injury group are reported below.

Interesting Facts

- The average age for the patients was 30 years.
- The average length of each hospital stay was 4 days, with a range of 1 to 366.
- The average hospital costs per year were $5,508,363.
- The average cost per case was $8,986.
- Over 75% of the hospital costs were paid through public funding sources.

More than $4 million in "public funds" is spent each year to care for suicide attempts, and those are just the documented hospital costs. Physician's fees and other specialist's fees are usually not included in the hospital costs. Also not included in hospital costs are self-inflicted injuries that result in death or long-term disabilities. These suicidal acts take a huge toll on individuals and families and are very difficult to quantify.

Conclusions

The method of choice for those being hospitalized for self-inflicted injuries was an overdose of some kind of medication, accounting for 77% of the cases. The predominant type of medication was Tylenol, which is very destructive to the liver in high doses. A public education program about the long-lasting side affects of Tylenol could possibly decrease its use as a substance for self-harm.

The hospital costs associated with suicide attempts in Alaska are considered by some experts to be less than one half of the actual expenses incurred for these cases. The annual hospital costs of over $5.5 million, balloons quickly when transportation, physicians, radiologists, surgeons, psychiatrists, psychiatric inpatient facilities, and other professional expenses are added. Also, follow-up care becomes an expense that could not be captured from the Alaska Trauma Registry. Approximately $1 million per year of these expenses have to be absorbed by the hospitals because the patients can't pay.

These monetary costs don't begin to cover the pain and suffering of individuals and families who are compelled to seek this form of resolution to their problems. More effort and funding should be devoted to screening, counseling, and other prevention programs.

www.hss.state.ak.us/suicideprevention

Council Historical Overview

By statute, the Statewide Suicide Prevention Council consists of 15 members, 11 appointed by the Governor and 4 by the Legislature. The Governor appoints: two executive branch state employees; one member of the Advisory Board on Alcoholism and Drug Abuse; one member of the Alaska Mental Health Board; a designee from the Alaska Federation of Natives, Inc.; a counselor in a secondary school; an adult active in a statewide youth organization; a person who has experienced a family member's death by suicide; one person who resides in a rural community not connected by a road or Alaska marine highway to the state's main road system; a member of the clergy; and a youth under eighteen. The senate president appoints one majority member of the Senate; the speaker of the house appoints one majority and one minority of the House.

The Council shall serve in an advisory capacity to the legislature and governor with respect to what actions can and should be taken to:

- Improve health and wellness throughout the state by reducing suicide and its effect on individuals, families and communities;
- Broaden the public's awareness of suicide and the risk factors related to suicide;
- Enhance suicide prevention services and programs throughout the state;
- Develop healthy communities through comprehensive, collaborative, community-based approaches;
- Develop and implement a statewide suicide prevention plan; and
- Strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

2006 Suicide Prevention Council Members

William Martin, Chair - Alaska Federation of Natives
Tom Pittman, Chair-Elect - Public
Noelle Hardt, Recorder/Treasurer - Statewide Youth Organization
Stan Tucker, Member-at-Large - Clergy
Kelsi Ivanoff, Student
Charles Jones, Public
Brenda Moore, Alaska Mental Health Board
Lucy Hudson, Advisory Board on Alcoholism and Drug Abuse
Mario Gatto, Secondary School
Bill Hogan, Department of Health and Social Services Deputy Commissioner
Renee Gayhart, Department of Health of Social Services, Tribal Health Manager
Sen. Ben Stevens
Sen. Kim Elton
Rep. Nancy Dahlstrom
Rep. Woodie Salmon

The Council would like to thank and extend their heartfelt appreciation to Jeanine Sparks and Karen Perdue for their dedication and support throughout their tenure on the council.

Kathy Craft
DHSS Office of the Commissioner
Statewide Suicide Prevention Council Coordinator
907-451-2017
Kathryn_Craft@health.state.ak.us

Alaska Suicide Prevention CARELINE: 1-877-266-4357
In Fairbanks, 452-4357
National LIFELINE: 1-800-273-8355

www.hss.state.ak.us/suicideprevention

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This publication is intended to provide information to the public on the Statewide Suicide Prevention Council.

PREPARED STATEMENT OF DONNA VIGIL, EXECUTIVE DIRECTOR, DIVISION OF HEALTH PROGRAMS, WHITE MOUNTAIN APACHE TRIBE, NORTHERN ARIZONA

My name is Donna Vigil, I represent the White Mountain Apache Tribe in northern Arizona in my capacity as executive director of the Division of Health Programs. I am a member of the White Mountain Apache Tribe, being born and raised on the reservation. I have here with me Dr. Noreen Ashley, director of the Apache Behavioral Services. Our tribe has approximately 17,000 members, of which close to 15,000 live on the reservation.

Before I go any further, I would like to say Ronnie Lupe, chairman of the White Mountain Apache Tribe sends his highest regards to all of you, especially to his close friend Senator McCain. He considers all the members of the U.S. Senate Committee on Indian Affairs as friends to the White Mountain Apache people.

Suicide is one of the greatest challenges facing our people, particularly our children and young adults. Our rates of attempted and completed suicide are 17 times higher than those of all other races in the United States, and five [5] times higher than all other American Indian and Alaskan Native tribes. Attempts among our youth have increased 11 percent in 1 year. In 2001, our tribe experienced the loss of four young people to suicide in a very short time period. Each suicide attempt or completion sends a ripple through our small tribal community of incalculable suffering, grief and years of productive life lost. I often wonder what would happen if Falls Church, VA were to suddenly experience an unemployment rate of over 50 percent, a high school drop out rate of over 54 percent, a substance abuse rate reaching epidemic proportions, and a suicide rate over 17 times the national average. What kind of Federal and State support would be forthcoming?

With little Federal support, our community has come together to address the issue of suicide on many fronts. Showing considerable foresight, the tribal council appointed a Suicide Task Force in 2001. The task force is headed by an employee of Indian Health Service who is a community member and a member of the tribe. The Suicide Task Force worked with Johns Hopkins University to obtain a NARCH grant to do research on suicide. Through the encouragement of the Task Force and NARCH the tribal council passed a resolution to establish a suicide registry. Those who have been identified as being at high risk are provided with referrals to our mental health facility for treatment and periodic case management. In a 1-year period, there have been over 300 referrals to two full time workers, who are monitoring and providing assistance.

In addition to the Suicide Task Force, a High Risk Response Alliance was established in October 2005 through the tribe's mental health clinic, Apache Behavioral Health Services. This was a grassroots effort to involve the community in responding to the suicides.

Our mental health center has attempted to tap into the cultural and spiritual underpinnings of Apache life to suicidal people. They have sponsored a Minister's Alliance, a group of ministers and pastors from the 60 churches on our reservation. One recent activity organized by the Minister's Alliance was a community prayer walk that focused on visiting the places where people had successfully killed themselves. More recently, a Traditional Alliance has formed and is in the process of planning a reservation-wide ceremony to engage those Tribal members who adhere to traditional beliefs. As Apaches, we are deeply spiritual people all efforts to combat suicide must include spirituality to be successful. As you have-heard, we are taking steps to address our suicide problem. However, our efforts are limited due to several critical barriers.

First, there are not enough professional and paraprofessional health care providers trained and skilled in suicide response that is also familiar with the Apache way of life and Native spirituality. Our desire is to train and employ more tribal members to meet this need. We need Apache speakers, people who know the culture and the community to work with our suicidal tribal members. Thus, we want to train more Apache people to reach out to our suicidal family members, friends and neighbors. Unlike the majority culture, we do not have a professional class to do this work. We must do it ourselves. Our mental health center, Apache Behavioral Health Services, is partially funded by a Public Law 638 contract agreement with Indian Health Service. It is also supported though third-party billing of Arizona's Medicaid programs. We are fearful that because of new professional and educational certification requirements in counseling and substance abuse treatment, our paraprofessional workers will eventually lose their ability to receive reimbursement for their good work. This must not happen. Even though he or she may not possess a doctorate in psychology, a well-trained Apache mental health outreach worker with a high school diploma who visits suicidal people in the field can often do more to decrease the risk of suicide of an Apache person than any doctor-degreed non-Apache person.

Therefore, we must retain our ability to bill Medicaid programs for services provided by qualified, non-degreed paraprofessional mental health workers.

Second, we need to develop a 24-hour crisis response center whereby family members, friends and any concerned person can contact a trained crisis response professional or trained volunteer to provide immediate assistance. By necessity, this center would need to have satellite locations throughout the 1.7 million acre Fort Apache Reservation in order to be able to provide the rapid response needed when persons are considering suicide as a solution to their immediate problems.

Third, substance abuse is a major underlying causal factor of suicide among our people. Data indicates that more than 30 percent of White Mountain Apache adults abuse drugs and more than 50 percent abuse alcohol. This is also related to the high morbidity and mortality rates among the WMAT people. Fundamentally, we need resources to expand outpatient and residential substance abuse treatment on our reservation. The current system for substance abuse treatment in the State of Arizona cannot meet the unique needs of White Mountain Apache adults and youth requiring services. In fact, it is nearly impossible to locate a culturally appropriate residential substance abuse center for Native American adults and teenagers in Arizona.

In conclusion, our needs are great and our resources are few. Our suicide rates are among the nations' highest and continue to escalate. While we have made great strides in responding to suicide attempts, we lack the resources to implement wide-scale prevention. Specifically, we need Federal support to:

1. Provide 24-hour culturally competent crisis intervention for youth and adults suffering with suicide ideation;
2. Create community-based substance abuse prevention and early intervention initiatives;
3. Establish a culturally competent substance abuse treatment facility on the reservation for adults and youth; and
4. Ensure Medicaid reimbursement for qualified, non-degreed paraprofessionals working in suicide response.

The White Mountain Apache Tribe and I are grateful that the U.S. Senate Committee on Indian Affairs has taken the time to investigate the needs of our people in the area of suicide prevention. It is our hope that this testimony has served to help define what measures must be enacted to assist us in reducing the number of suicide attempts and completions amongst Native American people.

One Sky Center

The American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health 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

U.S. Senate Committee on Indian Affairs
Oversight Hearing on Suicide Prevention Programs and their Application in Indian Country

May 17, 2006

Introduction and Overview

Mr. Chairman, Vice-Chairman, and members of the Committee, my name is R. Dale Walker, MD, and I am the Director of the One Sky Center, the American Indian/Alaska Native National Resource Center, funded by Substance Abuse and Mental Health Services Administration, and located at Oregon Health & Science University in Portland, Oregon. I would like to thank the Committee for inviting the One Sky Center to testify on the subject of suicide prevention and intervention in Indian Country, and to comment on recently introduced legislation by Senate Committee on Indian Affairs Chairman John McCain.

In June 2005, the One Sky Center had the honor of testifying on the issue of teen suicide prevention. As the first National Resource Center for American Indians and Alaska Natives dedicated to improving substance abuse and mental health services in Indian Country, the One Sky Center has been involved at several levels and at diverse venues to discuss and provide training, technical assistance, and lend expertise in the field and the topic of suicide prevention and intervention affecting American Indian and Alaska Native people and tribal communities.

The most frequent question we are asked about actual suicides is "why?" Original research and statistical data beyond the current limited information provided by the Centers for Disease Control and the Indian Health Service is needed to provide more insight to the cause and extent of the problem in Indian country, and for public education.

Lack of access to behavioral health services in Indian Country is a major problem and limiting step in addressing high incidence rates. For example, referrals from general

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health clinics, school counselors, and hot lines do not help when there is not behavioral service to access. The major funding shortfalls that the Indian Health Service experience on an annual basis continues to exacerbate the problem of providing the necessary clinical and behavioral health services tribal people and youth desperately need. In July 2003, the US Commission on Civil Rights documented the lack of Federal funding for healthcare, education, housing, public safety and tribal infrastructure development in their report, *the Quiet Crisis*. One year later, the Commission completed another report, *Broken Promises*, which clearly finds under funding for mental health and addiction services. One Sky Center staff consultations and technical assistance visits and evaluations confirm these findings. Lack of access is a problem.

Some tribal communities and organizations are becoming savvy, creative, innovative, and proactive to make changes happen on their own. This increases the productivity of federal investments toward improving access and effectives of behavioral health services. It would be useful if this were happening at a more rapid pace; but it is not.

One Sky Center Recent Efforts

The One Sky Center has developed an *American Indian/Alaska Native Community Assessment Tool Kit* (www.oneskycenter.org) that has proven to be effective and useful in tribal communities. I used this community assessment tool in working with the Standing Rock Sioux Reservation. This tool kit supports a "system of care" approach to organizing planning, policy and services. The community-based, systems of care approach are best practice in Indian Country. A plan that is developed for the community by the community with cultural relevancy and sensitivity rooted in tribal custom and values works best for tribes and their members.

Clusters of suicides and violence are major disasters on Indian reservations such as Standing Rock and Red Lake. In small tribal communities, everyone is connected with everyone else, including providers of care. The entire community is traumatized. In a way similar to Hurricane Katrina, the challenges overwhelm local capacity. Facilities are insufficient (e.g., ambulances). Systems of care crash when caregivers are directly victimized or crippled with grief. External support becomes essential. Tribal communities need to know how to work through and deal with the losses, as well as resolving the causes, and preventing further occurrences.

Last week, I presented at the Bureau of Indian Affairs Office of Indian Education Programs Emergency Preparedness and Response Symposium: *Strategies for Safer Education* Conference in Denver, Colorado. Tragedies have been occurring on Indian reservations. Public, private, BIA operated, and tribal schools are beginning to realize the need for emergency preparedness and response for their schools, and the surrounding tribal communities. Whether it's a suicide, violence, or a natural disaster, Indian Country needs to stand ready.

One Sky Center has sponsored the printing of a Native Youth Training Manual referred to as *Native H.O.P.E.* (Helping Our People Endure) authored by Clayton Small, PhD, and

Ernie Big Horn. The manual is a curriculum based on the theory that suicide prevention can be successful in Indian Country by Native Youth being committed to breaking the "Code of Silence" prevalent among all youth. The program also aims to increase "strengths" as well as awareness of suicide warning-signs among Native youth. The program supports the full inclusion of Native Culture, traditions, spirituality, ceremonies, and humor. A *Native H.O.P.E Training Facilitators Manual* is also available to assist adults and experience youth to serve as facilitators, rovers, and clan leaders in delivering the Native H.O.P.E. Curriculum.

Indian Country and its tribal leadership are stepping up its fight against teen suicide. The One Sky Center is one of many partners working with the National Congress of American Indians (NCAI) Policy Research Center on the issue of native youth suicide prevention. Next month at NCAI's mid-year conference in Michigan, a one-day *Native Youth Suicide Prevention Think Tank Discussion* will take place amongst some key tribal organizations and professionals. One Sky is pleased to be a part of this distinguished group of panelist, and to be a part of the ongoing dialogue in the area of suicide prevention and intervention. This meeting is a stepping stone leading up to next year's 2007 *AI/AN Policy Summit On Transforming Mental Health Care for Children and Families Through Planning, Policy, and Practice – Practice and Culture Based Solutions For Suicide Prevention, Intervention, and Healing* lead by NCAI, National Indian Child Welfare Association, Georgetown University, and its partners, including the One Sky Center.

The One Sky Center has been proud to be a strong force in elevating the profile of Indian health, but more specifically drawing attention to the issues of substance abuse and mental health in Indian Country, namely suicide prevention and intervention as it relates to best practices that have been successful in tribal communities. For the last two years, and once again next month, One Sky has been a contributing partner of the *Indian National Indian Behavioral Health Conference* sponsored by the Indian Health Service and the Substance Abuse Mental Health Services Administration. This annual conference has been steadily gaining momentum in the critical areas of substance abuse and mental health services in Indian Country, and *although the One Sky Center has been actively and substantively involved in the year's past, it is unclear as to what the future holds for the One Sky Center as its current cooperative agreement with SAMSHA concludes June 30, 2006. We hope to continue in the future as a leader and partner with Indian Country in these important and critical areas affecting Indian people. By providing leadership training, technical assistance and consultation, we see the One Sky Center as a critical link in the Senate's proposed Suicide Prevention legislation, the multiple agencies that will provide the services, and the tribal programs.*

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McCain Discussion Draft Comments:

Overview

The One Sky Center is honored to be able to offer its comment, suggestions, and recommendations to the Senate Committee on Indian Affairs on the McCain legislation on teen suicide prevention. In general, the One Sky Center supports the McCain legislation as a good step in addressing suicide prevention and intervention. However, the bill does not include some underlying substantive issues of teen suicide that still need to be addressed. The legislative suggestion to include tribal participation in current mainstream suicide prevention networks (the Lifeline Network), and use other federal agency technologies (Department of Defense and CDC) are cost-efficient, practical attempts to include and align American Indian and Alaska Native services and infrastructure with the mainstream. However, federal interagency coordination and cooperation on Native health concerns (which is less than satisfactory now) will be necessary to make these efforts successful.

Sec 4. Coordinator of Indian Telemedicine Programs

There certainly is room for continued involvement and use of telemedicine throughout Indian Country Telemedicine is a powerful means of delivering consultation and education to the front lines from centers of expertise. It requires infrastructure and expertise at both sending and receiving ends. There are jurisdictional and policy issues to be worked among the Tribes, medical associations, states, and liability insurers. To realize Telemedicine's potential, a great deal for infrastructure development, professional capacity building for utilization, operation, and maintenance, and the financial ability is needed. It would be helpful to have national leadership in orchestrating the multi-site, multi-jurisdiction, and multi-capacity development needed to make Telemedicine a more widely used resource.

Building Systems of Care

Embedded in Sec 4 under Duties (c) is an extremely important mission which could be seen separately from Telemedicine and could be entitled *Building Systems of Care.* Subsec (1) lines 6-17 "...shall identify and enhance...connections between health-related programs and services...including...by the Service and...by Indian Tribes...." Strategic planning, coordination, and harmonization of operational plans, finance, policy, and services would, indeed, be a major contribution. Lack of such system is a significant source of inefficiency and ineffectiveness, in our observation.

Sec. 5. National Suicide Prevention Lifeline Network Indian Demo Project

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National Suicide Prevention Lifeline Network Indian Demo Project would be beneficial to complement the existing National Suicide Prevention Lifeline Network by adding a culturally relevant American Indian and Alaska Native model program. The goals and objectives of the existing program would be useful to the native community; however, there are questions as to whether or not this program could succeed with five select centers in Indian Country, the tribal staffing needs that would be required, the operations and maintenance of the network, in addition to financial and capacity sustainability concerns. Although there is always some preliminary skepticism within Indian Country of anything new and unprecedented, the concept is one worth exploring as a viable option to address some of the need of suicide prevention and intervention. A demonstration project for five regional IHS areas could lead the way to future incorporation of the Network.

Sec. 6. National Violent Death Reporting System

Currently, the CDC has a national system for reporting deaths, including suicide. However, this system lacks information on context and victim/victimizer characteristics, which are vital to discerning causal patterns and planning amelioration. The National Violent Death Reporting System, which does include such information, is being piloted in five states. There are various Tribal privacy needs, attitudes toward death, historical difficulties with researchers, and lack of infrastructure. Very substantial effort may be required to actually collect the data. A grant program to establish a system for data collection and information for the National Violent Death Reporting System could be beneficial. The system could provide insight as to why American Indian and Alaska Native suicides happen, and can build upon existing limited data of CDC reporting of deaths to better assess and evaluate the extent of the problem and cause of suicide in Indian Country.

Recommendations

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There are several issues that could be addressed in this proposed legislation:

First, there is a need to consider tribal infrastructure. Will there be trained staff available, and how can we maintain their licensure certification? Technical assistance and coordinated training of staff and tribal leadership by a national coordinating center would greatly enhance quality of care and sustainability.

Second, there needs to be an interagency task force working with tribal leadership at each site that will implement better shared and coordinated programs to reduce fragmentation and silo funding. Multiple funding streams and diverse project agenda without coordination make the overall health care system overly complex and misdirected.

Third, the idea of implementing a national suicide network will require strategic planning and placement. Again, the use of a national coordinating center with a steering committee and advisory body would greatly improve successful outcome. Tribal involvement and input from the National Indian Health Board and the National Congress of American Indians would be useful.

Finally, telemedicine could be useful after face-to-face contact not just with direct patient care but also with technical assistance, consultation and training of tribal leaders, staff and the entire community. We have used this approach at the One Sky Center and have found it to be quite effective as long as there has been initial contact and a positive, trusting relationship is established. All of these efforts require close study and follow-through in a team approach from the administration of resources to the direct services provided. We at One Sky Center are ready to assist in that coordination.

Conclusion

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The unmet needs of American Indian and Alaska Native people in the areas of health care, substance abuse, and mental health services have been neglected. It has reached a point that the U.S. Civil Rights Commission labeled the problems a "quiet crisis." Sadly, one direct result of the shameful neglect is a severity of substance abuse and mental health issues that plague tribal people and their communities. Suicide, violence, methamphetamine abuse, and HIV/AIDS are all issues that are not traditional to native people or their traditional communities. These problems are increasing throughout most of Indian Country and creating panic, alarm, demoralization and great concern in families, tribal communities, and in the mainstream national dialogue to find answers and solutions. There is a long way to go with many complex issues to address, but the McCain legislation on native teen suicide prevention is one step to put a strategic plan in place.

As this Committee and Indian Country now realizes, there is a crisis throughout Indian Country involving suicide, other and mental health problems, and substance abuse. The One Sky Center came into existence to be on the front lines to address some of these issues, but as the crisis is reaching a breaking point, the future of our Center is uncertain and unclear. We look forward to working with your Committee on that front in hopes that Indian Country will continue to be able to rely on the One Sky Center on this and related issues.

We commend Senators McCain, Dorgan, and the Senate Committee on Indian Affairs for holding this hearing, requesting comment on the McCain legislation, and especially to the Oregon Delegation for their support on these issues, namely Senator Gordon Smith. The One Sky Center stands ready to assist the Committee on this issue, and we will hope to exist in our committed work beyond our June 30, 2006 conclusion date under our current SAMSHA cooperative agreement.

Thank you very much. This concludes the written part of my testimony.

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May 16, 2006

Senator John McCain
241 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

Dear Senator McCain:

As a Native American woman and a mother of a son who committed suicide in the year of 1998, I find it a blessing and an honor to write this letter to you to be able to share my deepest concerns of my native people, and my innermost thoughts. I am at times very troubled at our situations here on our reservations where there are things that happen to our children through no fault of their own.

We have children that still feel that their lives are not worth living. They feel that they are worthless, and that they have no potential. There are no kind of facilities to provide the right kind of care that our children so desperately need.

The poverty here on our reservation is, as well as other reservations, sad, very sad. We have children in our school who sometimes come to school without a meal all weekend, or are wearing dirty clothes. They have no running water, no heat, no electricity.

This leaves the churches and the school the only alternative for most of our children to turn to for help. Sometimes we can't fill all their needs, such as love and affection, and just a loving touch from someone who cares and will comfort them.

I am a recovering alcoholic, and a Christian who loves the Lord with all my heart, and dedicated my life to Him if only He would help me. I love my Indian people so much and see how much our children hurt from all these terrible things that the alcohol and drugs are doing to these families. My life as a single mother wasn't the best for my children. I did all that I had to do to keep my children fed and clothed. It wasn't easy.

When my son took himself from me, I wanted to die, too. I even asked God to take me, too. When all the suicides continued in 1998, I wanted to help our children so bad, but what could a women, a mother, do all by herself? What could I do to help our people! Who would listen to me! Bring somebody, GOD, was my plea, send someone who cares. Send us someone who won't just be in it for themselves, and receive all the glory, and not just throw us all by the wayside, as most people who said they cared did.

People are always trying to do things here, but don't have the heart. They just see the dollar sign and the glory. I give all the glory to the Lord for what He is doing in my life. Today, as I write this letter to you, I am using the computer at the school where I am currently employed. I have never had access to one before in my life. The God I love has placed me in this school system where all of the children are. And He has a plan for me in being a speaker for our children. And loving children all my life, I have been a caregiver to children, to homeless people who feel that they are condemned by the community for the disease that they have, and at one time I had also; alcoholism.

It's not a pretty picture, but a true one. Our lives here in this community isn't what we would like it to be. My concern in the safety of our children, but the drugs and

the alcohol is all that seems to be the only thing that they have to look forward to doing, aside from the gambling, that I believe brought the seemingly more neglect of our families.

The pain and neglect, and loss of spirituality among our people, and no one around to commit to the children of our community to help our young ones to become involved in projects. We need people out there who show great concern for our native people. There is so much depression and loss of identity that people think that it's the natural way of life. They believe this is how it's supposed to be; but it isn't. Finding myself and my identity as a child of God and feeling all the hate and scornfulness of one another in different cultures and society. Even among our own culture we have prejudice toward one another.

I don't understand this, but I do understand that we need to help our children, our people, my people, my neighbor, my native brother and sister, my brother and sister in Christ.

I've been to ASSIST training for suicide, to learn how to talk to people on the phone, to talk to them when a person feels or has the thoughts of suicide; but what if we couldn't be there?

We need counselors. We need anger management camps. We need much more than just the talks. We need concerned people such as you. I would like to thank you from the bottom of my heart for the concerned and caring person that you are. I am raising grandchildren that I want a better life for, and for them to know that they are worth everything that God put them on this earth for, that they have a life. With help from others, they will prosper. They are our future and will be leaders, and lead the right way.

Thank you for caring. Once again, I am honored to be writing to you on behalf of my Standing Rock Nation and myself and family.

Respectfully,

Donna Archambault

Donna Archambault
Home School Coordinator
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May 14, 2006

Senator John McCain
241 Russell Senate Office Building
United States Senate
Washington D.C. 20510

Dear Senator McCain:

I am writing to you with concern for the condition of our youth on the Standing Rock Sioux Reservation. I was unable to testify in person due to community commitments for high school graduation this week; but due to the importance of this matter, I still wanted to share with you the condition of our area, as I see it. Over the past two years, we have seen a large number of youth suicides achieved and also a large number of suicides attempted. Every time I hear an ambulance siren, I pray it is not another suicide attempt. I personally have known six of the suicide victims in the McLaughlin, South Dakota area. It is difficult to watch children grow up, knowing that they are full of potential and possibilities, and see them give up due to hopelessness.

As a Christian and a pastor's wife, I believe that this is a spiritual problem. Lack of truth and knowledge about God, the One who created us, leads to hopelessness. When mixed with chemical dependency and addiction, that problem can prove to be lethal. I realize that the government's solution to this problem is more funding. Where funding can create facilities, it is not the final answer. What we have currently is a band-aid to a severe infection. Until the drug and alcohol problem is dealt with properly, we will not see an end to this problem.

Even in our small community the drug and alcohol supply is overwhelming. Law enforcement at all levels hide behind the sovereignty issue, shifting the burden of solving the problem back and forth to each other. This allows for drug trafficking to thrive. It is evident even to those that are not professionally trained in this area when the drug traffickers are in town. Methamphetamines are being made in the community and sold. Youth can find an ample supply of affordable drugs and use them to fill the void of hopelessness.

Many youth find their homes unsafe and very threatening. Some choose living in abandoned cars, condemned homes, alleys, etc., to escape their terrible home life. These children become victims to the people selling the drugs in this area. There are no "safe homes" available for these children to seek refuge.

Living in rural South Dakota, services for mental health, detoxification and chemical dependency are very minimal. Youth in this area find it very difficult to get transportation to these facilities for the treatment that they do need. Community-based support is lacking.

I have lived in the McLaughlin area, located right in the middle of the Standing Rock Sioux Reservation, for 16 years. I have come to know and love the people that reside on the reservation. The children are so very special to me. Their creativity and their talents are truly a gift from God. It is heart-breaking to realize that I have attended

more funerals for youth over the past few years than I have attended in my 39 years of life. To me that is a sobering thought.

I thank you, Mr. McCain, for your care and concern for this matter. I consider it an honor to write to you and share my thoughts with you. I know that we need to see a lot of changes in order to properly deal with this problem. Two weeks ago, another 15-year-old boy died from suicide; two other boys lived after attempting. For some of the youth in our area it is too late, but for the others it is worth continuing the fight. Thank you for your help.

Respectfully submitted,

Patricia Schmeichel

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